

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

Service needs and uptake amongst children in out-of-home care and their carers





Pathways of Care Longitudinal Study

Research Report No. 10

Service needs and uptake amongst children in
out-of-home care and their carers.

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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.

About the information in this report

All the information in this report is accurate as of February 2018. The analyses presented are based on a an almost final version of the Wave 1 and Wave 2 unweighted data collected in face-to-face interviews with children, young people and caregivers; and FACS administrative data.

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

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Contents

Contents	iv
List of abbreviations	viii
Preface	ix
Executive summary	1
1. Introduction	7
2. Research questions	8
3. Literature review.....	9
3.1. Introduction.....	9
3.2. Methodology	9
3.3. Wellbeing of children in OOHC.....	11
3.4. Definition	13
3.5. Aim of the literature review	13
3.6. Health	13
3.7. Education	19
3.8. Casework	29
3.9. Conclusion.....	37
4. Sample, definitions and methods	38
4.1. Introduction.....	38
4.2. Data sources	39
4.3. Outcome measure and independent variable derivation and definitions	39
4.4. Derivation of child service needs items	39
4.5. Description of sample used in analysis.....	42
5. Children's need for services	45
5.1. Measuring need for services using the POCLS	45
5.2. Study child general physical health	46
5.3. Potential need for services	47
5.4. Combined number of types of service needs	49
5.5. Regression—potential need for services by placement type	51
5.6. Summary—need for services at Wave 1	53
6. Children's change in need for services.....	55
6.1. Change in rating of overall health over time	55
6.2. Change in potential need for services associated with carer-reported long-term health conditions.....	57

6.3.	Change in potential need for services associated with socio-emotional development	58
6.4.	Change in potential need for services related to cognitive development	60
6.5.	Change in service need associated with physical development	60
6.6.	Change in the mean number of types of service needs over time	61
6.7.	Summary—change in need for services over time	64
7.	Health service and specialist utilisation	66
7.1.	Service use analytic definitions	66
7.2.	Service use prior to Wave 1 interview	66
7.3.	Service use across both waves	67
7.4.	Regression—service use at either wave	69
7.5.	Carer rating of service needs being met	70
7.6.	Regression—need for services being met across both waves	71
7.7.	Summary—health and specialist service use	72
8.	Barriers to service use	74
9.	Support for carers	75
9.1.	Casework support for carers	75
9.2.	Informal support for carers	80
9.3.	Professional support for carers	83
9.4.	Summary—carer support	88
10.	Discussion	90
11.	Limitations	93
	References	94
	Appendix Outcome measure derivation and definitions	103

List of figures

Figure 5.1	Average carer rating of study child's current physical health (1 = very poor, 6 = excellent) at Wave 1 by age group	46
Figure 5.2	Prevalence of potential needs for services related to socio-emotional issues, cognitive issues and carer-reported long-term psychological health conditions amongst children in care at Wave 1	48
Figure 5.3.	Prevalence of potential needs for services related to physical development and carer-reported long-term physical health conditions amongst children in care at Wave 1	49
Figure 5.4	Average number of types of services potentially needed by children in care at Wave 1	50
Figure 5.5	Number of needs/issues at Wave 1 by age group	51

Figure 5.6 Estimated marginal means—Poisson regression of number of service needs/issues by child age group at Wave 1	52
Figure 5.7 Estimated marginal means—Poisson regression of number of needs/issues by children placement type at Wave 1	53
Figure 6.1 Change in carer rating of children's overall health, Wave 1 to Wave 2....	56
Figure 6.2 Change in the existence of any long-term health conditions, Wave 1 to Wave 2	58
Figure 6.3 Change in socio-emotional development needs/issues, Wave 1 to Wave 2	59
Figure 6.4 Change in cognitive development issues, Wave 1 to Wave 2	60
Figure 6.5 Change in physical development issues, Wave 1 to Wave 2 (children aged 9 months to 5 years only)	61
Figure 6.6 Mean number of service needs/issues at Wave 1 and Wave 2 by children's age at Wave 1	62
Figure 6.7 Count of service needs/issues at Wave 1 and Wave 2 by children age at Wave 1	63
Figure 7.1 Service use during current placement at Wave 1	67
Figure 7.2 Service use, Wave 1 and Wave 2 and change between waves	68
Figure 7.3 Carer rating of how well study children's needs for services are being met at Wave 1, by children's age at Wave 1	70
Figure 7.4 Carer rating of how well study children's needs for services are being met at Wave 2, by children's age at Wave 1	71
Figure 8.1 Barriers to service access amongst carers reporting any barriers in Wave 1 and/or 2, multiple choice.....	74
Figure 9.1 Ability to reach caseworkers when needed—foster and relative/kinship carers, Wave 1	76
Figure 9.2 Assistance from caseworkers, foster and relative/kinship carers, Wave 176	
Figure 9.3 Working relationship with other agencies related to study child, foster and relative/kinship carers, Wave 1	76
Figure 9.4 Average satisfaction rates for caseworker and associated agencies amongst foster and relative/kinship carers across Wave 1 and Wave 2.....	77
Figure 9.5 Frequency of face-to-face contact between caseworker and relative/kinship and foster carers Wave 1	79
Figure 9.6 Frequency of phone or email contact between caseworker and relative/kinship and foster carers Wave 1	79
Figure 9.7 Average contact frequency with caseworker across waves 1 and 2.....	80
Figure 9.8 Type of informal support often or always used by carer across Wave 1 or 2	81
Figure 9.9 Amount of informal support for carers, Wave 1 and Wave 2	82

Figure 9.10 Professional services and supports used by carers across Wave 1 or Wave 2	84
Figure 9.11 Average number of professional services used across Wave 1 and Wave_2	84
Figure 9.12 Mean rating of helpfulness of professional services used in Wave 1 and Wave 2	86
Figure 9.13 Difficulties in obtaining professional support services across Wave 1 and Wave 2	86
Figure 9.14 Services and supports used when study child first placed.....	87
Figure 9.15 Number of services used by carer when child first placed, Wave 1	87
Figure 9.16 Services desired but not received by study child-carers reporting a need, Wave 1	88

List of tables

Table 4.1 Cut-off information and age coverage for health and development measures.....	41
Table 4.2 Characteristics of children at Wave 1 and 'n' and '%' of respondents with two waves of responses	43
Table 5.1 Summary of ordinal regression of carer rating of study child's physical health at Wave 1.....	47
Table 5.2 Poisson regression summary—number of potential service needs/issues amongst children and young people at Wave 1.....	52
Table 9.1 Univariate analysis of regression summary—average carer satisfaction with relationship and assistance from caseworkers and associated agencies across Waves 1 and 2.....	78
Table 9.2 Univariate analysis of regression summary—average carer contact with caseworker across Waves 1 and 2.....	80
Table 9.3 Univariate analysis of regression summary-average amount of informal support for carer across waves 1 and 2.....	83
Table 9.4 Poisson regression summary—average number of service types accessed by carer across Waves 1 and 2	85

List of abbreviations

The following is a table of definitions of terms used in the analysis.

Term	Definition
BITSEA	Brief Infant-Toddler Social Emotional Assessment
CALD	Culturally and Linguistically Diverse
CBCL	Child Behaviour Checklist
Children	Child or young person
FACS	NSW Family and Community Services
FACSIAR	Family and Community Services Insights Analysis and Research
KiDS	Key Information Directory Service
OOHC	Out-of-Home Care
POCLS	Pathways of Care Longitudinal Study
Wave 1	Wave 1 of the POCLS
Wave 2	Wave 2 of the POCLS

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 www.community.nsw.gov.au/pathways.

Executive summary

The Pathways of Care Longitudinal Study (POCLS) is a large-scale prospective study that follows children and young people age 0–17 years entering Out-of-Home Care (OOHC) for the first time under the *NSW Children and Young Persons (Care and Protection) Act* (1988). It follows children regardless of their trajectory, including after they have left care. The POCLS includes children of all ages, all geographic locations in New South Wales (NSW), and all placements with government and non-government agencies (New South Wales Department of Family and Community Services, 2015) (Paxman, Tully, Burke, & Watson, 2014).

This report provides an analysis of two waves of the POCLS. The analysis focuses on the need for and access to services for children, focusing on specialist services such as paediatricians, as well as universal services such as dentists and general practitioners. The report also examines the formal and informal supports for carers. The report includes a review of the Australian and international literature on service engagement for children in OOHC.

Other than the care provided by the carer, services such as health, education, childcare and counselling are likely to have the most impact on the wellbeing of children in OOHC. In particular, the role of the caseworker is crucial, providing direct support to the child and the carer, but also acting as a case manager, referring to other agencies where necessary and coordinating those services. Despite this, there is relatively little empirical evidence for the impact of services generally or of casework on children's outcomes in OOHC.

The literature review confirms that, in Australia and internationally, children in OOHC have very high levels of need and therefore require access to a range of mainstream and specialist services.

What issues are children in the POCLS cohort experiencing that may be associated with a need for services?

In this report, children and young people are considered to have a potential need for services if their carer reported that they are experiencing a long-term health condition lasting six months or longer, or if socio-emotional, cognitive and physical development scores collected via standardised measures were outside of the cut-off for usual development according to age. These items are referred to as potential needs for services (shortened to service needs/issues in some cases). Due to the method in which the need for services is calculated (which means that both carer reports and standardised measures are combined), these results are not intended to align with other analyses of the wellbeing of the POCLS cohort using the same standardised measures. In addition, this report does not present a diagnosis-based analysis of need for services, as no diagnostic information is available in the survey. These results therefore represent a proxy measure of service need. The samples used for this report vary according to the analysis; however, overall there are 1,285 children at Wave 1 and 1,032 children who had responses recorded for both Waves 1 and 2. More information about the derivation of service need and other definitions is available in Section 4.

- A high proportion of children and young people in care have indications of potential need for services: 39% with a socio-emotional development issue; 44% with cognitive development issues and 16% with carer-reported long-term psychological conditions; 40% with a carer-reported physical health condition. Half of the children aged 9–35 months (48%) and 31% of children aged 3–5 years had a physical development issue. Despite this, most carers rated the overall physical health of children in their care as good or excellent.
- Taking into account age group, placement type, cultural background and location, very young children (9–35 months) had more need for services than older children.

Multivariate logistic regressions of each service need group, indicated that children in residential care were more likely to potentially require services related to socio-emotional development and psychological issues. Children in relative/kinship care are less likely to require services compared to other placement types, apart from services associated with long-term physical health issues. These findings are likely to be due to selection effects; for example, older children who have more vulnerabilities being more likely to be placed in residential care.

How does children's health and need for services change over time whilst in care?

- Carers reported that over half of the cohort (54%) had the highest overall health rating at Wave 1. By Wave 2, 24% had a better health rating than at Wave 1. Changes were consistent across age groups, placement types, location and cultural background. In contrast, 19% of all children were reported as having worse health at Wave 2 than at Wave 1, with those aged 12–17 and children in residential care being most likely to have deteriorated in their health ratings. Of all children, 57% had the same health rating at Wave 2 as at Wave 1.
- Analysis of the number of service needs/issues at Wave 1 showed that 48% of children had at least two types of issues assumed to be associated with a potential need for services, and 30% had one type. By Wave 2, the number of service needs experienced by children in care decreased across all age groups, with a 14 percentage-point reduction in the proportion of children with two or more types of service needs and an increase in the proportion of children with no types of service needs. Although there was an overall reduction, bivariate and multivariate tests found that age, cultural background, placement type, location and change of household were not associated with a change in the number of types of service needs.
- Analysis of change in carer-reported long-term health conditions between Waves 1 and 2 found that 17% of children had at least one long-term health condition in both waves, 16% of children had a long-term health condition at Wave 2 but not at Wave 1, and 27% had no health condition at Wave 2 after having one at Wave 1. Few demographic or placement variables were associated with a deterioration or improvement of a reported long-term health condition. Children age 6–11 years at Wave 1 were more likely to be reported

as not having a long-term health condition at Wave 2 after being reported as having one at Wave 1. Children in residential care were most likely to have a condition in both waves (i.e. at least one long-term health condition in both Wave 1 and Wave 2). Children who changed households were also more likely to have a health condition in both waves compared to those who stayed in the same household.

- No measured independent variables were associated with change in the level of needs/issues related to cognitive development between waves. With respect to changes in needs/issues related to socio-emotional development, children in residential care and those aged 12–17 years were more likely to experience a need in both waves. Children aged 9–35 months and those in foster care were most likely to improve in socio-emotional functioning. No other independent variables were clearly associated with improvement.
- There were mixed results relating to children who changed households between the two waves. Carer ratings of health went down between Wave 1 and Wave 2; however, carers also said that these children had their service needs met ‘very well’ in both waves. These findings may be a result of different carers responding in the two waves.

Which services are utilised by children in care?

In the POCLS, carers were asked to report whether the child or young person in their care had attended a range of health and allied services and specialists during the current placement. The results represent yes/no responses to questions about service use for a series of 12 service types (10 service types plus two grouped types representing ‘other services’ and ‘other specialists’). This information was collected at both Wave 1 (i.e. an average of 18 months after entering care) and Wave 2 (an average of 36 months after entering care). The results in this report do not report on the intensity or frequency of service use. Service use in the POCLS is also not directly associated with the reasons for use, nor is it associated with a known and diagnosed need for service.

- Services were generally well utilised by children after entering care. The most common service type attended was general practitioners, who were seen by almost all children in both waves.
- The type of service attended depended on age and estimated needs/issues experienced by the children. Early Childhood Health Centres and paediatricians were more likely to be attended by younger children; and dental services, speech pathology, behaviour management and counselling/psychology were more likely to be attended by older children. Hospital emergency departments were more likely to be attended by the oldest (12–17 years) and youngest (9–35 months) age groups; however, the reason for service use is not directly recorded in the POCLS.
- Multivariate analysis indicated that children with service needs related to socio-emotional development were more likely to attend speech pathology, paediatricians and behaviour management services if younger (under 6 years

of age), and paediatricians, counselling/psychology services and behaviour management services if older (aged 6 or older), compared to those in the same age groups with no socio-emotional service needs. Younger children with any carer-reported long-term health conditions at Wave 1 were more likely to attend a hospital emergency department, hospitals for an overnight/longer stay, paediatricians or counselling/psychology services compared to children of the same age with no carer-reported long-term health conditions.

- Young children in relative/kinship care were less likely to have attended Early Childhood Health Centres, dental services and speech pathology compared to young children in foster care. Amongst older children, those in residential care were more likely to access behaviour management services compared to those in other placement types.
- Young children in the northern non-metropolitan areas were more likely to attend a hospital emergency department, dental service, speech pathology or counsellor/psychologist compared to young children in the reference area (Southern Metropolitan¹). Older children in the northern non-metropolitan area were more likely to attend a counsellor/psychologist compared to those in the reference area. Those living in the western non-metropolitan areas were more likely to attend hospital emergency departments compared to those living in the reference area. No other locations were found to be influential in individual service access.
- Older Aboriginal children were less likely to attend counselling/psychologists compared to older children in other cultural groups; no other cultural background effects were observed and, overall, Aboriginal and CALD children had similar access to services as other Australian children.

How does service utilisation change after entering care?

- Similar averages in the proportion of children accessing services in each wave were observed, with the age of a child making the largest difference to service access. As expected for the cohort growing up, the largest increases in service access were also age-related, such as dental and behavioural services and speech pathology. Early childhood services and paediatricians showed the largest reduction in service access across waves.
- With respect to carer rating of a child's potential need for services being met, logistic regression found that carers rated children's needs being less likely to be met depending on location, age (increasing age), potential need for services related to socio-emotional development and/or cognitive issues at Wave 1, and any carer-reported long-term health conditions at Wave 1.

¹ NSW Family and Community Services districts were grouped into metropolitan and non-metropolitan in order to complete some analysis due to small cell sizes. More detail is available in Section 4.

- Children who changed households between Waves 1 and 2 had an increased likelihood of being rated as having their average service needs being very well met, despite results indicating that those who change household/carer are measured as increasing in their potential need for services at Wave 2.

What, if any, are the barriers to service utilisation?

- Relatively few carers reported that their child needed a service but could not access it.
- The most common reported barrier to service access was long waiting lists.
- No additional analysis was undertaken due to very small sample sizes amongst those reporting that the children experienced a barrier.

What kinds of casework, professional and informal supports are carers receiving?

- Overall foster carers and relative/kinship carers expressed high levels of satisfaction with caseworkers and with other supports they were receiving.
- In general, relative/kinship carers accessed lower amounts of professional, informal and casework support. Although they also have children with fewer potential needs for services, these relationships remained once potentially confounding variables were accounted for using multivariate regression analysis.
- Relative/Kinship carers had lower average satisfaction rates regarding the communication, relationship and assistance from caseworkers and 'associated agencies'² compared to foster carers.
- Carers of children with a potential need for services reported lower satisfaction rates with the communication, relationship and assistance from caseworkers and associated agencies compared to carers whose children did not have a potential need for services.
- Foster carers report significantly more contact with caseworkers across both waves of the survey compared to relative/kinship carers. No other variables had significant associations with contact between carer and caseworker, including numbers of needs/issues of children in their care.
- Face-to-face contact with caseworkers on a less-than-monthly basis was most commonly reported amongst both foster carers and relative/kinship carers; however, foster carers reported more face-to-face contact compared to relative/kinship carers. There were larger differences in frequency of phone/email contact, with 29% of foster carers reporting weekly contact, compared to 8% of relative/kinship carers. Monthly phone/email contact was reported by 49% of relative/kinship carers compared to 27% of foster carers.

² The term 'associated agencies' is taken directly from the questionnaire and is not further specified.

- Relative/Kinship carers also reported lower rates of informal support compared to foster carers, both in the range of supports that often or always provide support to the carer, and the overall amount of informal support. Again, this relationship remained once other potentially confounding variables were included.
- Informal support rates were highest amongst those living in the western non-metropolitan area, and lowest for carers in the southern metropolitan area.
- There were large differences in the types of professional services used; the largest difference was for carer support organisations and groups, which 44% of foster carers and only 16% of relative/kinship carers reported using.
- Amongst relative/kinship carers, childcare, respite care and counselling/psychology services were the most commonly used services, whereas amongst foster carers, carer support organisations, child care and respite care were most commonly used.

Overall, the findings from this analysis indicate that the POCLS cohort was faring relatively well in their first years of being in OOHC:

- Wellbeing appeared to be improving over the two waves.
- Access to services was generally good.
- Carers do not report significant barriers to services.
- Carers are generally satisfied with casework support and communication.
- Aboriginal and CALD children seem to be doing as well as others and have similar access to services.

1. Introduction

This report provides an analysis of the first two waves of the Pathways of Care Longitudinal Study (POCLS) for children in Out-of-Home Care (OOHC) in New South Wales (NSW).

The POCLS is a large-scale prospective study that follows children and young people aged 0–17 years entering OOHC for the first time under the *NSW Children and Young Persons (Care and Protection) Act (1988)* across NSW within an 18-month period between May 2010 and October 2011. It follows children regardless of their trajectory, including after they have left care. The POCLS includes children of all ages, all geographic locations in NSW, and all placements with government and non-government agencies (New South Wales Department of Family and Community Services, 2015; Paxman, Tully, Burke & Watson, 2014).

The POCLS includes children and young people who enter care and:

- remain with the same carer
- move to a new carer
- are restored to their birth parents (planned and self-restored)
- are adopted
- re-enter care or
- leave care because they are ageing out.

See Section 4 for more details and

<https://www.facs.nsw.gov.au/resources/research/pathways-of-care> for further information about the cohort, the methodology for the study and other reports related to the study.

The analysis examines the need for and access to services for children in the POCLS cohort. The report also examines the formal and informal supports for carers, who have their own needs arising from their personal circumstances as well as their role as carers. A particularly important service for children in OOHC and their carers is the support provided by caseworkers. Caseworkers not only provide direct support to both carers and children, but also act as a conduit to other services and supports. The report therefore has a specific focus on engagement with caseworkers. The report includes a review of the Australian and international literature on service engagement for children in OOHC. The literature review confirms that, in Australia and internationally, children in OOHC have very high levels of need and therefore require access to a range of mainstream and specialist services. The review found very little research on the nature and extent of services use by children and carers, or the outcomes of service use in terms of the wellbeing of children. The report is therefore intended to fill in some of these gaps in the evidence base. As this is an analysis of only two waves of the POCLS, the report does not address the outcomes of service use.

2. Research questions

The analysis in this study focusses on the service and support needs and utilisation of children in the POCLS cohort and their carers.

The analysis was designed to address the following questions in relation to these groups of children and their carers:

- What issues are children in the POCLS cohort experiencing that may be associated with a need for services?
- How do children's health and need for services change over time whilst in care?
- Which services are utilised by children in care?
- How does service utilisation change after entering care?
- What, if any, are the barriers to service utilisation?
- What kinds of casework, professional and informal supports are carers receiving?

3. Literature review

3.1. Introduction

This is a review of the Australian and international literature regarding the access to services by children in OOHC and the impact of health, education and other services on the wellbeing of children in care and their carers.

3.2. Methodology

The review draws on academic databases (Social Abstracts) and Family & Society Studies Worldwide, as well as the National Child Protection Clearinghouse (Australia); published reports from specialist research institutes; government reports and other web-based literature.

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

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

- British Association for Adoption and Fostering (BAAF)
- Center 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

The following Australian websites were utilised:

- Anglicare Victoria
- Anglicare Tasmania
- 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
- Social Justice Unit, Uniting Care
- Social Policy Research Centre, University of New South Wales
- Southern Cross University
- Queensland Child Protection Commission of Inquiry
- The Winston Churchill Memorial Trust of Australia

The literature reviewed was limited to English-language publications.

The Australian literature this review draws upon includes meta-reviews and research reports produced by FACSAR and its predecessors. 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 this work, Bromfield & Osborn (2007) provided a synopsis and critique of Australian OOHC research completed between 1995 and 2006. They found that, in general, the Australian research was of a very high quality; however, their survey of literature found that 11 of the 21 studies were based on data from a single South Australian longitudinal study (Bromfield & Osborn, 2007).

Audits of Australian child protection research have included a National Audit of Australian Child Protection Research 1995–2004 (Higgins et al., 2005) and 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 OOHC (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. A small number of European studies has also been included. 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 populations, legislation and systems of OOHC. 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 Australia. However, despite these system differences, international studies on factors and outcomes are relevant to the Australian context.

3.3. Wellbeing of children in OOHC

An overview of the current research into the wellbeing of children in OOHC conducted by the Commission for Children and Young People and Child Guardian (CCYPCG) in Queensland, found numerous research studies indicating that children and young people in OOHC, compared with their contemporaries, have lower levels of wellbeing (QLD, CCYPCG, 2013).

Many factors contribute to low levels of child wellbeing in care, including: poor health (e.g. multiple physical and mental problems); education and school problems (e.g. difficulties with reading, spelling, maths, etc.); lower levels of social competence and relationship problems; impact of the pre-care environment (e.g. maltreatment, social and emotional deprivation); and placement instability and/or multiple placements.

The overview found in relation to foster care placements, however, that there are many positive factors which can lead to improved wellbeing for children and young people. These include: mitigation of risk factors (i.e. safety); development of protective factors and resilience building for children; development of stable, secure and nurturing relationships with carers; better peer relationships; reduction over time of pre-existing behaviours; and involvement in decision-making. Carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are also important for improving children's wellbeing.

A survey of children and young people conducted by the CCYPCG (2013) found that certain placement characteristics indicated improved wellbeing. The survey of young people ($n=1,180$) and children ($n=829$) was based on the *Views of Children and Young People in Foster Care* survey, which covered children's and young people's attitudes towards and perceptions of their own education. Areas covered included educational status, key markers of educational disadvantage including suspensions and exclusions, and specific problems children and young people experience at school, as well as children's and young people's enjoyment of school and aspirations for the future. Information about educational support, including Educational Support Plans and support provided by Child Safety Officers and Community Visitors are also presented. The survey followed similar surveys in Queensland conducted in 2006, 2007 and 2009. A key finding of the survey was that:

Those with higher levels of wellbeing were more likely to have entered care at a younger age and have more stability in their lives, with better placement and school stability and continuity in their CSO [Community Services Officer]. 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. There are also clear benefits from well-matched placements, involving children and young people in decision making and lessening the impact of being in care by supporting children and young people in out-of-home care to live a 'normal life' through the provision of timely permissions and opportunities to engage in activities enjoyed by their peers who are not in care. (CCYPCG, 2013:2)

Meeting the needs of children and young people in care placement is crucial in ensuring that their wellbeing (in the domains of physical health, socio-emotional wellbeing and cognitive development) is being addressed, and that placement stability is being supported. Zinn et al., (2006) described two types of support that are required: child-specific services and placement-specific services. Children's needs are often age-specific and based on histories of past trauma and the impact of abuse and neglect. Their main types of support/services include health services (particularly mental health services), optical, dental, educational and therapeutic services (e.g. counselling, speech, physiotherapy), and recreational activities (McHugh, 2002; Sinclair & Wilson, 2003; Zinn et al., 2006). Placement-specific services include casework, case planning and management (McHugh, 2002; McHugh & valentine, 2010).

Timeliness of service provision

National literature on OOHC indicates that children coming into care have increasingly complex needs and challenging behaviours. Therefore, it is important that service provision is adequate, appropriate and timely. Delays in service provision impact on the ability of those responsible for the day-to-day care of children (e.g. foster and kinship carers, workers in residential settings) to carry out the tasks associated with their caring roles. 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.

The time period in which children in care begin to receive the services they require is critical. Research (Jones, 2010:9) indicates that 'the first six months of a placement are particularly important, with 70% of disruptions occurring within this timeframe'. A study in NSW by O'Neill et al., (2010) found that the first year of a placement requires the highest number of hours of worker and carer involvement, and that 'first year placements require intensive support' (O'Neill et al., 2010: 31). This finding is echoed in another Australian study which found that children frequently need intensive services as soon as they enter care (Stuck, Small & Ainsworth, 2000). KPMG (2010) found that foster parents wanted quicker access to therapeutic, health and education services. Difficulty in accessing services early in the placement has been found to be highly detrimental to children—it not only delays effective intervention, but can also affect placement stability (KPMG, 2010: Chambers et al., 2010). Evidence of being unable to access services and resources to support children in their placements also resonated in a Queensland study of foster and kinship carers ($n=20$) (Withington et al., 2016).

Type of placement

There is a persistent theme in national and international studies indicating that statutory kinship carers, when compared to foster carers, are less likely to receive the support and services they require to ensure that the needs of the children in their care are met (McHugh, 2013). It is argued that poor support and inadequate provision of appropriate services for statutory kinship placements (predominant placement type in NSW) is 'a reality that threatens to compromise the quality of care' (Falconier et al., 2010: 415). There is no research on the relative access of foster vs kinship carers to informal family and community supports.

3.4. Definition

In relation to child protection and/or child welfare systems in Australia, the term 'service/s' has a wide application. It is commonly used in the names of government departments responsible for child protection/welfare (e.g. Family and Community Services, and Child and Family services), implying that the whole OOHC system is a service. This literature review of service use is confined to the availability, access to and adequacy of a range of specific services that may be required to meet the individual needs of children, once placed in care. These include universal and specialist health and community services such as childcare, as well as services such as housing and other support. Finally, it includes services provided by caseworkers. The review covers the main care types utilised in OOHC: foster care, kinship care and residential care.

In conducting this review, web-based searches and selected national and international child organisations and government websites were used to source literature in relation to service provision for children in OOHC.

3.5. Aim of the literature review

The review focusses predominantly on child- and placement-specific services in the following areas:

- health (e.g. health care assessments, mental health, dental and other therapies)
- education (including education plans and child care), and
- casework (including nature, quality, intensiveness of visits/contact, case plans, annual reviews, child information and birth family contact).

Where research evidence is available, consideration is given to service provision reflecting various age groups, cultural diversity and disabilities of children in care. Available research evidence on the effect of placement type (i.e. foster, kinship and residential care) on services for children is also examined. The strength of the evidence for research findings is also commented on where appropriate.

3.6. Health

Children in care, compared to other children, have been found to experience more serious physical, mental and emotional health problems, many of which are undiagnosed and untreated on entry into care. National (Delfabbro & Osborn, 2005; Ford et al., 2007; KPMG, 2010; Sawyer et al., 2007; Tarren-Sweeney & Hazell, 2005, 2006) and international research studies (Clyman, Harden & Little, 2002; Halfon et al., 1992; Jarmon et al., 2000; Osborn & Delfabbro, 2006; Pecora et al., 2010; Vostanis, 2010) report that children and young people in care, compared to children in the general population, have higher levels of moderate to severe mental health

problems. In Australia, except for a 'handful of academic research papers, relatively little has been recorded about the health of children in OOHC' (Webster, 2016:10, 13). Unlike in the UK and the US, there is no national data set on the health needs of children in OOHC in Australia (Webster, 2016).

In their NSW studies of children in OOHC ($n=347$), Tarren-Sweeney & Hazell (2005; 2006) found that children presented with complex disturbances, including conduct problems, defiance, attachment insecurity, attention-deficit/hyperactivity, trauma-related anxiety and inappropriate sexual behaviour. A quarter of the children in their 2006 study were found to display clinically significant eating problems.

One NSW study found only three per cent of children ($n=122$) placed in care who underwent a hospital assessment had no health problems. Twenty per cent of the children failed a vision test and a quarter (26%) of the children assessed for hearing ($n=96$) failed the test. Speech delay for children under five years was found in 45% of the children, and 20% of older children had delayed language skills. Twelve per cent of the children had evidence of respiratory and skin infections. Dental problems were found in 33% of all children. The researchers also found behavioural or emotional health problems in over half (54%) of the children assessed (Nathanson & Tzioumi, 2007).

In another NSW study, researchers in a pilot project examining the referral, assessment and recommendation process for a cohort of Indigenous and non-Indigenous children ($n=52$) entering long-term foster/kinship care found that the most commonly reported issues/needs were aggression (30%), non-compliant and oppositional behaviour (28%), sleep disturbances (28%) and development concerns (28%). Speech and language deficits were also reported for a quarter (26%) of the children. Hearing problems affected 24% of children and 18% had vision deficits. Dental problems were found in half (52%) of all children over five years. At the second assessment (6–12 months later), the researchers found that less than half (40%) the recommendations covering a variety of services had been acted on. Contact (70%), medical (66%), and care and protection recommendations (62%) were more likely to have been followed up, compared to respite (44%), speech and language (40%), and caregiver support (40%) (Chalmers et al., 2010).

The researchers noted that providing services is more challenging when children present with high levels of comorbidity (i.e. physical, developmental and mental health problems) and that multiple problems necessitate multiple interventions. Whether recommendations were acted on depended on the availability of services (health and welfare) and ease of referral. Extensive waiting periods of 12 months or more for specialist counselling services; the scarcity and cost of private providers; and a lack of funding, treatment resources and options caused delays when attempts were made to access services (Chalmers et al., 2010).

A similar Queensland study of children placed in care who underwent a hospital assessment ($n=63$) found that 70% required multiple referrals to various health services, including paediatrician follow-up (41%), counselling services (30%) and audiology (26%). The study also found that foster carers appeared to underestimate the children's health needs. The researchers suggest that there is a need for

multidisciplinary health screens and training for carers to enable them to detect child health problems (Kaltner & Rissel, 2011).

The study by the Queensland Commission for Children and Young People and Child Guardian reported on the health vulnerabilities of children in care. Of interest was the comment by the Commission on reports of a child's 'disability' (e.g. cognitive/learning disorders, autism spectrum disorder, foetal alcohol syndrome, etc.). The Commission noted that some conditions were reported as a disability, but may more commonly be perceived as a health problem (e.g. attention deficit hyperactivity disorder (ADHD) and epilepsy). The commission suggests that the definition given by a respondent can inflate the numbers of children with mental health problems or children with disabilities (CCYPCG, 2010).

The Commission found that the rates of disability in the survey of children, young people and carers ($n=2,727$) varied depending on whether a child, young person or carer completed the survey. The Commission found that 18% of young people and 17% of children reported a disability. For carers of children (too young to self-complete the survey), the rate of reported disability was 23% (CCYPCG, 2010).

An overview of the health needs and health care of children and young people in OOHC in Victoria found a number of key contributing factors to the failure to monitor both health needs and care. Included among these factors were:

- underestimation by government of the life-long impact of child maltreatment on physical, developmental and psychological health;
- responsibility for decision making around identifying and meeting health needs and care being diffused and unwieldy;
- data on health needs not being adequately collected or analysed to inform policy and practice;
- excessive reliance by the OOHC system on foster and kinship carers in identifying and meeting children's complex and chronic health care needs;
- lack of adequate and/or reliable health histories and adequate input from health professionals;
- carers struggling to navigate complex health service systems for children, with many bearing significant out-of-pocket medical care costs;
- lack of collection and sharing of child and family health histories resulting in health professionals being unable to effectively assess children's health needs; and
- universal health service systems not being resourced to cater for the additional health service needs of children in statutory OOHC (Webster, 2016:1).

Health plans

For many children placed in foster or kinship care, the carer's general practitioner may be the first point of contact when children require health care or need a referral to a specialist (e.g. paediatrician). It is not unusual that when children are placed in care, family and medical history pertaining to the child may not be available to either the caseworker or carer (Chalmers et al., 2010).

In recognition that children in OOHC have significant, often unrecognised and unmet health needs, the Australian Federal Government, under the National Framework for Protecting Australia's Children 2009–2020, a *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care* has been introduced to enable general practitioners to conduct an initial and comprehensive health care assessment. The aim of the framework was to assist caseworkers in all jurisdictions to develop a child's health plan (Webster, Temple-Smith & Smith, 2012).

Awareness of the unmet health needs of children and a lack of health plans for children in OOHC led to the NSW Guardian conducting a Case File Audit (2008/09). The Audit found that where a child/young person had significant and/or complex health vulnerabilities, only one in 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, for example, asthma, epilepsy and diabetes. Whilst children may have been receiving appropriate treatment and/or services, it was not clear whether there was a consistent and coordinated approach in meeting children's needs (NSW Children's Guardian, 2010).

In 2010 in NSW, the OOHC Health Pathway Program was implemented. Similar to the Federal initiative discussed above, the program provides for the provision and coordination of health screening, assessment and intervention for children and young people in statutory OOHC based on the *Model Pathway for the Comprehensive Health and Development Assessments for All Children and Young People Entering OOHC*. An evaluation (case file audit in 2013–2014) of the program found that, in the three years since the program was introduced, 4,600 children had gained access to health assessments, clinical services and interventions. However, whilst most eligible children had been referred to the program, 'the timeliness of referrals remains at a low level' (Nous Group, 2014:1).

The development of a child's Health Management Plan (HMP) was a critical component of the program:

HMPs were generally completed within 90 days of the initial 2a primary assessment (91% based on audited case files). However, less than half of the HMPs were reviewed within the recommended time frames (based on the same audited case file data). (Nous Group, 2014:1)

Compared to non-Aboriginal children and young people, Aboriginal and Torres Strait Islanders have not fared as well as in regard to health assessments, clinical services and interventions. In part, this may be due to the difficulty in ensuring Aboriginal NGOs and carers take children and young people to appointments for services and interventions. (Nous Group, 2014)

Carer role and mental health vulnerabilities

In a study by Sawyer et al., (2007), the researchers interviewed carers of children in OOHC, who reported that over half (53%) of the children needed professional support for their mental health problems. Just over one quarter (27%), however, had been able to obtain this type of support during the previous six months. The researchers argue that the findings provide a major challenge for community and welfare services:

It is unrealistic to expect volunteer caregivers to provide 24-hour care and support for these young people unless they receive high-quality professional support and adequate respite. There is a great need to develop and evaluate new interventions to address the mental health problems experienced by these young people. (Sawyer et al., 2007: 184)

Studies have found that professionals (e.g. psychologists) need to 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). A UK study also notes the following:

- All foster parents and residential workers must have training in supporting the mental health needs of young people. This needs to be backed up with regular supervision and reflective support sessions.
- Young people identified foster parents, family members and participation workers as the adults they were most likely to talk to about their emotional wellbeing. These worked best and lessened the stigma of seeking help where relationships had been given time to develop and for trust to be earned, and support was provided in non-clinical settings whilst undertaking other activities. (Young Minds, 2012: 19).

Carer stress

The centrality of the carer role in managing behavioural and relationship difficulties was highlighted in the NSW study by Chalmers et al., (2010). At the time of the first clinical interview, the study found 21% of carers self-reporting stress levels of clinical concern, however, clinicians identified a level of caregiver stress in three quarters of all assessments. Whilst increased levels of carer support were recommended, 'Less than half (44%) of the recommendations suggesting increased caregiver support had been followed up by second assessment' (Chalmers et al., 2010: 520). The researchers point out that this lack of support for carers, especially in the area of mental health issues, can have significant ramifications not only for the carer, but for the child as well:

The mental health professional needs to be able to work with the carers on parenting strategies ... working with carers involves engagement with and assistance to them as they manage their own reactions to the child, their own stresses, and other relationships ... this work needs to be sanctioned by the agency ... and needs to be validated as part of their role ... there is a need to clarify the therapeutic role of any carer and provide relevant assistance to them. (Chalmers et al., 2010: 522)

Indigenous children

Mental health issues are also of concern for Indigenous children in care, who have been found to have a heightened risk of mental health difficulties (Sawyer et al., 2007 cited in Dobia & O'Rourke, 2011: 11). A small qualitative study, of predominantly Aboriginal kinship carers ($n=20$), reported that 18 of the children being cared for were on medication or receiving counselling from psychiatrists/psychologists for a range of conditions. The study also interviewed foster carers ($n=13$) and found, in relation to children's current health, that children of kinship carers had a broader range of physical and mental conditions than those in foster care.

Another small qualitative study found that the combined psychological disorders of Aboriginal children in kinship care also appeared more prevalent and serious than for non-Aboriginal children in foster care (McHugh, 2013). An analysis of 100 Aboriginal children's health records from an OOH clinic in south-western Sydney found that Aboriginal children had a similar range of identified health needs as other children in care and that the additional health needs of school-age children impacted on their ability to learn (Raman, Reynolds & Khan, 2011: 806).

Kinship placements

In an Australia-wide survey of formal and informal grandparents ($n=335$) raising their grandchildren ($n=576$), more than half of the survey respondents said that at least one of their grandchildren had physical problems, and more than 80% said their grandchildren had emotional or behavioural problems. 'More than one out of three survey families had grandchildren with both physical and psychological problems' (Brennan et al., 2013: 111). Evidence from this and other Australian studies indicates that many kinship families cannot access and/or afford appropriate support and services (including for mental health) for the children in their care (Brennan & Cass, 2013; Council on the Aging (COTA), 2003; Dunne & Kettler, 2006).

Research studies from the US have also found that children in kinship care have significant health vulnerabilities. In one study, children in kinship care were more likely than children in foster care to have pre- and post-natal substance-abuse exposure. Pre-natal drug exposure increases the risk of HIV, mental problems and developmental delays in children (Casey Family Programs, 2008; Falconnier et al., 2010; Keller et al., 2001). Another US study, examining the rate of mental health problems (i.e. emotional and behavioural problems) of children in kinship care, found that, similar to other children in kinship care arrangements, custodial grandchildren were reported by their caregivers to have higher levels of behavioural and emotional disturbances than children in the overall US population (Smith & Palmeri, 2007). US researchers suggest that children in kinship care 'are potentially at great risk for significant unmet mental health needs', due to a lack of support (Carpenter & Clyman, 2004: 675).

Australian studies of kinship carers reveal that some carers are reluctant to seek or accept assistance from government/non-government agencies (Brennan et al., 2013; Gerard, Landry-Meyer & Roe, 2006; McHugh, 2013). The researchers from these studies suggest that policies may need to be 'more sensitive and responsive' (Brennan et al., 2013: 65), and services should be 'more visible, accessible,

affordable and tailored specifically to the unique needs of grandparent caregivers' (Gerard, Landry-Meyer & Roe, 2006: 376).

Summary

Numerous national and international studies highlight the multifaceted health problems of children and young people on entering care. There is no national data set on children's health needs, provision and receipt of services for this group, so little can be said about their health outcomes, either whilst in care or when they leave care.

The implementation of health plans for all children entering OOHC acknowledged the necessity to meet their often unrecognised and unmet health needs. The limited amount of research evidence available appears to indicate that following on from the development of the plans, timely decision making and measures to ensure that appropriate medical and ancillary services are made available for children have not been taken. This impacts on the child's wellbeing, and carer (foster and kinship) stress levels and the carers' ability to provide quality and stable care.

The ultimate responsibility for addressing children's health needs appears to lie with a small group of professionals: the child's caseworker, the child's general practitioner and the various health services working with carers. Again, the limited evidence appears to indicate that these partnerships/relationships have not been particularly successful in achieving the desired outcomes for children in regard to health. An under-resourced universal health service system, with long waiting lists for specialist services and therapies, may also contribute the delay for children in care receiving the services they require.

Research indicates that improved training and increased support for foster and kinship carers in understanding and coping with children's health needs should be given higher priority.

3.7. Education

As with the growing national and international literature addressing the health and service needs of children in care, there is an increasing number of studies on educational needs and corresponding support services. 'Numerous studies, both local and international, have found that children in care have poorer educational results than other children' (Australian Institute of Health and Welfare (AIHW), 2015a: 1). A pilot study by the AIHW of children ($n=895$) on guardianship/custody orders found that they were considerably less likely to have achieved the national benchmarks for reading and numeracy across school years three, five and seven, compared with all children in each jurisdiction (Hunter & Mathur, 2007).

To gain a better understanding of the educational attainment of children in care, AIHW was funded to work with the jurisdictions in developing a national methodology for reporting on education outcomes. The inclusion of education-specific national indicators in the National Framework for Protecting Australia's Children 2009–2020 in

conjunction with *Australian National Standards for Out of Home Care*³ has increased the importance and urgency of implementing ongoing national data on educational outcomes of children in care (AIHW, 2013: v).

AIHW researchers linked data from the Child Protection National Minimum Data Set (CP NMDS) and the National Assessment Program—Literacy and Numeracy (NAPLAN) to compare results for Australian children in care with children in the general population (school years three, five, seven and nine)⁴. The results, based on the proportion of children who reached the national minimum standard (NMS), highlighted the gap between children in care and other children, with the gap increasing for children in the older age groups:

The study population had consistently and considerably lower NMS achievement rates than all students in Australia ... The gap between the NMS achievement rates of the study population and all students in Australia generally rose with increasing year level ... across assessment domains, rates were lower among the study population by 13–20 percentage points for Year 3 students, 13–25 percentage points for Year 5 students, 20–35 percentage points for Year 7 students, and 24–39 percentage points for Year 9 students (AIHW, 2015a: 10).

A recent study in England, using comparable methodology to the AIHW study, reports similar findings in relation to poorer outcomes for children in care compared to other children, and the widening of the gap for children in care in older age groups (Sebba et al., 2015). The research suggests that, in relation to older children (e.g. adolescents), it is not being in care itself which contributes to poorer outcomes, but other factors which may impinge on their progress. These factors include later entry into care for some children with more challenging difficulties and special educational needs. The research suggests that being in care may provide benefits, ‘but it does not fully reverse the damage that may have been done [earlier]’. In addition, the research suggests that adolescence brings with it its own set of difficulties/stresses for young people, which may lessen their focus on doing ‘well’ at school (Sebba et al., 2015: 5). This understanding of adolescents is reinforced in a Victorian study which surveyed educational outcomes for a group of children and youth in OOHC placements ($n=141$). The study found one group of students described as a ‘disengaging’ group ($n=39$).

Their characteristics were as follows:

- mean age of 15;
- moderate incidence of long-term health condition (18%);
- moderate incidence of learning difficulty (15%);

³ National Standard 6: Children and young people in care access and participate in education and early childhood services to maximise their educational outcomes.

National Standard 7: Children and young people up to at least 18 years are supported to be engaged in appropriate education, training and/or employment.

⁴ NAPLAN – National test of literacy and numeracy allowing policy makers to measure students’ achievements and provide data on student progress as they move through school.

- carers are younger (M=45), less likely to agree that they can help with homework and help child do well at school and have the least contact with schools;
- considerably older when first placed in care (M=8.9 years);
- moderately low incidence of specialised education support (13%); use of specialised support for behavioural and emotional problems;
- more likely to be attending TAFE or enrolled in school part-time;
- less likely to have homework, to have a suitable place to do homework and to get help from their carer;
- like school the least; absent from school more; read the least often, watch more TV and socialise out of school more; and
- high rates of school suspension (18%) (Wise et al., 2010: 21).

A number of issues, affecting all school-age children in care in relation to their educational progress, have been highlighted in national and international studies and include:

- pre-care experience (e.g. abuse and neglect);
- frequent school changes (student mobility);
- multiple placements;
- multiple suspensions and/or expulsion from school;
- lack of an education plan;
- lack of additional support (e.g. from regular teacher, school aide, tutor and carer);
- lack of focus by caseworkers and carers on educational progress and academic potential;
- likelihood of being older than others in their grade or repeating a class;
- transitioning from primary to secondary school;
- have attended a larger number of primary/high schools than other students;
- lower scores on standardised tests (indicating poor literacy and numeracy skills);
- missing substantial school periods (due to behaviour problems, suspension/expulsion and placement moves);
- truancy;
- bullying;
- high school dropout rates; and
- co-occurrence of health problems (e.g. behavioural and emotional disturbances) with educational issues.

Many of these issues, and how support and services may ameliorate these aspects, are covered in the literature reviewed below.

International studies

Few international studies indicate which specific educational interventions or services would 'best' improve foster children's educational prospects (Cox, 2012; Forsman & Vinnerljung, 2013). An overview of 11 intervention studies of children in care found that:

Tutoring programs at present have better empirical support, and also stronger theoretical foundations ... Other interventions with positive results focused on tailored individualized support or the use of an education liaison officer. (Forsman & Vinnerljung, 2012: 1089)

An overview of foster care studies in the US found that having high expectations for student success is a key factor influencing educational outcomes (Hattie, 2012). Similarly, a Canadian study of young people ($n=687$) in OOHC indicated that the support from foster families and their involvement with the child in an educational context—providing tutoring, helping with homework, availability of books in the home and academic expectations (of the caregiver)—predicted the academic success of youth in care (Cheung, Lwin & Jenkins, 2012).

One UK study found that three quarters of children in care are assessed as having special educational needs (Berridge, 2012). To support children in care with their educational needs, additional funding (£1,900) has been provided to local authorities in England for additional educational support (e.g. specialist tuition or one-on-one coaching) for every child in care (Children & Young People Now, 2013).

Australian studies

Findings from a National CREATE survey (McDowall, 2013) indicate that significant numbers of children ($n=168$) of primary school age in care had attended four or more schools. Primary school-age children in residential care were more likely to have changed school four or more times compared to children in other types of placements.

School changes and multiple placements

The CREATE study found that Indigenous primary school-age children in care were more likely to have changed schools four or more times compared to children from other cultures. The percentage of primary school-age children who had attended only one primary school varied between the jurisdictions, ranging from 54% in the ACT to 36% in Tasmania. In relation to secondary school-age children, the proportion attending one school only ranged from 77% in NSW to 54% in SA. The study found that Indigenous respondents had more placements (and greater placement instability) than those from other cultural backgrounds (McDowall, 2013).

Studies indicate that multiple placements and school changes are likely barriers to educational progress. A Queensland study found a positive correlation indicating that 'children and young people who had experienced more placement changes were also more likely to have experienced more school changes' (CCYPCG, 2013a:10). An earlier study linked multiple placements for young people with fewer years of schooling: young people who had not completed Year 10 had, on average, 10 placements, whereas those who had completed Year 12 had significantly fewer placements (Cashmore & Paxman, 2007). The impact of school changes on all children, including those in care settings, cannot be overemphasised. A study (using data from 2008–2014) by the NSW Centre for Education Statistics and Evaluation (CESE) of student mobility in government schools found:

Mobility has a detrimental impact on student outcomes, over and above other disadvantaging background factors and prior achievement. Compared to stable students with similar backgrounds and levels of prior achievement, mobile students achieve lower reading and numeracy results and are more likely to leave school prior to completing Year 12. The analysis indicated that the more times a student moves schools, the greater the impact, and that moves made during the year are more detrimental than moves made between school years. (NSW, CESE, 2016: 7)

School suspension/expulsion

In the CREATE study, the rates of school suspension indicate that children living in residential care were more likely to have been suspended and were more likely to have more frequent suspension than children in home-based placements. Males were more likely to be suspended than females. Children ($n=204$) who had to repeat a year of schooling were no more likely than other children to have been suspended (McDowall, 2013). Findings from an earlier study by CREATE indicate that:

Only 35.3% of care leavers [$n=196$] in CREATE's sample completed year 12 ... of the 27% of young people still in care [$n=275$] who already had left school, one-fifth did so because they had been expelled. (McDowall, 2011:10)

Educational services/support

Surveyed participants ($n=1,591$) in the later CREATE study responded to the question of who, besides their regular teacher, assisted them with their school work. The participants were more likely to nominate their carer first (32%), followed by a teacher aide (20%), a friend (16%), a tutor (10%), a family member (9%), a parent (8%) and a counsellor (1%) (McDowall, 2013).

The types of educational support that children ($n=947$) thought would be useful included: help with schoolwork (30%), help with homework (25%), help to control bullying (13%), financial support (11%), help making friends (11%), counselling (7%) and other support (4%). The researcher suggests that the finding that a third and a quarter of the surveyed children needed support with schoolwork and homework respectively raises issues which need to be addressed. This includes assistance within the classroom, tutorial assistance after school and carer training to assist children with their homework (McDowall, 2013).

Research suggests that to increase foster carers' knowledge and skills, 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, low self-esteem);
- how to instil educational aspirations and encourage/support academic achievements in children; and
- information on supporting career planning for young people in their care (Centre for Excellence in Child and Family Welfare, 2015; McCausland, 2014; McHugh & Pell, 2013).

Similar to the international studies, national researchers also highlight that the expectations and aspirations of a child's carer are critical 'to the educational engagement and attainment of children in OOHC' (Smith & McLean, 2013: 102). A recent study suggested building carers' understanding of their role in supporting the education of children in their care 'by providing positive encouragement and support with homework, reading and participation in extra-curricular activities' (Beauchamp, 2015: 20).

Special schools

In all Australian jurisdictions, depending on their educational needs, children may attend 'special' schools catering for children with high needs (e.g. disabilities, challenging behaviours, emotional disturbances, etc.) In the recent child protection inquiry in Victoria, it was noted in the final report that 'alternative learning settings' may be a better option for young people who cannot be, or prefer not to be, maintained in the mainstream education system (Cummins, Scott & Scales, 2012). A more negative assessment of 'special units' for children in care was reported in a UK study which found the units: 'offered limited academic opportunities and ... were ultimately stigmatising' (Working Group on Education for Children and Young People in Out-of-Home Care in Queensland, (WGEchildrenQ) 2011: 9).

Education plans

Children in care in all Australian jurisdictions are required to have an individual education plan. The names of the plans vary across the jurisdictions; however, in principle they have similar features. The aim of a plan, developed by the school (e.g. child's teacher) in collaboration with the caseworker, carer and child, is to identify the child's support or service needs in relation to educational progress and outline how desired goals are to be achieved⁵. In NSW, 10 OOHC Education Coordinators are available to assist schools in understanding the needs of children in care and improving compliance in the preparation of individual education plans (Beauchamp, 2015).

Despite the advantages of implementing education plans, it appears their use is limited (see Hattie 2012 and McDowall, 2013). A Commission of Inquiry into child protection concerns in Queensland found a number of failings with the plans. They were poorly implemented and funded, with little or no monitoring ascertaining whether funds were spent as intended. The plans were not developed as a collaborative effort. They were often left to a teacher to develop on their own, with little participation from caseworkers, carers or the child. The Commission found that only a third of the children said they had been involved in the development of their plan. The Commission noted a tendency for the plans to focus on managing behaviour, rather than engaging a child academically (Queensland Child Protection Commission of Inquiry, 2013: 236).

⁵ 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).

Another Queensland study suggests that foster carers, 'overloaded in their care duties' or feeling 'ill-equipped in their understanding of education systems and processes', limit their participation in educational plan meetings (WGEchildrenQ, 2011:11). In the CREATE study, only a quarter (25%) of the surveyed children ($n=267$) reported knowing of their plan. Knowledge was higher for children in Queensland and South Australia compared to children in the ACT, NSW and Tasmania. More children in residential care knew of their plan compared to children in other placement types. The survey findings indicated that few children were involved in the development of the plan. There was also great variability in jurisdictions as to the importance young people gave to being involved in planning. Benefits were seen by children in the ACT, the Northern Territory, South Australia and Victoria but not in NSW, Queensland or Tasmania (McDowall, 2013).

More positive findings on educational progress were found in a Queensland study with children and young people in care ($n=1998$). Only one quarter (25%) of all children had been kept back a year at school; most (88%) said they enjoyed school 'most of the time'; over half (53%) had an Education Support Plan, with most young people reporting the plan had been helpful; and most (88%) expected to complete high school (CchildrenCGa, 2013).

Education models/programs

An innovative model introduced by Berry Street, Victoria, focuses on the foster/kinship carer role in supporting the learning of children and young people in care, from early childhood and through their school years. The model 'Raising the Bar' utilises informal learning, which is defined as 'learning that is unstructured without time constraints and delivered casually between a caring mentor and the learner' (Berry Street Childhood Institute, 2014: 8). The model incorporates the use of a manual designed to help caseworkers train/support the carers in their role. Guidelines, supported by a range of resources, including tip sheets, checklists and education templates, are provided to caseworkers and carers. An evaluation of a pilot project trialling the carer education support model reported a raised level of carer awareness and understanding of the educational requirements for children in care, and participants found the training extremely valuable and relevant. The evaluation found:

When carers understood the concept of lifelong learning, and the need to assist children in care with the foundation skills that underpin formal learning, they could see a greater level of importance in their educational support role. (McCausland, 2014: 11)

In 2015, a review of Anglicare Victoria's TEACHaR 1 ('Transforming Educational Achievement for Children in Foster and Residential care') pilot program implemented in 2012 was conducted (David, 2015). The program used paid experienced teachers to provide direct support (e.g. one-on-one tuition, group work and flexible, informal learning) to children ($n=63$: 63% foster and 37% residential) in their home and classroom environments. The program also offered information, in-class support and professional development to school staff ($n=200$) about the care system, the impacts of development trauma, and children in care's special educational needs and learning difficulties. The evaluation found positive changes across a number of

educational domains for students in the program. Among the positive outcomes, the evaluation found that for children experiencing 12 months of intervention:

- the number of students working hard at school at an average level or above nearly doubled (32% to 59%);
- the majority of students (95%) were assessed as usually happy to be at school;
- approximately 20% more students were actively engaged in learning tasks following 12 months of support (59% to 78%); and
- a greater number of students (87% compared to 70% before program entry) were remaining in the same educational placement (school or preschool), increasing school stability (David, 2015: 41).

A further Victorian initiative is the establishment of LOOKOUT Education Support Centres in four areas of Victoria. Using a holistic and integrated approach, the Centres use education experts and support staff to work in partnership with schools, students and carers, to monitor and evaluate educational progress of children in OOH, set targets, and co-ordinate resources and activities to support the child's education at school and at home (Education, Victoria, 2015).

A small pilot program in Victoria had success in improving the educational engagement of children in care. The study of 25 children was conducted by The Smith Family and OzChild. The model included a full-time education worker and a support network consisting of agency and departmental case workers, carers, parents (where possible), teachers and other support staff. Each child had an Individual Education Plan, and The Smith Family provided literacy programs for the project. The project's evaluation found:

- some improved educational outcomes;
- some students' behaviour improved;
- children's happiness (i.e. well-being) increased or remained constant; and
- confidence at school improved.

A significant outcome for the agency (OzChild) was a better understanding of the education system for caseworkers and carers, and improved caseworker ability to advocate for individual children's educational progress (The Smith Family, 2012).

The Smith Family also provides long-term support through a national scholarship program called *Learning for Life*, set up for children (Aboriginal and non-Aboriginal) from disadvantaged backgrounds, including children in foster care placements. Students can begin the program in their first year of school and continue through to the completion of tertiary education (The Smith Family, 2016).

The program provides biannual payments to families, a program co-ordinator to work with the family and a range of short programs to assist children to develop the skills, knowledge, attitude and behaviour needed for long-term educational participation and success. Approximately 34,000 students are supported annually across all

Australian communities. The total average cost per student is around \$1,000 annually.

The program measures school attendance, school completion and post-school engagement in employment, education and training. Favourable outcomes from the program were as follows:

- high school attendance rates for children (91% for primary; 89% for secondary);
- over two thirds (68%) of young people had advanced to Year 12 (figures for 2013); and
- the majority (84%) of young people who left the program in Years 10, 11 or 12 were in employment, education or training 12 months later. The rate for Indigenous young people was 74% (figures for 2015) (The Smith Family, 2016: 8).

All Australian children have universal access to early childhood education (i.e. 15 hours per week) in the year before full-time school, with many children attending an early childhood education service. In 2014, close to 300,000 (n=297,400) children in the 4–5 year age bracket attended a pre-school program (ABS, 2015). However, it has been pointed out by researchers that:

A third of Australian children do not attend preschool for the number of hours needed to make a difference and children in poorer communities have fewer high-quality services available to them. More than one-in-five children start school with vulnerabilities that can make it hard for them to take up the opportunities that schooling provides ... Each year, 15 per cent of the children from the lowest socio-economic quintile and around 60,000 children in total enter school developmentally vulnerable. (O'Connell et al., 2016: v, vii)

There is limited Australian research on the participation rates of children in care in childhood education services (Beuachamp, 2015; Wise, 2015). In relation to younger-age children, particularly those at risk of abuse and neglect and/or being developmentally vulnerable, national and international studies indicate the importance of intervening early by providing high quality childhood education services (AIHW, 2015b; O'Connell et al., 2016; Ward et al., 2009; Wise et al., 2005). The AIHW welfare report indicated the particular importance of intervening early with regard to children from an Indigenous background:

Indigenous children were more than twice as likely as non-Indigenous children to be developmentally vulnerable on one or more domains of the Australian Early Development Census at school entry in 2012 (43% and 21% respectively). (AIHW, 2015b: 110)

A literature review of early childhood services, conducted by AIHW, noted research studies indicating that 'Children from disadvantaged backgrounds show the greatest gains from attending high-quality child care' and 'Indigenous children were most likely to benefit from high-quality preschool programs' (AIHW 2015c: vi).

Researchers suggest that if access to early education opportunities and school 'readiness' for Indigenous children is not ensured, their disadvantage may become cumulative, resulting in an increase in the educational gap between Indigenous and non-Indigenous students (Dobia & O'Rourke, 2011).

National Standards and Early Childhood Education Services: The National Standards for OOHC, introduced in 2011, have 13 standards with agreed and defined measures. Measure No. 6— 'Children and young people in care access and participate in education and early childhood services to maximise their educational outcomes'—has as one of its measures: 'The number and proportion of 3 and 4 year-old children who participate in quality early childhood education and child care services'. This measure is yet to be implemented; currently there is no national or state data on the number of preschool age children in care attending childhood education services (AIHW, 2015c).

NSW policies and programs

A number of policies have been developed in NSW to improve the educational outcomes of children in OOHC in the state. These include:

- In 2005, FACS and the Department of Education implemented a memorandum of understanding (MOU) that outlined collaborative work to help children and young people in care overcome obstacles and disadvantage through the sharing of information on services and research, joint case planning and regional protocols.
- In 2011, as part of the Keep Them Safe reforms, the MOU and Regional Protocols were revised to support a more coordinated approach with government schools (under the Education Pathway) to address the educational needs of children and young people in statutory OOHC.
- In 2012, FACS and the Catholic Education Commission NSW signed a separate MOU to identify, plan and respond to the educational needs of children in statutory OOHC in independent schools and preschools.
- In 2015, FACS and the Association of Independent Schools signed a separate MOU to identify, plan and respond to the educational needs of children in statutory OOHC in independent schools and preschools.

Summary

National data on educational outcomes for children in care allow departments and agencies to gain a better understanding of where to focus their priorities for improving educational outcomes, especially for children in older age groups. The Victorian study (Wise et al., 2010) clearly indicates that not only is more specialised education support required for older youth, in their home and classroom environment, but carers need greater support and training in developing their skills to assist children with homework, and to support and encourage school age children to do well at school. Depending on their own educational levels, some foster/kinship carers are unable to assist older children who may struggle with contemporary school work curriculums and required homework assignments. Better matching of children and

carers in relation to educational attainment of the carer and the need for educational support for the child, when children first enter care, could assist in preventing multiple placements and frequent school changes, and could promote the educational progress of all children in care.

Similar to health plans, the implementation of education plans requires partnerships/relationships between children, carers, caseworkers and teachers. Research evidence suggests that more can be done in this area to improve the involvement of children in their plan and ensure better educational outcomes. The three Victorian models discussed above indicate what works in assisting carers and teachers to support the learning progress of children in care.

It is of some concern that no national data is available on the attendance of preschool age children in early education centres. It is evident that there are significant gains to be made in ensuring that vulnerable groups—particularly children at risk of abuse and neglect or who are in care—have regular access to good quality early childhood education.

3.8. Casework

In all Australian jurisdictions, the provision of casework to children in care is a critical component of OOHG programs. In ensuring that the needs of children in care are met, a child's caseworker must develop a meaningful and supportive relationship with the child and the child's carer. In regard to placement stability, carer retention and achieving positive outcomes, the importance of child/carer/worker relationships cannot be overemphasised (AFCA, 2001; CCYPCG 2013b; Gilbertson & Barber, 2003; McHugh et al., 2004; Triseliotis, Borland & Hill, 1999).

Good relationships between worker/child and worker/carer allows children to confide in their caseworker, and carers to discuss their concerns with the caseworker (Cashmore & Paxman, 1996). It would appear, however, that relationships between workers and children are not always as strong as could be expected. When surveyed, children in the CREATE study were asked who they would confide in if they were worried about an issue:

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)

Foster carers

A NSW survey of foster carers ($n=450$) found that the majority of carers had a caseworker. Over two thirds of the carers (66%) had a very good/good relationship, one fifth (22%) said it was reasonable and just over a tenth (12%) rated their relationship with the caseworker as poor/very poor. Many carers were generally quite positive about a number of aspects of a caseworker's interactions with them. Around half (48%) were satisfied that the caseworker 'visited often enough', whilst a sizable proportion (45%) were not. Two thirds of the carers agreed that their caseworker

responds to telephone requests in a prompt and helpful manner, with over a quarter (28%) disagreeing with this statement (McHugh et al., 2004).

A significant majority (73%) agreed that the caseworker was interested in what they had to say and listened to their problems, and a similar proportion felt that the caseworker appreciated the work they do. Over two thirds of carers (67%) valued their caseworker's experience and suggestions and more than half (60%) of carers feel that their caseworker provided valuable input into the problems they face. When carers were asked what they considered was the most important type of support for maintaining and retaining carers, they responded overwhelmingly (84%) that it was more support from their caseworker (McHugh et al., 2004).

A national online survey was conducted with foster carers ($n=187$) of children age 4–12 years on the types of support they 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%). Carers were also asked: 'Who would be 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).

In a Queensland survey of foster carers ($n=778$) of young children, just over half (52%) of the carers stated that the CSO (Child Safety Officer) visited the child in their care monthly; a quarter (25%) said it was every three months; a tenth (11%) every three months; and around 12% saw the child's CSO once a year or less. A significant proportion of carers (81%) stated that they could contact their CSO most of the time (CCYPCG 2010).

An important aspect of the relationship between carer and caseworker is the notion that both are working together to meet the needs of the child in care. Dissatisfaction at not being treated as a partner of a child's care team, and not being involved in the decision-making process regarding the child, was highlighted in recent national consultations with foster carers ($n=92$). There was a consistent view by carers that this had an inhibiting effect on achieving best outcomes for the child (KPMG, 2010). Similar carer views were also expressed in a small Queensland study of foster and kinship carers ($n=20$) (Withington et al., 2016).

A study of foster carers ($n=796$) in the UK, investigating the qualities of caseworkers (i.e. Family Placement Officers) sought by foster carers found that the amount of regular contact between caseworker and carer predicted whether carers intended to continue or cease fostering. Carers who intended to continue fostering (79%) received weekly telephone contact from a caseworker compared to those who intended to cease (21%). Similarly, the comparison between the two groups who received telephone contact every two weeks was 86% and 14%, and for those who received telephone contact once a month 83% to 17%. The researchers found that having a good relationship with their caseworker influenced carers to continue fostering. The researchers note that telephone contact can only achieve certain purposes—it does not replace worker visits to the carer and/or child. They suggest:

Telephone contact, however, if carefully and systematically used, could reassure the foster carer as to the availability and interest of the social worker, alert the latter to problems before they became crises and save time on both sides. (Fisher et al., 2001: 232)

Kinship carers

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 (Brennan et al., 2013; McHugh, 2009; Yardley, Mason & Watson, 2009). In one study, it was reported that over a third (37%) of grandparent carers received caseworker support. Another third (29%) did not have a caseworker but would have liked to. A further third (34%) did not receive caseworker support and did not need it (Brennan et al., 2013: 25).

In a study of both foster and kinship carers in NSW, the carers reported mixed experiences in relation to having a caseworker, having one they were happy with or having one they felt they could contact if needed. Caseworker support for some foster carers, particularly those with long-term placements, appeared inadequate, though being experienced and knowledgeable helped carers to do what they thought was important for children. Some kinship carers were ambivalent about having a caseworker involved in their family lives, though others were pleased to have a worker they thought was 'good'. Kinship carers were less likely to say that they had a caseworker, and the lack of caseworker support appears to have been detrimental for some carers, as they had little understanding of the support they may have been entitled to receive (McHugh, 2013:35).

Children in care

An Australia-wide survey by CREATE, involving Indigenous and non-Indigenous children and young people in care ($n=1,069$), examined the relationship they had with their caseworkers regarding casework support and case planning. The children were aged between eight and 17 years and were in foster ($n=573$), kinship ($n=281$), residential ($n=104$) or other types ($n=111$) of care settings (McDowall, 2013).

Over two thirds (67%) of the surveyed participants said they could access their caseworker when they wanted, though children in older age groups appeared to have greater access than younger children. In regard to how helpful caseworkers were and how comfortable children and young people felt with their caseworker, 'average ratings of between "reasonably" and "quite helpful/comfortable" were received'. Younger children found caseworkers more helpful, and were more comfortable with them than the older group. Young people in residential settings found staff 'particularly helpful and welcoming of approaches from respondents' (McDowall, 2013:36, 86).

A Queensland study of children and young people in care ($n=922$) found that more than half (54%) reported seeing their caseworker monthly, and a further quarter (25%) reported seeing their caseworker every three months. Over a tenth (12%) reported seeing their caseworker yearly or less. Of those who had needed to contact their CSO, over a third (40%) reported that they could do this at any time, and a further third (31%) said they could do this most of the time. Close to two thirds (58%)

of young people, when asked if their CSO listened to them, said they did this all the time, whilst over a quarter (28%) said they listened most of the time (CCYPCG, 2010).

In a later survey of children and young people in care, the Queensland Commission found that of the 90% of young people who had met their caseworker, half (50%) saw their caseworker once a month, a third (31%) saw them every three months, and less than one tenth (7%) saw them annually or less. Close to three quarters (72%) of children who needed to contact their caseworker could do so, whilst smaller percentages (12%) could 'never contact' them or could contact them 'not very often' (16%) (CCYPCG, 2013b:17).

In focus groups with children and young people in care ($n=47$), conducted by CREATE in Queensland, the participants were asked about their relationships with their CSO (i.e. caseworker in NSW). Many participants provided statements of support for their CSO ($n=10$). They saw them 'as helpful adults who listened; provided material and emotional support; and ensured safety and stability'. Another significant group ($n=15$) expressed negative perceptions of their CSO and 'felt neglected, ignored and shut out of key processes that affected their lives' (CREATE, 2013:3).

Findings from a longitudinal study of children in foster care ($n=59$) in NSW, in relation to visits by caseworkers and the level of support offered to carers and children, indicate that a majority (63%) of carer families were visited fortnightly or monthly. In an 18-month period, caseworkers had visited with the carer/child 15 times and with the child alone, 11 times. As reported by caseworkers, the level of support they provided to carers was rated 'most frequently as "moderate work on a continuous basis" (37%) and their direct work with the child most frequently as "moderate work on a continuous basis" (44%)' (Fernandez, 2009: 1097).

A national survey of children in care ($n=2,083$) found that the majority (67%) reported that 'they usually get to have a say in what happens to them, and people usually listen to them'. In addition, most children (74%) reported that 'people usually explained the decisions made about them' (AIHW, 2015d: 7). Meaningful participation by children and young people in decision making benefits children's wellbeing: 'participation can build children and young people's self-esteem, sense of agency and enhance their dignity' (CCYPCG, 2013b: 10).

Case plans

Overall, just over a third (37%) of children and young people surveyed by CREATE had 'knowledge' of their case (or care) plan, with older children more aware of a case plan than the younger group. Only a fifth (21%) of respondents from NSW—the jurisdiction with the largest number of children in care—reported knowledge of a case plan. One third (33%) of participants who had knowledge of the case plan had been involved in the case planning process and another third (34%) had little to no involvement. Older children had more involvement than younger children (McDowall, 2013). McDowall suggests caseworkers could improve their performance in relation to involving children in developing their case plan. He argues that:

This process supposedly should involve the people whose lives are directly affected. Unfortunately, less than one third of respondents knew anything about the plan developed for them, and only one third of those who did know something of its contents had been involved to a significant extent in its preparation. Lack of participation was of particular concern in NSW. (McDowall, 2013: xix)

A large Queensland study involving young people ($n=527$) in care found that 63% of young people had a case plan, with 42% reporting that they knew what was in their plan. Over half (53%) of the young people reported they were mostly, or always involved, in developing their plan. Over two thirds (68%) of young people indicated that decisions were explained to them all, or most, of the time. The most common suggestion from carers when responding to the question 'on the type of things that should be done differently for the child in their care' ($n=256$) was that there should be better case planning and better case management by the department (CCYPCG 2010:63).

Young people's frequent suggestions for improvements included:

Wanting to see the CSOs more, wanting better trained or consistent CSOs or more CSOs (so that their workloads would be reduced allowing more time to be spent with children and young people). (CCYPCG 2010:63)

A case file audit ($n=205$) of children in care in South Australia found that over half (56%) of the children 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. Over half (51%) had been included in decision-making meetings (Gilbertson & Barber, 2004).

Activities and sport

Important to children's wellbeing is not only the provision of required services, but participation in a range of activities, similar to those enjoyed by children not in care. Case plans for children are meant to ensure that activities appropriate to the child's age and gender are included. Findings from the CREATE survey of children and young people ($n=699$) found that close to two thirds (65%) had the opportunity to be involved in activities similar to their peers (McDowall, 2013: 68).

In relation to involvement in a sporting activity, around half (47%, $n=504$) said they were involved in sporting activities other than those organised through school. A quarter (25%) reported little or no involvement in sport. The survey reported that children and young people in foster care were more involved in sporting activities than those in other types of placements (McDowall, 2013: 58).

Most children in the CREATE survey also reported being able to have some contact with their friends outside school. Over half (56%, $n=595$) saw friends 'quite often', with one third (31.4%, $n=335$) stating they saw their friends 'sometimes'. One tenth ($n=113$) of children in the survey did not see their friends (McDowall, 2013).

A survey of school-age foster children ($n=141$) conducted in Victoria found that in relation to children's use of electronic media, reading for pleasure and participation in

organised activities outside school hours, the cohort's experiences were similar to those of other children in the community (Wise et al., 2010).

A national survey of children in care ($n=2,083$) found the majority of children (87%) reporting that they 'received adequate support (from their carer or someone else) to participate in sport, community or cultural activities' (AIHWd, 2015: 8).

Youth services

The CREATE Foundation, based in every Australian jurisdiction, provides a range of programs and services for children and young people in care. CREATE offers 'clubCREATE', which links together all children and young people who are members of the club. Various activities and events (camps, parties, workshops, outings, etc.) are organised for children and young people to participate in within their local area. Young people (age 14–25) can participate in 'Speak Up'—a three-level training program to become a CREATE Young Consultant. Grant schemes are also available to assist young people in their endeavours; for example, to purchase laptops, take driving lessons, acquire educational resources or pay for accommodation and living expenses. Youth advisory groups meet regularly, and young people are encouraged to discuss any issues they have with the care system (CREATE, 2016).

Numerous non-government and/or charitable organisations throughout Australia offer a range of youth services for disadvantaged and vulnerable young people, including young people in care. For example, the Police Citizen Youth Clubs (60 clubs in NSW) offer opportunities for youth to engage in various sporting, dance, music and educational activities.

Contact

One of the most problematic areas in case management can be the maintenance of contact (where appropriate) between children in care and their birth family members. Studies have highlighted the difficulties faced by both foster and kinship carers (Indigenous and non-Indigenous) in relation to contact/access visits with family members, and managing the impact visits can have on children and themselves. It is evident from studies that, when it is required, inadequately supported contact can be highly stressful and detrimental to children, parents and carers (Bullen, Taplin & Barry, 2015; Kiraly & Humphreys, 2011; McHugh, 2013). In handling difficult family relationships, research participants in one study noted that caseworkers need skill development in engagement and mediation (Kiraly & Humphreys, 2015).

This is not to suggest that many children in care do not have well supported, positive and successful contact visits with their birth families, which can add to the stability of the placement (Bullen, Taplin & Barry, 2015, Kiraly & Humphreys, 2015; McHugh, 2013). In the CREATE survey of children in care in 2012, less than half (45%) of children responding to questions on how supportive caseworkers and carers were in supporting contact rated their caseworker 'quite' or 'very supportive', compared to over two thirds of children (69%) giving the same rating to their carer. One of the key messages from the children in the study was that they wanted more contact with family members, particularly with their siblings. The research suggests that caseworkers, who have a central role in contact arrangements, may need to work

more closely with carers and children, ensuring that visits with all birth family members are as rewarding as possible (McDowall, 2013).

In a large Queensland study, wanting more contact with their birth family was also requested by a significant proportion (43%) of surveyed children ($n=527$) and young people ($n=922$) in care (CCYPCG 2010).

A national survey of children in care asked children about their satisfaction with the type (e.g. visiting, talking, and writing) and amount of contact they had with birth family members. Data based on responses from children ($n=2,052$) found that the majority (70%) reported satisfaction with one or more contact type, around half (49%) reported satisfaction with two or more types of contact and around a third (30%) were satisfied with all three types of contact. Fifty per cent of the children were happy with their contact arrangements and did not want any changes. Around one third (32%) requested more contact with different family members (AIHW, 2015d: 11).

Indigenous children and cultural plans

A recent study highlighted the importance of having an appropriate cultural support plan for Indigenous children, whether with Indigenous or non-Indigenous foster/kinship carers. The study also noted that caseworkers needed to have cultural awareness training to ensure that children's needs for contact and connection, with family and others within their community, are met (Kiraly & Humphreys, 2011).

The CREATE study found that 30% of Indigenous respondents ($n=309$) had 'little connection with their cultural community'. Only 10% of survey respondents ($n=32$) knew/were aware of their right (National Standard OOH, No. 10) to a cultural support plan, and around half of the 32 had been involved in developing their plan (McDowall, 2013). In a Queensland survey of children and young people in care, over two thirds (71%) of Aboriginal and Torres Strait Islander young people ($n=300$) stated that they were in touch with their communities. Where young people and carers were of the same cultural background, over three quarters (78%) of the sample felt they were in touch with their community, compared to 60% of those whose carers did not share their cultural background (CCYPCG, 2013b).

A national survey of children in care asked children (Indigenous and non-Indigenous) about their sense of connection with their community. Most (86%) reported that they 'had at least some knowledge of their family background and culture' (AIHW, 2015d: 12).

Support for young people leaving care

A national survey of children in care asked a cohort of young people age 15–17 years ($n=130$) about the support they were receiving in preparation for leaving care⁶. The key findings were as follows:

- over half (58%) reported they were receiving as much support as they needed; and

⁶ Data was for young people in Western Australia, South Australia, Tasmania and the Australian Capital Territory.

- around one third (30%) were getting some support but wanted more (AIHW, 2015d: 14).

A Victorian study involving Indigenous care leavers examined the supports and services available for this cohort of young people. The study was mainly conducted with staff ($n=36$) of nine agencies and other child and family organisations (both Indigenous and non-Indigenous) delivering OOHC, leaving care or post-care services. Three of the nine agencies were Aboriginal Community Controlled Organisations (ACCOs). The main strength, for Indigenous young people in OOHC, was found to be the availability of ACCOs providing specific services. The study identified various systemic matters impacting on Indigenous care leavers, including:

- issues identifying Indigenous status and complex relationships between Indigenous and non-Indigenous services for both workers and young people;
- concerns around inadequate referral pathways to ACCOs;
- limited funding for Indigenous-specific programs and supports; specifically, funding for completion of Cultural Support Planning; and
- resources to implement plans was identified as a key barrier for cultural connectedness of Indigenous adolescents in care (Mendes, Saunders & Baidawi, 2016:7).

The study also found that many Indigenous young people had either left care, or were absent from their placement, prior to being eligible to receive leaving care services. Some young people, through homelessness or youth justice services, re-engaged post care, seeking support and services. The study identified two useful strategies for supporting Indigenous adolescents in the transition to adulthood: earlier leaving care planning (e.g. commencing from age 14) and lowering the age-threshold for leaving care eligibility (Mendes, Saunders & Baidawi, 2016:8).

Summary

The casework required by children and their carers is wide-ranging and covers all aspects of a child's wellbeing. The research evidence, whilst mixed, supports the notion that many children in the care system and their carers have reasonable relationships with their caseworkers, and many appear satisfied with the support they receive. The result for kinship carers is not so positive, with many kinship carers ambivalent about having a caseworker involved in their family's life.

Various surveys of children in relation to their case plans indicate that although significant numbers felt they had been involved in their plan, others did not feel involved and/or did not know anything about their case plan. Overall, it appears that more could be done in relation to better case planning and better case management, and more meaningful involvement of young people in the case planning process.

In relation to participation in sports, other leisure activities and having time with friends, significant numbers of children in care appear to participate as much as their peers do.

Workers and carers both play significant roles in ensuring that contact with a child's birth family members is maintained. Survey evidence suggests that significant numbers of children are satisfied with their arrangements, although more contact with their siblings and other family members was requested by surveyed children.

The importance of cultural plans for Indigenous children in care is highlighted in many studies. How well cultural plans are implemented appears to rely, in part, on whether an Indigenous child is with an Indigenous or non-Indigenous carer.

3.9. Conclusion

Overall, the literature indicates high levels of health and education needs of children in OOHC. In Australia and internationally, children in OOHC are more vulnerable than those in the general population, and therefore need more universal and specialist services. The literature highlights the importance of health and education plans to ensure that children receive appropriate services and that their service use is monitored while they are in care.

Although both carers and caseworkers are perceived to be important in linking children to appropriate services, none of the studies provide clear evidence of the key role played by caseworkers in facilitating access by children to the services they require. Very few studies link the provision of services to improvements in a child's wellbeing, and this is a clear gap in the evidence base.

Studies have established that the period when children are first placed is the critical time in which services need to be provided. It is also known that the first year of placement requires the highest involvement in time and energy by both workers and carers. What happens for children and young people in that first year of placement is likely the 'key' to understanding their cycle (whatever that period is) through the care system.

A child's age, gender, developmental status and assessed needs, the age when they are placed and 'who' they are placed with, are hugely variable and highly individual. Determining how caseworkers initially interact with children and carers in those first few weeks of placement, in relation to service provision, satisfaction of carers and wellbeing of children, will be evident after the analysis of the data from the two waves of data from the study.

4. Sample, definitions and methods

4.1. Introduction

The POCLS is a large-scale prospective study that follows children and young people aged 0–17 years entering OOHC for the first time under the *NSW Children and Young Persons (Care and Protection) Act* (1988) across NSW within an 18-month period between May 2010 and October 2011 ($n=4,126$). It follows children regardless of their trajectory, including after they have left care. The POCLS includes children of all ages, all geographic locations in NSW, and all placements with government and non-government agencies (New South Wales Department of Family and Community Services, 2015; Paxman, Tully, Burke, & Watson, 2014).

The POCLS includes children and young people who enter care and:

- remain with the same carer;
- move to a new carer;
- are restored to their birth parents (planned and self-restored);
- are adopted;
- re-enter care; or
- leave care because they are ageing out.

The study is not intended to be representative of every child in OOHC at any given point, and does not represent children in temporary care or children who entered care during the entry period but who had entered care previously. Further, it does not consider children already in care (New South Wales Department of Family and Community Services, 2015) (Paxman, Tully, Burke, & Watson, 2014).

This report uses data derived from the first two waves of the POCLS, funded by NSW Family and Community Services (FACS). It is divided into two broad groups of analyses; the first relates to children entering care for the first time (following receipt of final care and protection orders). It includes analysis of service need associated with physical and mental health and development issues (shortened to service needs/issues in some locations⁷), analysis of change over time in service utilisation, and a brief analysis of barriers to service use follows.

The second group of analyses relates to carer support and examines professional, informal and casework support to carers at both waves of the POCLS.

Children and their carers were interviewed for Wave 1 following the receipt of final care and protection orders—18 months, on average, after entering care for the first time. Wave 2 interviews were conducted 18 months, on average, after the first interview.

A description of the sample used in this report is available at Section 4.5.

⁷ See section 4.4 for details on the individual items comprising these measures.

4.2. Data sources

Carer surveys formed the primary source of information for these analyses and were used for information about development indicators, service use and child health. All child demographic information was linked to the carer surveys. FACS-linked administrative data provided information about child location at a FACS district level at the time of the survey.

Information about the data sources and survey tools are available on request from FACS at <http://www.community.nsw.gov.au/about-us/research-centre/pathways-of-care-longitudinal-study>.

4.3. Outcome measure and independent variable derivation and definitions

A range of variables were derived and used as outcome measures for each section of the report. Most of the outcome variables were taken directly from reports provided in the carer survey about the study child; however, some variables were computed from a combination of variables. The main outcome measures for children include child need for services, child health variables, the number of services used, the change in use of services and the barriers to service use. For carers, casework support, informal support and professional support variables have been used for this analysis.

In addition, a range of variables relating to the child and carer demographic characteristics and placement characteristics were computed and used in all analyses. These include child age categories, child cultural background, placement type, location of placement (metropolitan and non-metropolitan in most cases; however, some results relate to FACS district) and whether the child changed household between waves. Carer age group, spouse in household indicator and cultural background were created.

More details, including the source and definition of all items used as outcome measures, and independent variables are located in 0.

4.4. Derivation of child service needs items

In this report, children and young people are considered to have a potential need for service if their carer reported that they are experiencing a long-term health condition lasting six months or longer, or if socio-emotional, cognitive and physical development measures are outside of the cut-off for usual development (i.e. they are classified as being 'at risk', in the clinical range or having atypical development). Carer reports of health conditions are included in order to pick up any potential needs for which may have received a diagnosis that is not captured in the measures relating to socio-emotional issues or cognitive issues. These items are referred to as potential needs for services, (shortened to service needs/issues in some cases). Due to the method in which the need for services is calculated (which means that both carer

reports and standardised measures are combined), these results are not intended to align with other analyses of the wellbeing of the POCLS cohort using standardised measures only. In addition, this report does not present a diagnosis-based analysis of need for services, as no diagnosis information is available in the survey.

These results therefore represent a proxy measure of estimated service need. It is important for the purpose of this report to include carer reports of long-term health conditions, because it includes issues that may need treatment or at least a diagnosis, but may not meet the criteria that standardised development measures use. More information about the rationale for these proxy items is found in Section 5.1.

The proxy measures for potential need for services uses developmental measure binary cut-offs rather than more detailed indicators (such as percentile) as a more nuanced understanding of development was not required for this report. This means that estimates of service need amongst this cohort will necessarily be higher than other reports that examine developmental outcomes obtained through standardised measures only. Other reports specifically examining child development over time will focus more on the detailed percentile scores.

In this report, the following items were combined to create indicators of the potential need for services amongst children and young people:

- A child or young person is considered to have a service need/issue if the carer reported that they have an issue⁸ or that children are experiencing any long-term health condition (this was included to capture any issues that may not have been formally diagnosed, or where the children may still need support but be under the critical development cut-off).
- Each age group has at least one measure that corresponds with the need/issue measured.

Once these measures were created, the number of service needs/issues were counted and used as an outcome measure, defined as being the count of any of the following: any cognitive development issue, any physical development issue (if within the age group measured), any socio-emotional development issue, any long-term physical health condition or any long-term psychological health issue⁹. The maximum number of types of service needs/issues is five. These were grouped into three categories: children with no need for services, children with one type of service need/issue and children with two or more types of service needs/issues¹⁰.

⁸ Physical health does not have cut-off points, but is a yes/no answer based on carer reports.

⁹ Psychological health issues are based on carer reports and socio-emotional wellbeing measures are based on standardised tools. However, there is no way of determining whether the carer reported issue is the same as the socio-emotional issue, so there may be some cases of double counting in instances where the carer reports a psychological health issue and the standardised measure indicates a socio-emotional issue and they are about the same issue.

¹⁰ As the focus of this report relates to potential need for services, we have given the same weight to carer reports and standardised measures of issues and needs that the child or young person is experiencing.

More information about measuring service need can be found in Section 5.1.

Table 4.1 Cut-off information and age coverage for health and development measures

Measures	Cut off used	9–35 mths	3–5 years	6–11 years	12–17 years
Cognitive development issues					
Children are considered to have an indication of cognitive development issues if any of the following items were outside the relevant cut-off					
MCDI—vocabulary	<15 th percentiles	see note			
ASQ—problem solving, communication	<1 standard deviation of the mean	✓	✓		
PPVT	Below normal range		✓	✓	✓
Matrix reasoning test from Wechsler Intelligence scale	Below normal range			✓	✓
Physical development issues					
Children are considered to have an indication of physical development issues if any of the following items were outside the relevant cut-off					
ASQ—gross and fine motor	Atypical development	✓	✓		
Socio-emotional development issues					
Children are considered to have an indication of socio-emotional development issues if any of the following items were outside the relevant cut-off					
BITSEA	Above 75 th percentile cut-off (at risk)	✓			
CBCL	Above 94 th percentile (clinical range)		✓	✓	✓
ASQ—personal social	1SD from mean (atypical development)	✓	✓		
Long-term health conditions					
Children are considered to have an indication of long-term health conditions if the carer reported any of the following were present for at least six months or expected to last at least six months					
Any long-term physical health (or ‘other’) issues, any of the items below:		✓	✓	✓	✓
(Waves 1 and 2) <ul style="list-style-type: none"> Problems with hearing Problems with eyesight Problems with teeth/oral hygiene Food or digestive allergies Respiratory allergies such as hay fever Other allergies Asthma Bronchitis (Wave 2 only) <ul style="list-style-type: none"> Glue ear, (recurring) ear infections, may need grommets/chronic ear problems Eczema/skin rash, skin condition 	<ul style="list-style-type: none"> Heart condition or disease Epilepsy Diabetes Foetal alcohol spectrum disorder Cerebral palsy Kidney condition or disease Tonsillitis (recurring), may need tonsils/adenoids out 	<ul style="list-style-type: none"> Blood disorder Developmental delay—physical Any other condition (note that this was partially backcoded in Wave 2 but due to differences between waves, it has been classified as physical/other) 			

Table 4.1 continued

	Cut-off used	9–35 mths	3–5 years	6–11 years	12–17 years
Any long-term psychological health issue, any of the items below:		✓	✓	✓	✓
(Waves 1 and 2) <ul style="list-style-type: none"> • Developmental delay—emotional/social/behavioural • Developmental delay—cognitive/language (Wave 2 only) <ul style="list-style-type: none"> • Autism/autistic/autistic tendencies/possible autism 	<ul style="list-style-type: none"> • Emotional, psychological or nervous difficulties • Attachment/detachment disorder, reactive/indiscriminate attachment disorder 				

Notes:

+ Partial coverage—from 24 to 35 months

Abbreviations: MCDI: Macarthur-Bates Communicative Development Inventory; ASQ: Ages and Stages Questionnaire; PPVT: Peabody Picture Vocabulary Test; BITSEA: Brief Infant-Toddler Social Emotional Assessment; CBCL: Child Behaviour Checklist

4.5. Description of sample used in analysis

Only children with two waves of data are used in this analysis due to numerous outcomes being related to change over time.

Table 4.2 provides information on the demographic characteristics of the 1,285 children at baseline (Wave 1) and the 1,032 children within the Wave 1 cohort that responded to the Wave 2 survey.

The group with the lowest percentage responding to both waves of the survey were children aged 12–17 years. There were also differences by FACS district¹¹; however, the numbers were too small to be reliable.

¹¹ Not shown in table but available on request subject to maintaining confidentiality of the data.


Table 4.2 Characteristics of children at Wave 1 and ‘n’ and ‘%’ of respondents with two waves of responses

Characteristics		Wave 1 respondents	Wave 2 Respondents and %	
		n	n	% of Wave 1 respondents
Age at Wave 1 interview	9–35 months	567	481	84.8
	3–5 years	265	215	81.1
	6–11 years	329	264	80.2
	12–17 years	124	72	58.1
	Total	1,285	1,032	80.3
Study child cultural background	Aboriginal	469	388	82.7
	CALD	112	79	70.5
	Other Australian children	640	515	80.5
	Culture unspecified	64	50	78.1
	Total	1,285	1,032	80.3
Child placement type at Wave 1 interview*	Foster care	661	533	80.6
	Relative/Kinship care	598	487	81.4
	Residential care	26	12	46.2
	Total	1,285	1,032	80.3
District (higher level) at the time of interview	Southern metro	263	213	81.0
	Southern non-metro	108	92	85.2
	Northern metro	107	85	79.4
	Northern non-metro	385	308	80.0
	Western metro	201	153	76.1
	Western non-metro	220	180	81.8
	Total	1,284	1,031	80.3

Source: Authors’ calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6
Column totals for categories may be different because source information for district is based on FACS administrative data and this has resulted in some minor discrepancies in reported location of child at the time of the survey. In this case, the one response with an unclear location category was removed from the analysis; however, in subsequent analyses this child may be included depending on whether location was used as an independent variable.

* Since this is placement type at the Wave 1 interview, there are a small number of children who may have changed placement category between waves that are not accounted for here.

In order to determine whether there was any major bias associated with analysing only children who responded to both waves of the survey, a logistic regression examining the likelihood of responding to Wave 1 only, compared to both waves of the survey, was conducted. The regression statistically controlled for: type of placement, district (higher level), cultural background and age of child at Wave 1. Only the age of the child was found to have a significant association with responding to Wave 1 only—as expected, older children had higher odds of only responding to



Wave 1. Given that older children ageing out of OOHC will not be the focus of this report with respect to service use, it was decided that this age bias did not present enough of a problem to justify changing the sample used in the analysis. The full results from this analysis are available on request.

5. Children's need for services

This section provides the results of a range of univariate and multivariate analyses of the presence of potential needs for services and the number of types of service needs that children were experiencing. Change in the number and type of service needs are subsequently presented.

Service needs/issues at Wave 1 are taken to represent issues experienced by children after they had recently entered care (on average, Wave 1 interviews were conducted 18 months after final care and protection orders). Change over time in this report is the difference between responses at Wave 2 compared to Wave 1—an approximate 18-month difference.

All tabular results for this section are available on request subject to maintaining confidentiality.

5.1. Measuring need for services using the POCLS

The POCLS does not collect information that enables a definitive indication of children or young people's need for a particular service. There are a number of reasons that this is not collected:

- the ability of a carer or caseworker to be able to accurately assess a service need is limited and may underestimate or overestimate actual need;
- carers may not associate a behaviour with a need for service;
- carers also need to understand when the child needs a referral;
- where children change carers and/or caseworkers, information about need may not be known to new carers or caseworkers;
- the services required or attended by children and young people before they entered care may not be known; and
- using developmental diagnostic measures as the only source of information about need for services may underestimate the services required by children and young people that do not relate directly to the development measures.

This analysis therefore has had to create proxy variables relating to need for service. These are based on carer reports of diagnosed long-term (6 months or more) conditions as well as standardised measures in different developmental domains. It is important for the purpose of this report to include carer reports, because they relate to issues that carers identify as needing a service, but may not meet the criteria that standardised development measures use to measure the need for clinical intervention. They also enable a measurement of prospective need.

The limitations of this approach are that including carer reports of long-term health conditions into a measure of potential need for services means that estimates of

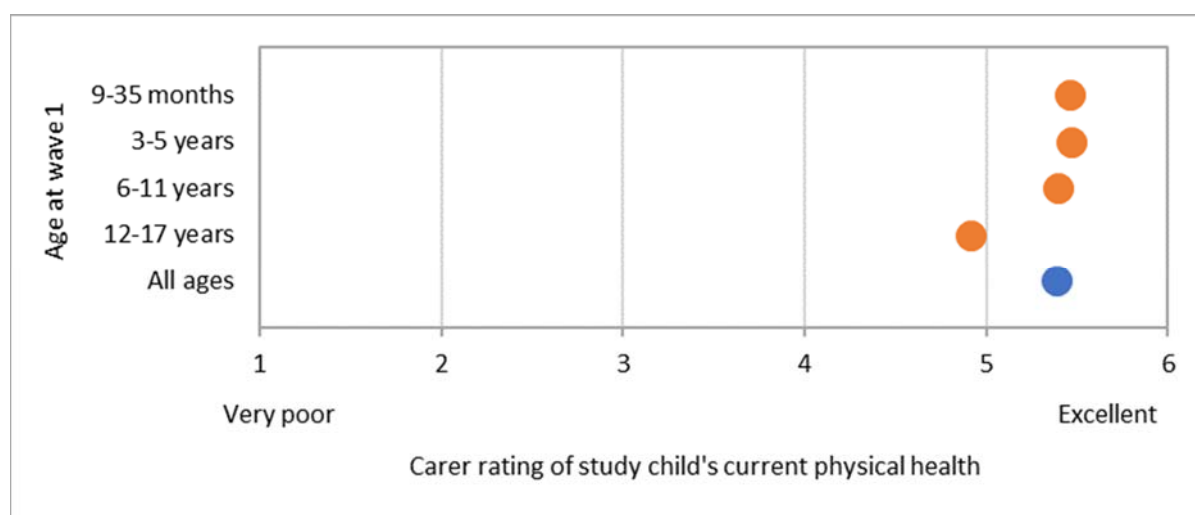
service need amongst this cohort will be higher than reports that examine developmental outcomes of the POCLS cohort obtained through standardised measures only. In addition, there is a very wide range of needs reported by carers. The service needs for a child with an allergy are very different to those with a cognitive delay or foetal alcohol syndrome, and this report has not analysed individual issues, because the groups of children with specific issues are generally too small. Thus, there is no analysis of the intensity or severity of issues that may require services.

Similarly, as indicated in Section 7, the POCLS only asks carers if children have accessed a particular service in a particular timeframe. The survey does not contain any information about how often the child attended the service, nor about the quality of the service, and therefore duration, dosage and quality of services received are not measured.

5.2. Study child general physical health

Carers were asked to provide a rating of the study child's current general physical health. The results, by age group of children, are shown in Figure 5.1. On average, 54% of children and young people were rated as having 'excellent' physical health, and the average rating was 5.4 out of 6. As shown below, young people age 12–17 years were rated as having lower general physical health than all other age groups.

Figure 5.1 Average carer rating of study child's current physical health (1 = very poor, 6 = excellent) at Wave 1 by age group



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

An ordinal regression of health rating with age group, location, placement type and cultural background found that once these items were controlled, carer rated physical health was only significantly different between the youngest (9–35 months) and oldest (12–17 years) age groups. The regression (Table 5.1) found that placement type predicted health rating. Holding age, location and cultural background constant, children in residential care had significantly lower health ratings, and children in relative/kinship care had higher health ratings than the other placement types.

However, due to very small numbers of children and young people in residential care, this result needs to be treated with caution.

Table 5.1 Summary of ordinal regression of carer rating of study child's physical health at Wave 1

	Estimate	Significance	95% Confidence Interval	
			Lower Bound	Upper Bound
Threshold				
Very poor	-6.92	***	-8.34	-5.49
Poor	-5.19	***	-5.86	-4.52
Fair	-4.23	***	-4.72	-3.74
Good	-2.37	***	-2.72	-2.02
Very good	-0.46	**	-0.78	-0.14
Excellent (ref)				
Location				
Relative/Kinship care	0.37	**	0.15	0.59
Residential care	-1.12	**	-1.93	-0.31
Foster care (ref)	0.00			
Southern non-metro	-0.21		-0.67	0.25
Northern metro	-0.41		-0.86	0.05
Northern non-metro	-0.51	**	-0.83	-0.18
Western metro	-0.23		-0.60	0.14
Western non-metro	-0.46		-0.84	-0.09
Southern metro (ref)				
3–5 years	-0.07		-0.36	0.22
6–11 years	-0.25		-0.52	0.02
12–17 years	-0.89	***	-1.30	-0.48
9–35 months (ref)				

Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6
Note: * $p < .05$, ** $p < .01$, *** $p < .001$

5.3. Potential need for services

This section presents the results of the individual components that relate to children and young people's potential need for services. The measures in this section are divided into two groups: firstly, measures relating to the potential need for services relating to socio-emotional, cognitive issues and carer reported long-term psychological health needs. The second group relates to the potential need for services amongst children and young people in care who have either physical development issues (amongst children up to 66 months only), and carer-reported long-term (six months or longer) physical health conditions.

As described in the introduction to this chapter and also in Section 4, children and young people are counted as having a potential need for service if their carer reports that they have a long-term physical health condition or long-term psychological condition, or if development measures are outside of the cut-off for usual development (i.e. they are classified as being 'at risk', in the clinical range or having atypical development). Carer reports of health conditions are included in order to pick

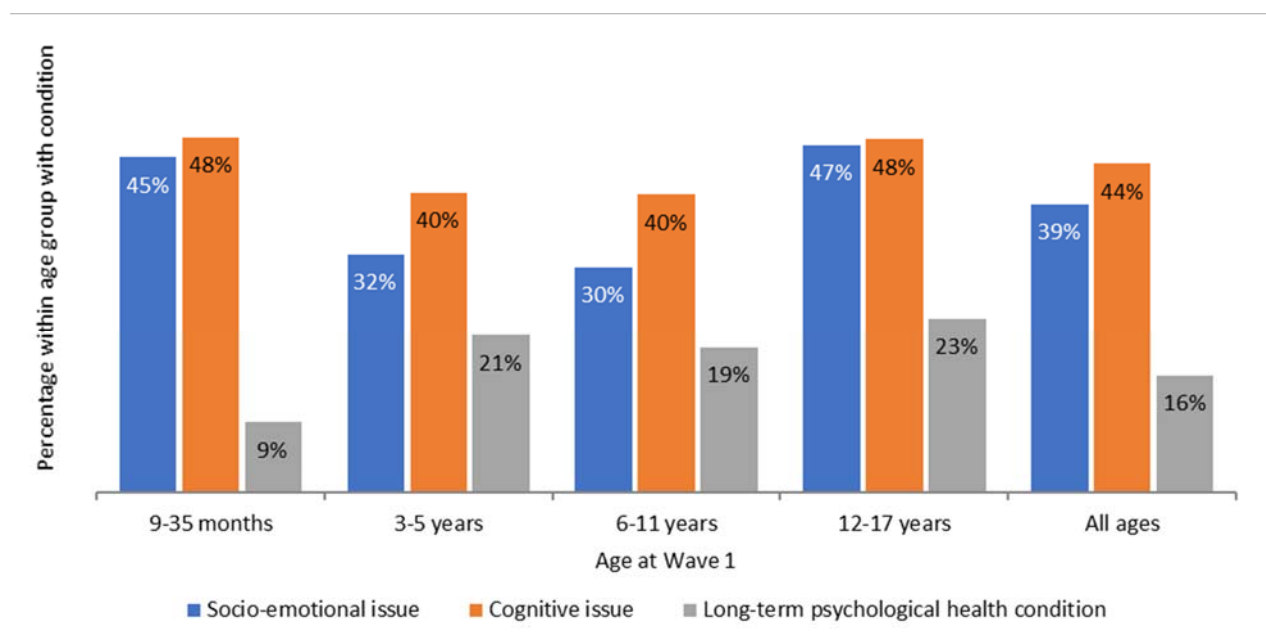
up any potential needs which may have received a diagnosis that is not captured in the measures relating to socio-emotional issues or cognitive issues.

Amongst children in care at the time of the Wave 1 interview, 39% were experiencing a socio-emotional development issue that may be associated with a need for service (Figure 5.2). The rates were higher amongst children age 9–35 months (45%) and 12–17 years (47%)¹².

An average of 44% of children experienced a cognitive development issue that may be associated with a potential need for service, with no significant differences between age groups (at $\alpha = 0.01$)¹³.

An average of 16% of children were reported by their carer to be experiencing a long-term psychological condition, with children age 9–35 months having the lowest rates (9%). This could be because they had spent less time with birth families than other age groups and therefore were less damaged by the experience, but it could also be that long-term psychological conditions tend to be diagnosed at ages over 35 months.

Figure 5.2 Prevalence of potential needs for services related to socio-emotional issues, cognitive issues and carer-reported long-term psychological health conditions amongst children in care at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

As shown in Figure 5.3, 40% of children in care at Wave 1 were reported by their carers to have a long-term physical health condition. Half of the children age 6–11

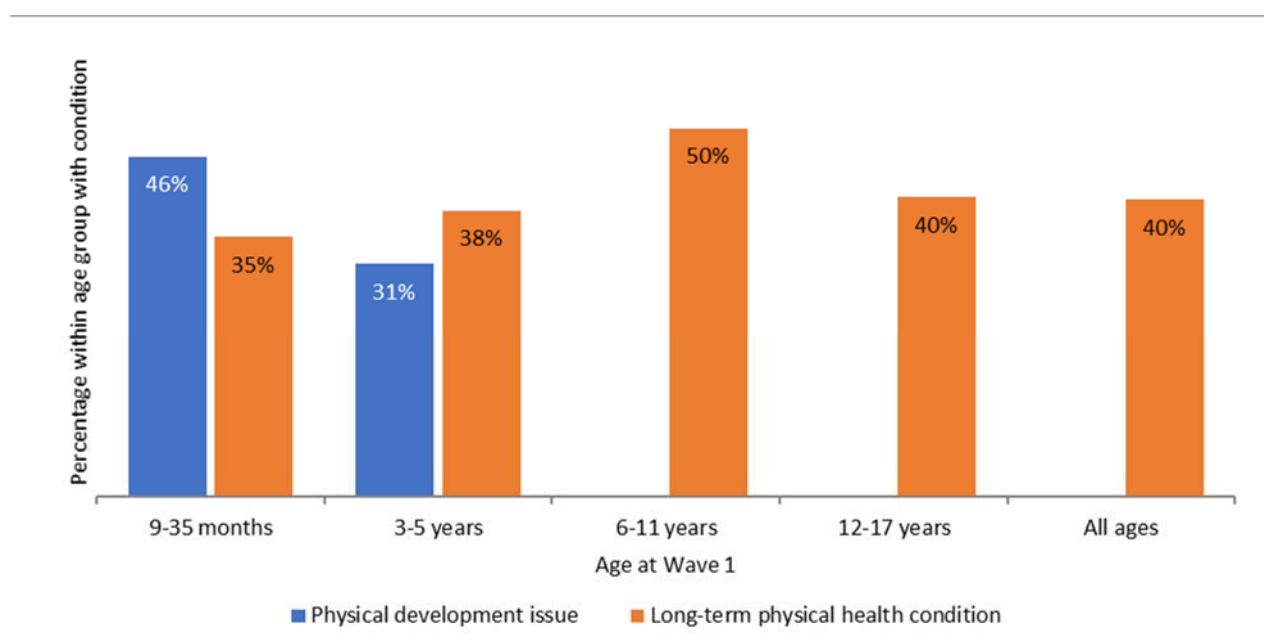
¹² See Section 4 for definitions.

¹³ Throughout this report, comparative results are not reported unless otherwise indicated and significant results are reported if the p-value of the associated test is below $\alpha .01$, unless otherwise indicated.

years reported as having a physical health condition—significantly more than children below 6 years.

Physical development issues that may be associated with a potential need for services were collected for children younger than 66 months. In these age groups, almost half (46%) of children age 9–35 months and one in three children (31%) age 3–5 years were experiencing a physical development issue at the Wave 1 interview.

Figure 5.3. Prevalence of potential needs for services related to physical development and carer-reported long-term physical health conditions amongst children in care at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6
 Note: ASQ only goes to 66 months so children age 67 to 71 months in the 3–5 bracket are not included. The age bracket has been maintained for consistency throughout the report. Carer-reported long-term physical health conditions also includes conditions labelled 'other'.

The findings in Figure 5.3 contrast with those of Figure 5.1. In Figure 5.3, a high proportion of children are shown to have a long-term physical health condition, whereas in Figure 5.1, the findings indicate that the majority of children are experiencing very good or excellent health. This could be explained by the fact that many of the conditions which are included in the question on long-term physical health, such as allergies, poor eyesight or impaired hearing, may not impede the child's overall general health (see Table 4.1).

5.4. Combined number of types of service needs

In order to examine the need for services and to subsequently control for increased need amongst this group, this section provides both a descriptive and multivariate analysis of the count of the types of issues experienced by children at Wave 1.

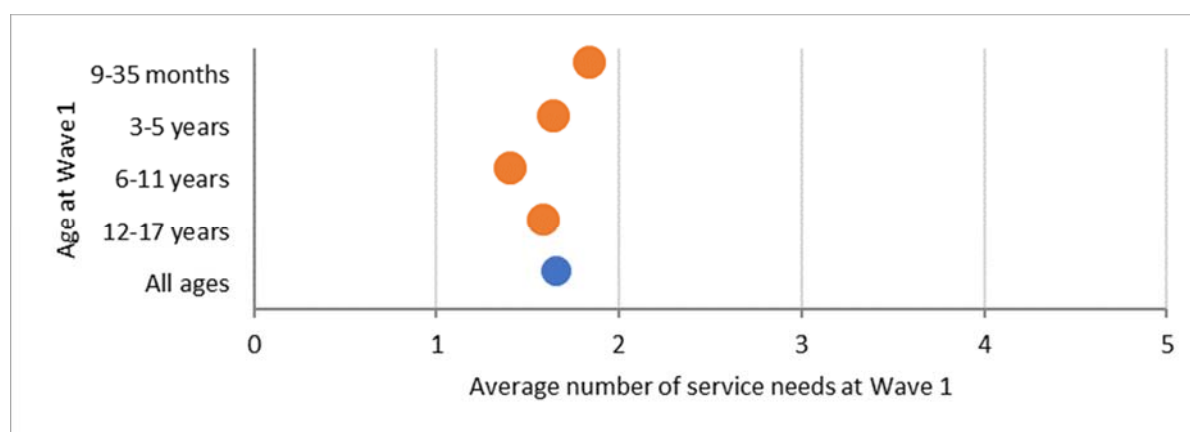
In order to calculate this measure, a count of the types of potential needs for services was summed for all children and young people. Children and young people could have up to five types of needs: socio-emotional development, cognitive development, carer-reported long-term psychological health issue, physical development and carer-reported long-term physical development issue.

This measure is not intended to be a precise count of the different types of services required by children and young people in care. Instead, it provides a general estimate of the number of children and young people with an increased need for services, in order to examine the overlap amongst children with any needs and to provide an indication of the number of children with multiple issues (i.e. 'complex' needs).

A limitation to note about this measure is that there is no cross validation between the carer's report of long-term conditions and the condition that is measured via the standardised tests. Thus, there may be some cases in which double counting occurs when a parent reports a long-term issue that is also measured as being above the development cut-off for the same issue. This is most likely to occur in relation to socio-emotional issues because the categories for these overlap with measures of socio-emotional development. Another limitation to note is that counting the number of services needed obscures the fact that some children may only have need for one service, but the child requires a substantial service response, whereas other children may have more than one need requiring substantial responses. The report has not analysed this due to small numbers in specific categories of need.

On average (Figure 5.4), children in care at Wave 1 had 1.7 issues related to a potential need for services.

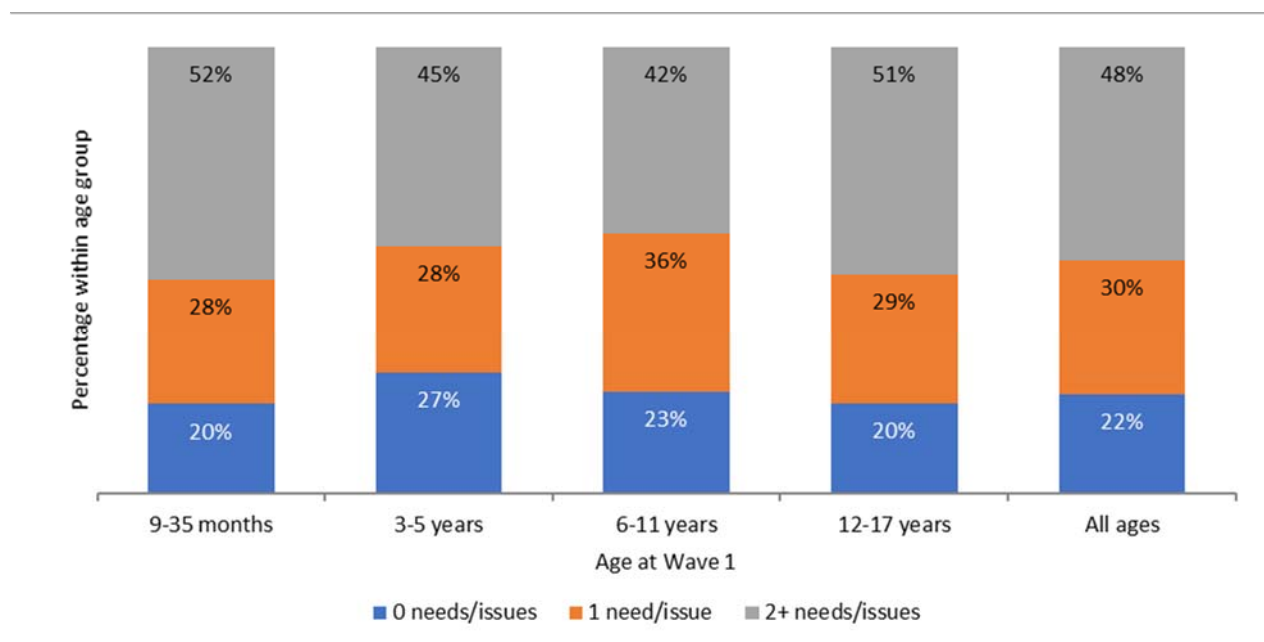
Figure 5.4 Average number of types of services potentially needed by children in care at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

The count of the combined number of service needs/issues was grouped into three categories: children with no service needs/issues, children with one need for services, and children with two or more needs for services. As Figure 5.5 shows, a high proportion of children in this cohort (48%) had two or more needs/issues, indicating that they were likely to have high service needs. An average of one in three (30%) had one need/issue, and 22% had no needs/issues.

Figure 5.5 Number of needs/issues at Wave 1 by age group



Source: Authors' calculation using POCLS carer and children Wave 1 and Wave 2 survey file V6

The age pattern for most needs/issues was a U shape, with the youngest and oldest age groups having higher levels of service need than those age 3–11 years at Wave 1.

5.5. Regression—potential need for services by placement type

In order to determine whether child demographic characteristics and placement type were associated with the number of potential needs for services, a Poisson regression was conducted, in which the count of needs/issues was entered as the dependent variable, placement type was entered as the primary independent variable, and child age group at Wave 1, location and cultural background and placement type were entered as other independent variables (control variables).

The results of the regression (summary in Table 5.2, full output available on request subject to maintaining confidentiality) indicated that given the age group, district and children's cultural background, children in relative/kinship care have fewer needs/issues than children in foster care; however, children in residential care and foster care have similar numbers of needs/issues. Children 6–11 years also had fewer needs/issues compared to children 9–35 months. No other variables (other age groups, location, cultural background) were significantly associated with an increase in the expected count of service needs.

Table 5.2 Poisson regression summary—number of potential service needs/issues amongst children and young people at Wave 1

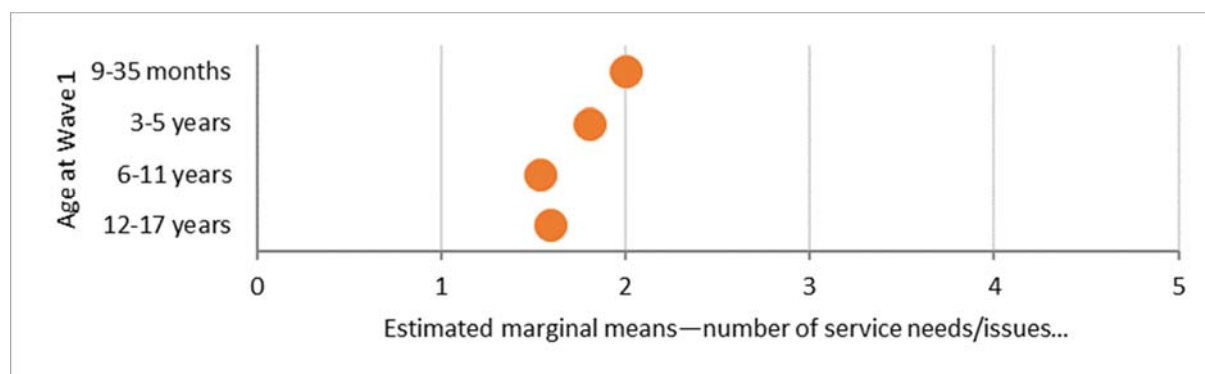
Parameter	B	Significance	Exp(B)	95% Wald Confidence Interval for Exp(B)	
				Lower	Upper
(Intercept)	0.70	***	2.01	1.77	2.27
Relative/Kinship care	-0.22	***	0.80	0.73	0.88
Residential care	0.29		1.34	1.06	1.69
Foster care (ref)					
3-5 years	-0.10		0.90	0.79	1.02
6-11 years	-0.26	***	0.77	0.69	0.86
12-17 years	-0.23		0.79	0.67	0.95
9-35 months (ref)					

Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Note: * $p < .05$, ** $p < .01$, *** $p < .001$

The following charts provide an illustration of the estimated marginal means of the expected count of service needs/issues amongst children by age (Figure 5.6) and placement type at Wave 1 (Figure 5.7). Pairwise comparisons found that children in the youngest age group had a significantly higher estimated mean number of service needs/issues than children age 6 and older whilst statistically accounting for placement type, study child cultural background and location.

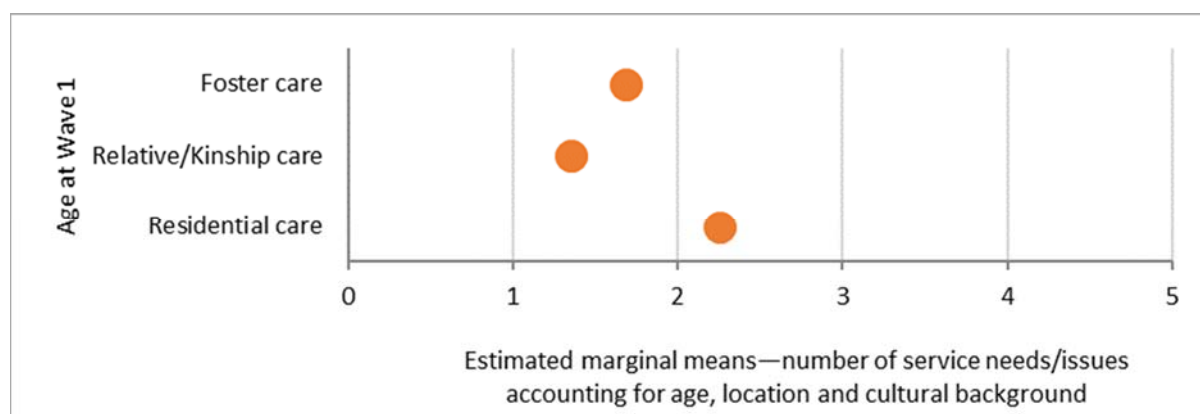
Figure 5.6 Estimated marginal means—Poisson regression of number of service needs/issues by child age group at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Additional pairwise comparisons found that children in both residential and foster care had a significantly higher estimated mean number of issues/needs than children in relative/kinship care whilst controlling child age group, cultural background and location.

Figure 5.7 Estimated marginal means—Poisson regression of number of needs/issues by children placement type at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

A series of logistic regressions (available on request subject to maintaining confidentiality) were conducted to determine whether any demographic characteristics at Wave 1 were associated with the presence of each individual need for service.

The results indicated that placement type was consistently associated with presence of a need for service—children in residential care had larger odds of experiencing a socio-emotional development issue and/or a long-term psychological health issue. Children in relative/kinship care had the lowest odds of the presence of each need/issue, except for carer-reported long-term physical conditions. These results account for location, child age group and child cultural background.

These findings are consistent with the literature reported in Section 3, and are likely to be driven largely by selection effects, i.e. that children with the highest levels of need are placed in residential care, and those with relatively low levels of need are placed in kinship care. Thus, the findings (especially at Wave 1) do not reflect the impact of placement type on the wellbeing of children, but rather the placement decisions of agencies.

Children in southern non-metropolitan areas had significantly fewer socio-emotional development issues and physical development issues. Children in western non-metropolitan areas were significantly more likely to be experiencing socio-development issues and physical development issues, accounting for age group, placement type and cultural background.

5.6. Summary—need for services at Wave 1

At the time of the Wave 1 survey, the results showed that:

- A high proportion of children and young people in care have indications of potential needs for services: 39% with a socio-emotional development issue; 44% with cognitive development issues and 16% with carer-reported long-term psychological conditions; 40% with a carer-reported physical health condition.

Half of children age 9–35 months (48%) and 31% of children age 3–5 years had a physical development issue.

- Almost half of all children in care had at least two types of service needs/issues, with a further one in three children experiencing one type of service need/issue.
- Placement type was the strongest predictor of overall general health rating, with children in residential care rated by carers as having the poorest health and those in relative/kinship care having the highest, although there were small numbers of children in residential care.
- Multivariate Poisson regression of the number of types of service needs/issues with child age group, placement type, cultural background and location as predictors indicated that children in foster care were expected to experience more types of needs for service than children in other care types, and very young children (9–35 months) had significantly higher numbers of services needed compared to children aged 6–11 years. Aboriginal and CALD children were no different from other Australian children in respect of the number of service needs/issues they experienced.
- Multivariate logistic regressions of the presence of each need/issue indicated that children in residential care were more likely to be experiencing socio-emotional development and carer-reported long-term psychological issues, and children in relative/kinship care were less likely to experience any service needs/issues compared to the other placement types, with the exception of carer-reported long-term physical health issues.

6. Children's change in need for services

This section examines how the potential need for services in the POCLS cohort changes between Wave 1 and Wave 2. On average, Wave 2 interviews were conducted 36 months after entering care, and therefore approximately 18 months after Wave 1. The results from this section demonstrate the association between change in need for service, and demographic and placement characteristics of children in care.

Given that age, placement type and location of children can change between survey waves, characteristics of children as at Wave 1 have been analysed here. An additional variable—household change¹⁴—has been created for use in this section of the analysis and subsequent sections related to change over time. This item serves two purposes: to indicate that these children have a different carer, which means that all carer-reported items may show inconsistent or discrepant ratings, and to determine whether household change is associated with the needs for services of children in care.

In order to provide a general measure of the change in the potential need for services amongst children and young people in care, all measures of change in Sections 6.1 through 6.5 use either a three- or four-category measure that compares the existence of the specified issue at Wave 2 with Wave 1.

Due to the general nature of this measure, change over time has been restricted to a change in the existence of needs/issues associated with a potential need for service. This is not meant to represent actual diagnosed change in development, but is intended to provide a general overview of whether the service needs of the cohort were increasing or reducing over the period they were in care.

All tabular results for this section are available on request subject to maintaining confidentiality.

6.1. Change in rating of overall health over time

The first part of this analysis relates to change in carer ratings of child health over time. In the previous section, results indicated that children were rated to have reasonably good overall health at Wave 1, with the average carer-reported child health rating being 5.4 out of a possible six, where six represents 'excellent health'.

The indicator for change in health over time is comprised of the following categories:

- No change, which means that either the child or young person had the same carer-reported health rating at Wave 1 and Wave 2;

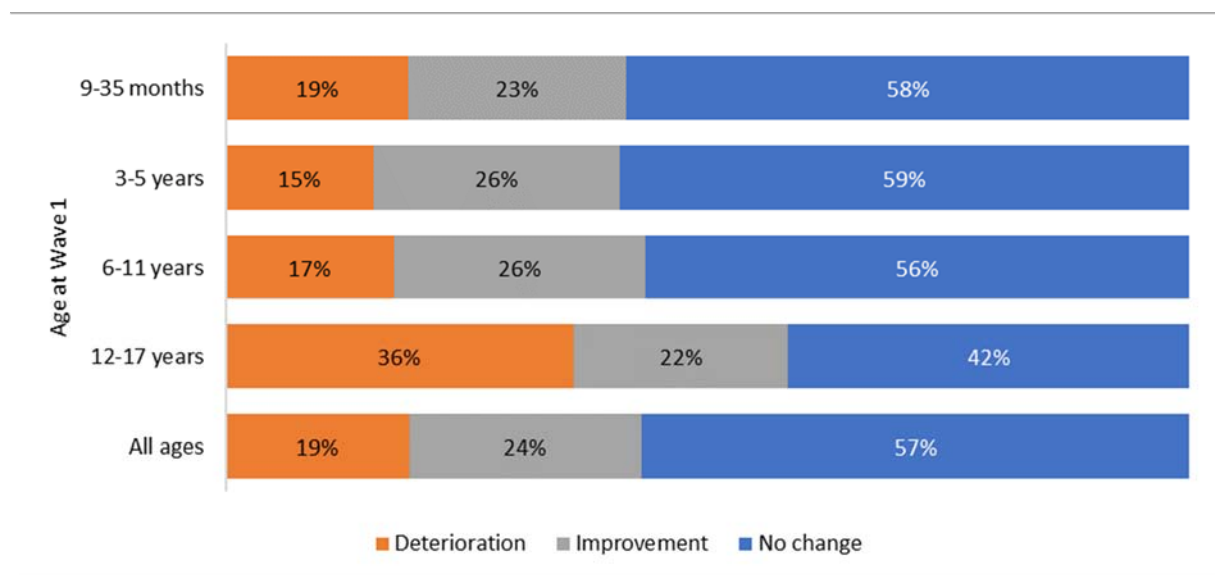
¹⁴ A study child was considered to have changed households if the household ID of the child in Waves 1 and 2 were different.

- Deterioration—the carer reported worse health at Wave 2 compared to Wave 1; and
- Improvement—the carer reported better health at Wave 2 compared to Wave 1.

Figure 6.1 provides an indicator of change over time. Amongst children who had two health ratings, 57% had the same rating at Wave 2 as Wave 1, 24% had an improvement, and 19% had a deterioration in health rating over time.

A series of bivariate analyses were conducted to determine whether children's age at Wave 1, placement type, cultural background, location or household change was associated with these changes between Wave 1 and Wave 2^{15 16}.

Figure 6.1 Change in carer rating of children's overall health, Wave 1 to Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

The bivariate analysis confirmed that children age 12–17 years were more likely to have a lower overall health rating at Wave 2 compared to Wave 1. There was no difference amongst other age groups. Children in residential care¹⁷ were also most likely to have a lower health rating at Wave 2 compared to Wave 1. Children who had changed household were more likely to have a deterioration in reported health at Wave 2 compared to Wave 1.

¹⁵ Results are based on Cramer's V which are appropriate for measures of nominal association.

¹⁶ As with the previous section, only results which are below $p < .01$ are reported unless otherwise indicated. To examine which cells were associated with the significant associations, adjusted (standardised) residuals were examined and those outside an absolute value of 3 (i.e. those outside 3 standard deviations) were considered to be influential.

¹⁷ Children in residential care tend to be older than those in foster or kinship care, which could account for this finding.

6.2. Change in potential need for services associated with carer-reported long-term health conditions

Change in long-term health conditions is described below in Figure 6.2 (table available on request subject to maintaining confidentiality). This result represents either a long-term carer-reported physical, psychological or 'other' condition that has lasted for at least six months or is expected to last six months or more.

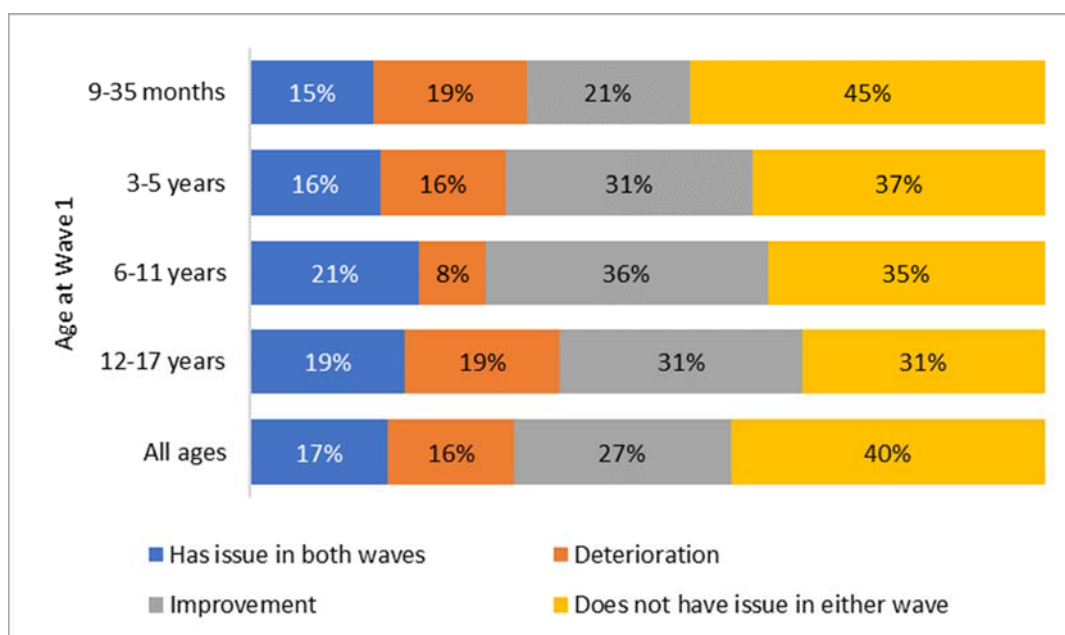
The indicator for change in the existence of carer-reported long-term health conditions is comprised of the following categories:

- Has an issue in both waves—the child or young person has at least one long-term health condition reported by their carer in both Wave 1 and Wave 2¹⁸;
- Improvement—the child or young person was reported to have at least one long-term health condition by their carer at Wave 1 but did not have any conditions at Wave 2. This represents a reduction in the existence of any carer-reported long-term health conditions;
- Deterioration—the child or young person was reported to have no long-term health conditions by their carer at Wave 1 but had at least one at Wave 2. This represents an increase in the existence of any carer-reported long-term health conditions; and
- Does not have issue in either wave—the carer did not report the child or young person as having any long-term health conditions in either wave.

Across all age groups, 17% of children were reported to have a long-term health condition in both waves. An improvement in health was experienced by 27% of children and 16% of children were reported as having deteriorated health by Wave 2.

¹⁸ The issues may be different between waves.

Figure 6.2 Change in the existence of any long-term health conditions, Wave 1 to Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

The results of the bivariate analysis indicated that child age at Wave 1 was associated with change over time in the existence of long-term health conditions. Children age 6–11 years at Wave 1 were more likely to experience an improvement, and least likely to experience a deterioration; those age 9–35 months at Wave 1 were least likely to experience an improvement. This may be accounted for by the fact that 45% of children in this age group had no needs/issues at Wave 1 and therefore could not 'improve'.

A significant association between placement type and health condition was observed but the only influential group was those in relative and kinship care, who were least likely to have an issue in both waves, whereas those in residential care were most likely to have an issue in both waves. The significance of age and residential care may reflect the way the POCLS cohort was sampled in that this is the first entry into care, and therefore the older age group may have experienced more adverse events and/or lack of access to services and support prior to entry into OOHC, leading to higher levels of need and a higher likelihood of placement in residential care.

Children who changed households were more likely to have a need/issue in both waves compared to those who stayed in the same household. There was no bivariate association between household change and deterioration or improvement.

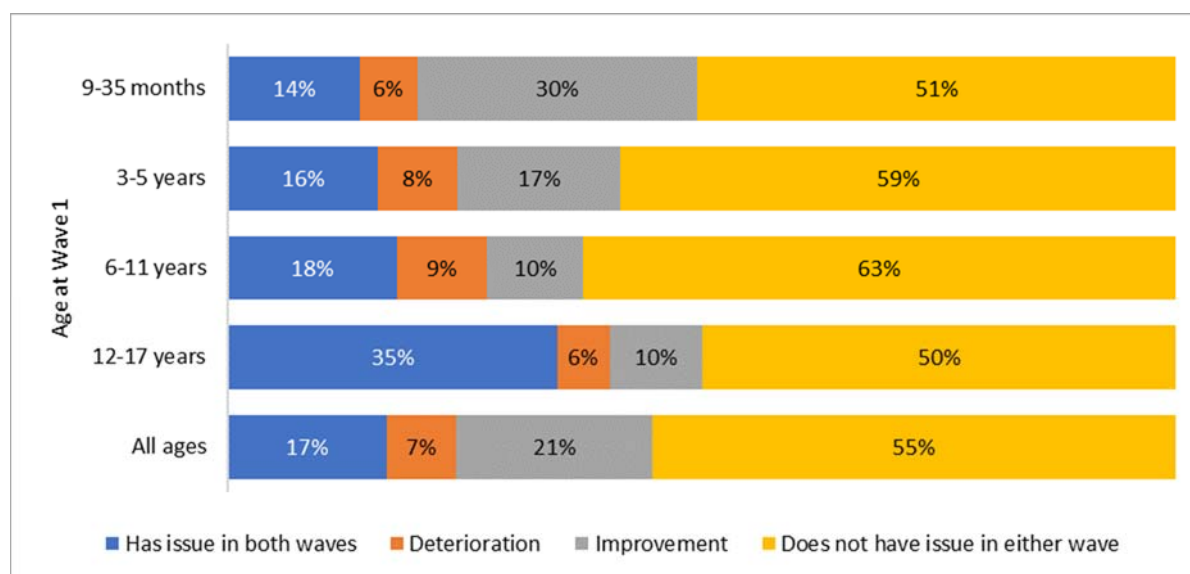
6.3. Change in potential need for services associated with socio-emotional development

Change in the existence of a socio-emotional development need/issue is illustrated in Figure 6.3. Because the source variable is binary, this variable is created by

examining the presence or absence of at least one socio-emotional issue, then comparing the difference between Wave 1 and Wave 2.

Across all age groups, 17% of children were reported to be experiencing a socio-emotional development issue in both waves. A deterioration was experienced by 7% of children, and an improvement was experienced by 21% of children.

Figure 6.3 Change in socio-emotional development needs/issues, Wave 1 to Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Bivariate analysis of child age at Wave 1, placement type, cultural background of children, location and household change found that age was significantly associated with long-term changes in socio-emotional development. Children aged 12–17 years were more likely to have an issue in both waves, and children aged 9–35 months were most likely to experience an improvement. Children aged 6–11 years were least likely to experience an improvement¹⁹.

Placement type was also associated with long-term socio-emotional need for services. Young people in residential care were more likely to have a potential need for services related to socio-emotional development in both waves, children in foster care were more likely to improve, and those in relative/kinship care were least likely to improve and also most likely to not have an issue in either wave.

Children who changed household were more likely to experience an increase in need for services related to socio-emotional development compared to those who remained in the same household. Those who were in the same household were also

¹⁹ Although the chart indicates that the same proportion of 12–17 and 6–11 year olds have improved, there were too few cases of 12–17 year olds who improved for a statistically significant result to be observed, so comparing within those who improved, children aged 6–11 years are the least likely to improve. Full tabular details available on request subject to maintaining confidentiality.

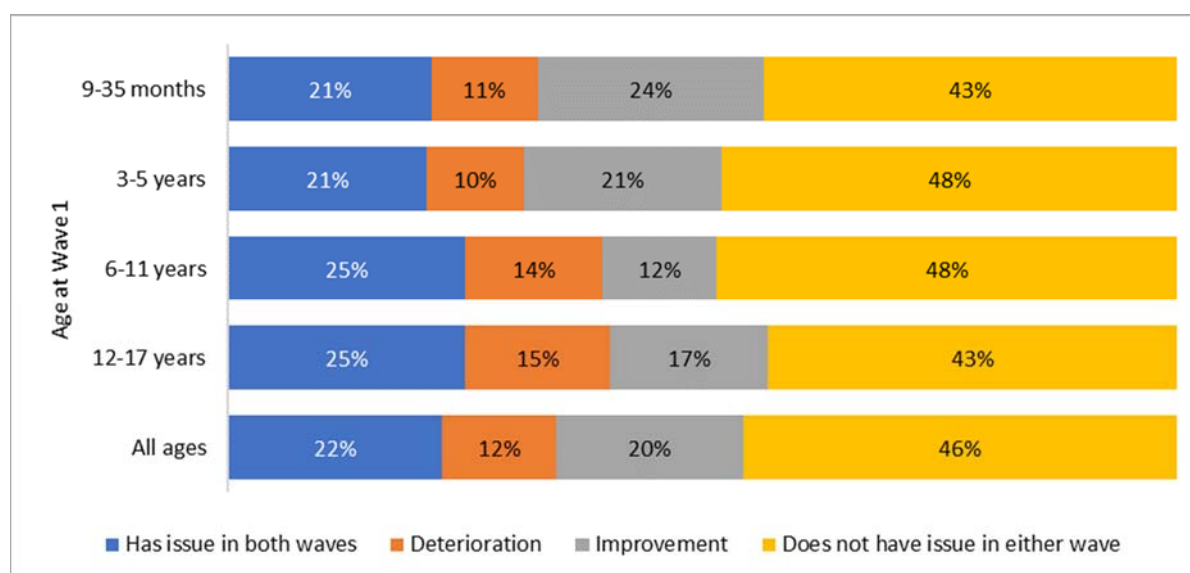
more likely to not have an issue in either wave compared to those who changed households.

6.4. Change in potential need for services related to cognitive development

Figure 6.4 illustrates the change in cognitive development issues amongst children in care between Wave 1 and Wave 2.

Across all ages, 22% of children were experiencing a potential cognitive development service need in both waves. A further 20% had a cognitive need/issue at Wave 1 but did not at Wave 2, and therefore showed an improvement. A deterioration in cognitive needs/issues was experienced by 12% of children.

Figure 6.4 Change in cognitive development issues, Wave 1 to Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

The bivariate analyses found no significant associations between age, placement type, cultural background, location or household change with change over time in cognitive needs/issues.

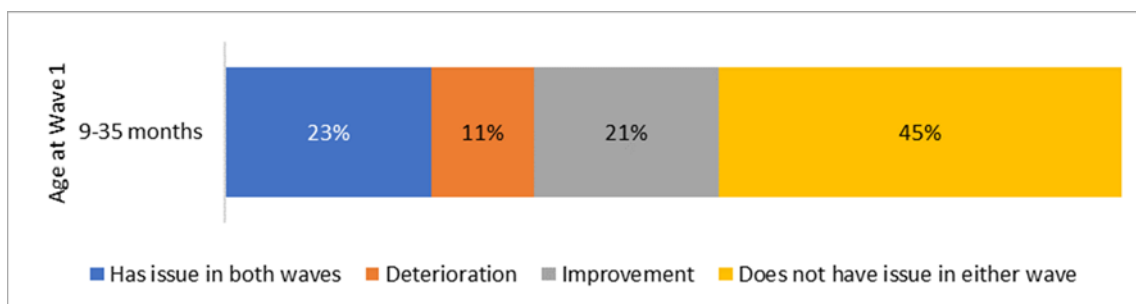
6.5. Change in service need associated with physical development

Physical development of children aged 9 months to 5.5 years was measured (Figure 6.5). Given that many in the 3–5 year age group at Wave 1 moved outside of the

measurement age by Wave 2, this analysis focuses only on children aged 9–35 months at Wave 1²⁰.

Nearly half of these children (45%) had no physical development issue associated with a potential need for services in both waves, 23% had a need/issue in both waves, 11% deteriorated and 21% improved.

Figure 6.5 Change in physical development issues, Wave 1 to Wave 2 (children aged 9 months to 5 years only)



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

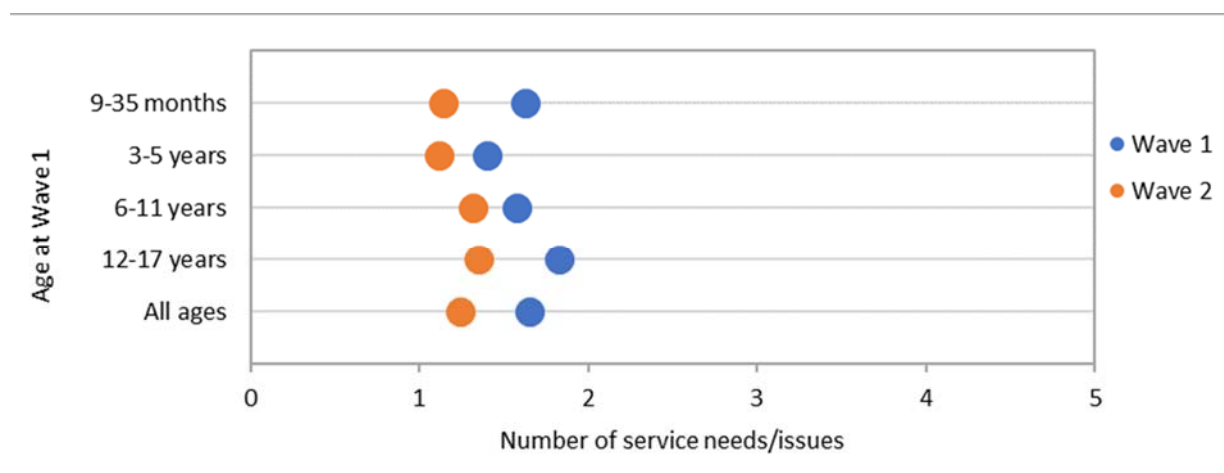
As with cognitive needs/issues, bivariate analyses found no significant associations between placement type, cultural background, location or household change and change in physical development over time.

6.6. Change in the mean number of types of service needs over time

The number of service needs at each wave is shown below in Figure 6.6, the measure is defined in Section 5.4. Across each age group, the mean number of service needs/issues decreased between Wave 1 and Wave 2.

²⁰ Children aged 35 months at Wave 1 will, on average, be 4.5 years old at Wave 2, given the average time between waves was 18 months.

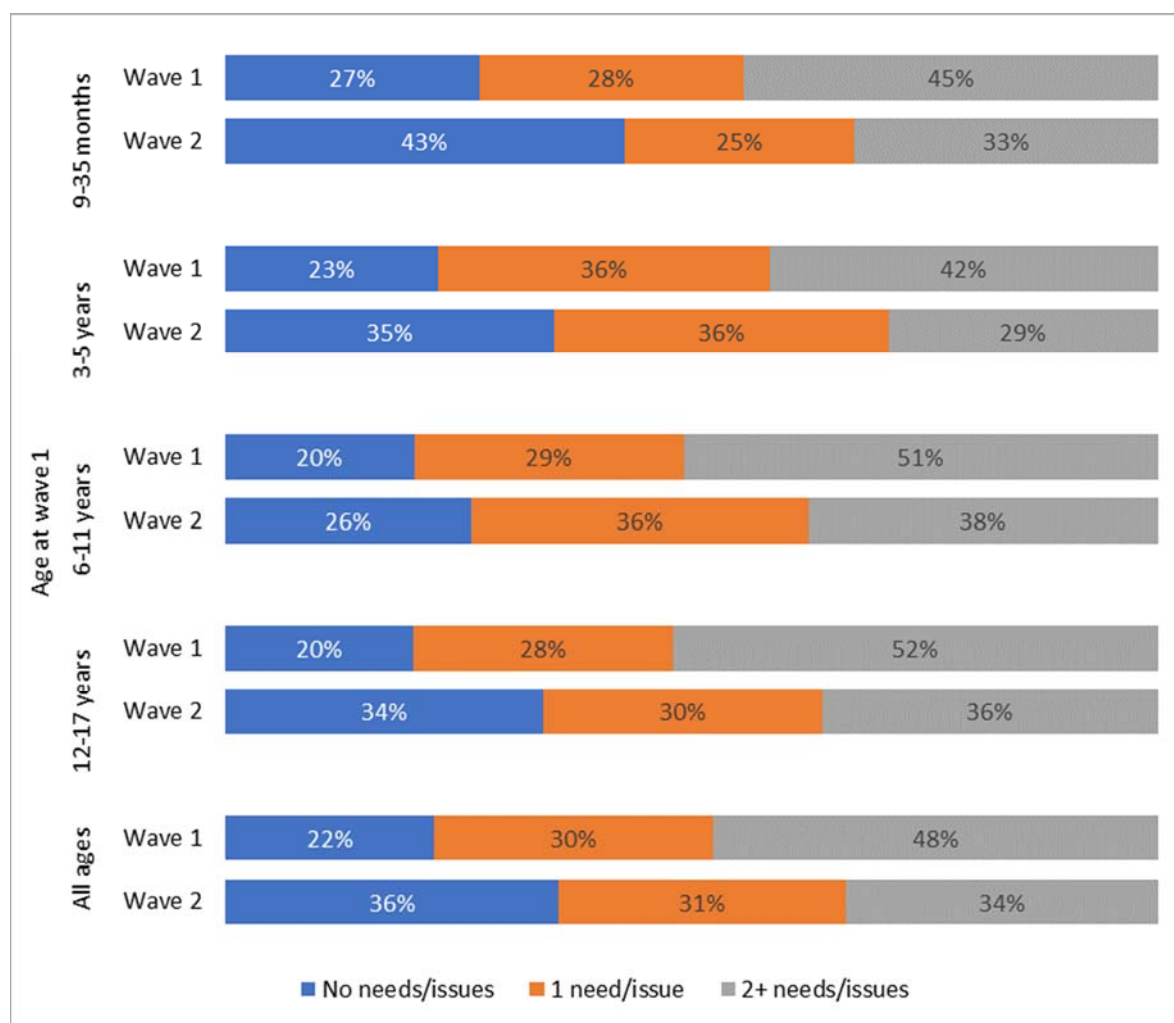
Figure 6.6 Mean number of service needs/issues at Wave 1 and Wave 2 by children's age at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Looking at the count of needs/issues over time, Figure 6.7 provides a comparison of the number across both waves by age group at Wave 1. Across all age groups, there was a 14-percentage point reduction in the number of children with two or more needs/issues at Wave 2 compared to Wave 1. A similar size increase can be observed amongst those children with no needs/issues, in which a 14-percentage point increase is seen. Overall, this analysis indicates that the number of needs/issues decreased considerably between Wave 1 and Wave 2 for all age groups.

Figure 6.7 Count of service needs/issues at Wave 1 and Wave 2 by children age at Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Change over time in the number of needs/issues was examined to determine whether there were any significant differences for change by child age, placement type, location, cultural background or changed household. None of these variables had a significant influence on whether children changed with respect to the number of needs/issues they experienced at Wave 2 compared to Wave 1²¹.

²¹ This analysis was initially run using bivariate associations of each independent variable against the grouped change variable (decrease, same, increase in number of needs/issues); however, no variable was significantly associated with the change. A multivariate ordinal regression measuring the actual change in number was subsequently performed; however, the model did not show any of the listed variables as being associated with change and in addition was not an ideal model for the data due to a very poor fit.

6.7. Summary—change in need for services over time

Wave 2 of the POCLS was conducted on average 18 months after Wave 1, which in turn was conducted on average 18 months after entering care for the first time (receiving final care and protection orders). Thus, children were in care for approximately 36 months by Wave 2.

Carer reports of children's overall health, as well as individual and combined service needs/issues, were examined over both waves to determine changes in children's issues related to potential need for services. The results showed that:

- A large proportion of children (54%) were reported to have the highest overall health rating at Wave 1. Amongst all children, 24% had a better health rating at Wave 2, and there was no difference between any demographic variables (i.e. age, placement type, location, cultural background). Fifty-seven per cent of children had the same health rating at Wave 2 as Wave 1 and 19% deteriorated, with those aged 12–17 and children in residential care being most likely to have lower health ratings at Wave 2.
- Analysis of the number of needs/issues associated with a potential need for services at Wave 1 showed that 48% of children in care had at least two of the need/issue types and 30% had one need/issue. By Wave 2, the number of issues experienced decreased across all age groups, with a 14-percentage point reduction in the proportion of children with two or more needs/issues and an increase in the proportion of children with no needs/issues. Although there was an overall reduction, bivariate and multivariate tests found that no demographic or placement variables (age, cultural background, placement type, location, change of household) were associated with a change in the number of needs/issues over time.
- Analysis of change in the existence of any long-term health conditions between Waves 1 and 2 found that 17% of children had at least one long-term health condition in both waves; 16% deteriorated in regard to long-term health issues, and 27% improved. Few demographic or placement variables were clearly associated with a deterioration or improvement in long-term health. Children aged 6–11 years at Wave 1 were more likely to experience a deterioration and least likely to experience an improvement over the two waves. Children in residential care were most likely to have a condition in both waves (i.e. at least one long-term health condition in both Wave 1 and Wave 2). Children who changed households were also more likely to have an issue in both waves compared to those who stayed in the same household, but the causal direction is not clear.
- Regarding individual needs/issues, no variables were associated with change in potential need for services associated with cognitive development between waves. With respect to change in potential need for services related to socio-emotional development, children in residential care and those aged 12–17 were more likely to be experiencing a need/issue in both waves. Children aged 9–35 months and those in foster care, when compared to other age groups, were most likely to experience a reduced need for services related to

socio-emotional development. No variables were clearly associated with increased need for service.

Overall, the findings indicate that children in the POCLS cohort had high levels of needs/issues. Generally, the wellbeing of children improved, with around double the proportion whose wellbeing improved between the two waves compared to those whose wellbeing deteriorated. There was no difference between Aboriginal, CALD and other Australian children in their level of needs/issues or their improvement/decline over the two waves.

7. Health service and specialist utilisation

This section provides the results of analysis of health service, professional services and specialist service use of children in care at Wave 1 and 2 of the POCLS.

7.1. Service use analytic definitions

The results in this section are based upon carer reports of children's service access and relate to the current placement as at the Wave 1 and Wave 2 interviews. Wave 1 service use relates to the time either from entry to care until the Wave 1 interview, or time in the current placement up until the Wave 1 interview if the children changed placements after entering care. Wave 2 service use relates to the time between the Wave 1 and Wave 2 interviews or to time in the current placement up until the Wave 2 interview if the children changed placements between Wave 1 and Wave 2.

With respect to referrals and response to services, the long-term health condition categories used in Section 5 are reused in this section (i.e. carer-reported long-term physical conditions and carer-reported long-term health conditions).

Service use relates to carer reports of whether children had ever accessed a range of services²² in the current placement. No information was recorded about the frequency of access or duration of access, so the results relate to the access or non-access of service types at Wave 1 and Wave 2. An additional summative variable has also been created that counts the number of service types utilised by children. As mentioned above, this does not represent the number of times children accessed services. Quality of services provided to the children is not measured in the POCLS either.

Finally, the service needs/issues examined in the previous sections are now used in this section of the analysis as control variables in addition to the demographic and placement-related variables used previously. Although there is not a direct link between specific health and development issues and services, the existence of these issues may influence service need and use, so it is important that they are included here.

All tabular results for this section are available on request subject to maintaining confidentiality.

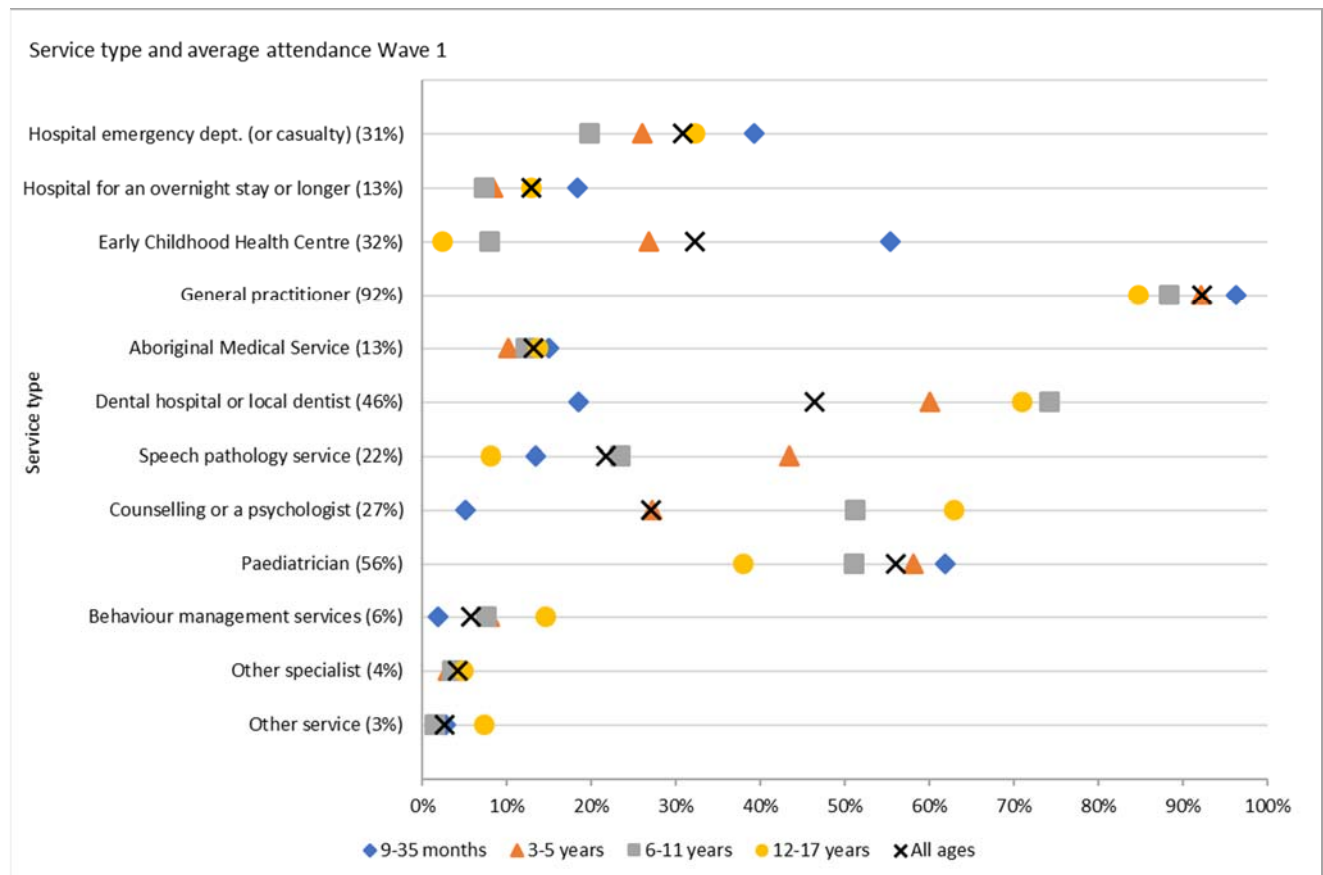
7.2. Service use prior to Wave 1 interview

Figure 7.1 provides an illustration of the percentage of children reported to have attended a range of services in the current placement as at the Wave 1 interview.

²² In Wave 2, a number of 'other' services were back coded; however, due to the need to analyse change over time, these have been retained as 'other' so that comparisons are consistent, particularly when counting the number of service types.

Across all ages, the most common service type attended was general practitioners, which 92% of all children had attended. The largest age difference in service use was for Early Childhood Health Centres and dental services. For the former, use dropped as children got older (which is to be expected given the service type). For dental services, children in the youngest age group had very little use, and again this is to be expected. Outside of 'other' services and specialists, the service with least service use was behaviour management services.

Figure 7.1 Service use during current placement at Wave 1



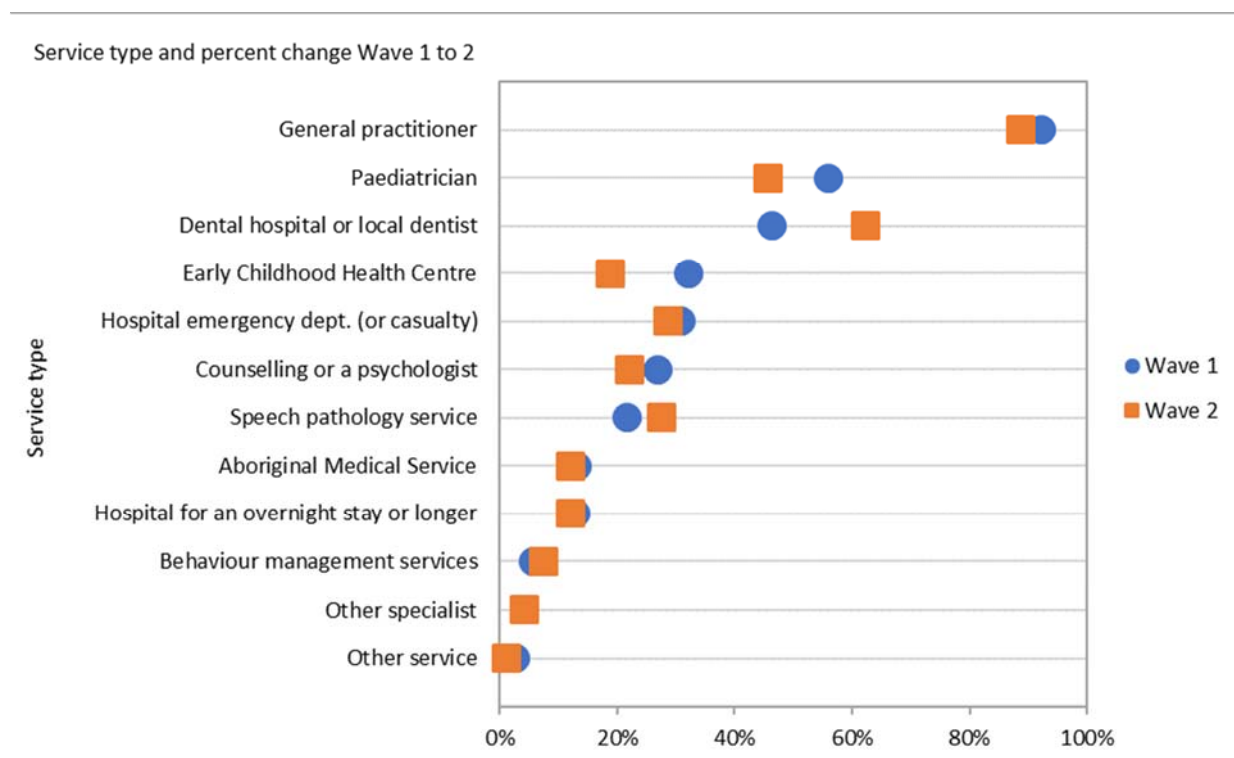
Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

7.3. Service use across both waves

Figure 7.2 provides results of service access for all ages in both Waves 1 and 2. The results indicate that the services with the largest changes in access were those related to particular ages. As Figure 7.1 indicates, dental services and speech pathology were accessed by older children and these were the services with the largest increase in access. Although behaviour management access has low overall access, it also increased with age and showed an increase over time.

Services aimed at very young children showed the opposite pattern, with early childhood services and paediatricians having the largest reduction in service access across waves.

Figure 7.2 Service use, Wave 1 and Wave 2 and change between waves



Source: Authors' calculation using POCLS carer and children Wave 1 and Wave 2 survey file V6

Overall, these findings indicate that children in the POCLS cohort did not change their levels of access to services over the two waves.

7.4. Regression—service use at either wave

In order to examine whether there were associations between any demographic, placement-related variables or needs/issues and service access, a series of logistic regressions were performed in which the outcome variable was derived as reported use of the service at either Wave 1 or Wave 2²³. The resulting binary variable represented 'Reported service use' or 'No reported service use'. Given that age was influential in access, the age groups were reduced to two (under 6 years and 6 years and over)²⁴ and separate regressions run for both age groups. Independent variables used in the analysis then included placement type, location, cultural background and indicators of socio-emotional development issues, cognitive issues and reported long-term health conditions at Wave 1. Regressions were not performed for general practitioner use due to their almost universal use. Regressions were also not performed for the 'other' categories due to small service use numbers. Details of the results can be provided on request subject to maintaining confidentiality.

The results indicated that accounting for cultural background, location and needs/issues, and placement type was significantly associated with some types of service access: children younger than 6 years in relative/kinship care were less likely to have attended Early Childhood Health Centres, dental services and speech pathology. Amongst children older than 6, those in residential care were more likely to access behaviour management services.

Location of children was also associated with some service access. Accounting for placement type, cultural background and needs/issues, children under 6 years of age had higher odds of attending a hospital emergency department, dental service, speech pathology or counsellor/psychologist if living in the northern non-metropolitan area. Amongst children aged 6 and older, those living in the northern non-metropolitan area were also more likely to attend a counsellor/psychologist but less likely to attend an Early Childhood Health Centre. Those living in the western non-metropolitan areas were more likely to attend hospital emergency departments.

Aboriginal children aged 6 and older were less likely to attend counselling/psychologist; no other cultural background effects were observed. This includes a separate regression of Aboriginal children only and analysis of access to Aboriginal Medical Centres, in which no associations were significant.

With respect to service needs/issues, the results indicated that holding placement type, location, cultural background and other service needs statistically constant, children under 6 years of age with potential needs for services related to socio-emotional development at Wave 1 were more likely to attend speech pathology, paediatricians and behaviour management services. Amongst those over 6 years of age, socio-emotional development issues at Wave 1 were associated with an

²³ This may underrepresent services use amongst children who changed placements prior to Wave 1 or between the Wave 1 and Wave 2 interviews due to carers reporting service use for the current placement only.

²⁴ Age groups were reduced to two to maintain efficiency in modelling. Some age groups and independent variable combinations are too small to be reliably modelled—the under/over 6 partition was based on the general Wave 1 service use results previously shown above.

increased likelihood of attending paediatricians, counselling/psychology services and behaviour management services.

Children under 6 with cognitive development needs/issues were less likely to attend a counsellor or psychologist than those without cognitive development needs/issues.

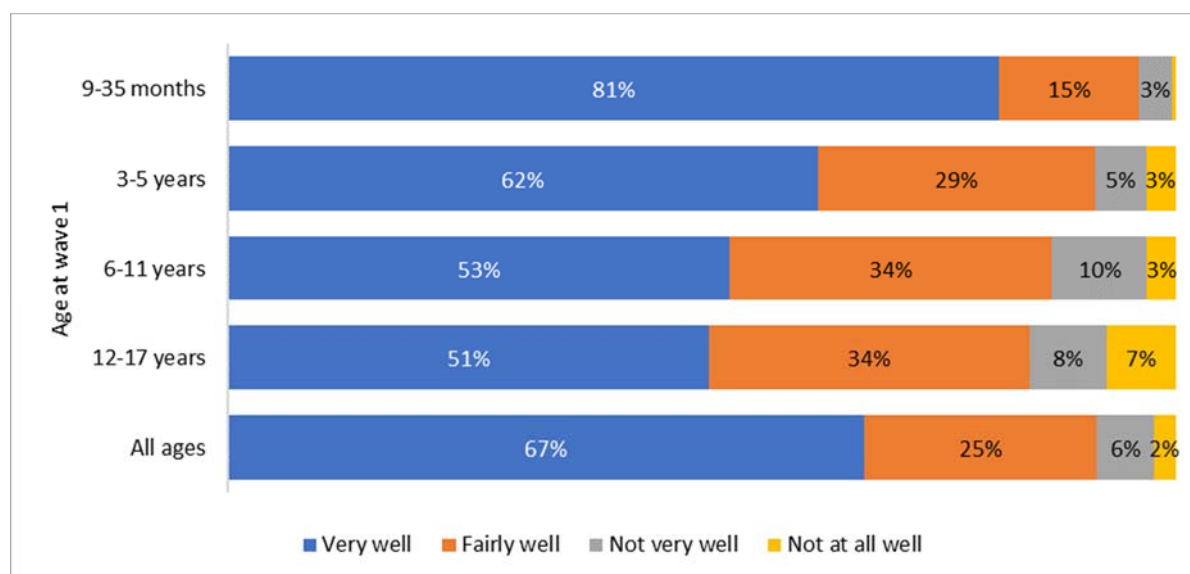
Children under 6 with any carer-reported long-term health conditions at Wave 1 were more likely to attend hospital emergency departments, hospitals for an overnight/longer stay, paediatricians or counselling/psychology services compared to those without long-term health conditions.

7.5. Carer rating of service needs being met

This section provides a description of the carer rating of the study children's service needs being met at both Wave 1 and Wave 2. The original variable is a four-point scale ranging from 'very well' to 'not at all well'.

Figure 7.3 illustrates the Wave 1 results to this question. Across all ages, 67% of carers rated the study child's service needs as being very well met. This rating decreased with age. Amongst children aged 12–17 years, 7% of carers responded that the study child's needs for services were not at all well met.

Figure 7.3 Carer rating of how well study children's needs for services are being met at Wave 1, by children's age at Wave 1

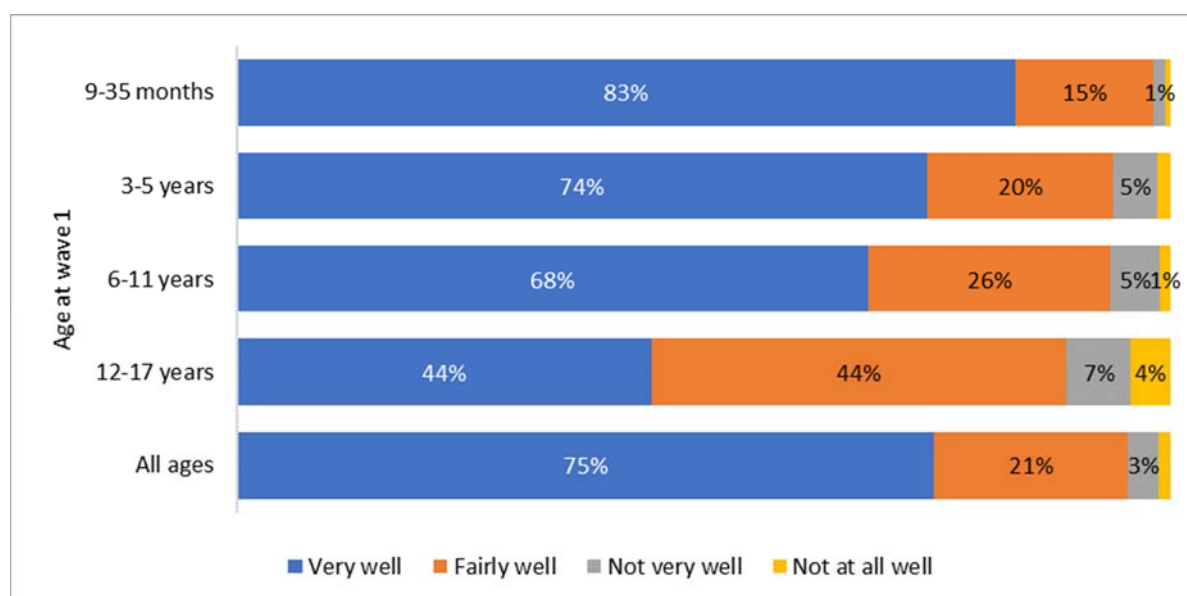


Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Looking at the Wave 2 responses shown in Figure 7.4, there is an overall increase in the percentage of carers rating their child's service needs being met 'very well' compared to Wave 1, and an overall decrease in those rating their child's service needs as being met 'fairly well'. There was a slight overall reduction in those that were rated 'not very well' and 'not at all well'.

The largest change in individual item response was amongst the small number of 12–17 year olds who responded to Wave 2. This group showed a deterioration in their rating of services meeting young people’s needs ‘very well’. However combining ‘very well’ and ‘fairly well’ showed little change. Amongst children aged 3–5 years, there was an increase in the percentage of carers reporting their service needs were met ‘very well’ but again, combining ‘very well’ and ‘fairly well’, little change is observed. Children aged 6–11 years showed an increase in service needs being met over time both for carers rating their needs being met ‘very well’ and when combining ‘very well’ and ‘fairly well’. Amongst the youngest group, children aged 9–35 months, there was a small increase in service needs being met ‘very well’ over time. Overall, therefore, carers’ perceptions of the degree to which children’s needs for services were being met improved slightly as the children progressed through care.

Figure 7.4 Carer rating of how well study children’s needs for services are being met at Wave 2, by children’s age at Wave 1



Source: Authors’ calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

7.6. Regression—need for services being met across both waves

In order to explore which variables were associated with the ratings of need for services, a logistic regression was performed in which the carer ratings were averaged over both waves. Since there were so many responses in the top category (very well met) and relatively few in the lower categories, there was not enough data to undertake a more complex multivariate analysis, so the average response was converted to a binary variable representing ‘service needs being very well met in both waves’ and ‘lower rating’. The tabular results of this regression are available on request subject to maintaining confidentiality.

The regression results indicated that location, age (increasing age), socio-emotional development issues at Wave 1, cognitive issues at Wave 1, and any long-term health conditions at Wave 1 were associated with lower average carer ratings of the study

children's service needs being met. With respect to location, the reference area in this analysis was southern metro; children in the northern and western regions (both metropolitan and non-metropolitan) all had lower ratings of child service needs being met compared to the reference area.

Children who changed households between Wave 1 and Wave 2 had an increased likelihood of being rated as having their overall service needs being very well met.

7.7. Summary—health and specialist service use

- Services were generally well-utilised by children after entering care. The most common service type attended was general practitioners, who were seen by almost all children in both waves.
- The type of service attended depended on children's age and needs/issues. Early Childhood Health Centres and paediatricians were more likely to be attended by younger children, and dental services, speech pathology, behaviour management and counselling/psychology were more likely to be attended by older children. Hospital emergency departments were more likely to be attended by the oldest (12–17) and youngest (9–35 months) age groups.
- Children with potential needs for services related to socio-emotional development were more likely to attend speech pathology, paediatricians and behaviour management services if under 6 years of age, and paediatricians, counselling/psychology services and behaviour management services if aged 6 or older. Children under 6 years of age with any carer-reported long-term health conditions at Wave 1 were more likely to attend a hospital emergency department, hospitals for an overnight/longer stay, paediatricians or counselling/psychology services.
- Young children in relative/kinship care were less likely to have attended Early Childhood Health Centres, dental services and speech pathology. Amongst older children, those in residential care were more likely to access behaviour management services.
- Young children in the northern non-metropolitan area were more likely to attend a hospital emergency department, dental service, speech pathology or counsellor/psychologist. Older children in the same area were more likely to attend a counsellor/psychologist. Those living in the western non-metropolitan areas were more likely to attend hospital emergency departments. No other location effects were found to be influential in individual service access.
- Children from Aboriginal, CALD and mainstream backgrounds had very similar levels of access to services, other than that Aboriginal children over 6 had lower use of counselling services.
- With respect to carer rating of child service needs being met, carers rated the vast majority of services as meeting the child's needs very well. Logistic regression found that location, age (increasing age), socio-emotional

development issues at Wave 1, cognitive issues at Wave 1, and any long-term health conditions at Wave 1 were associated with lower average carer ratings of the study children's service needs being met. With respect to location, the reference area in this analysis was southern metropolitan, and children in the northern and western regions (both metropolitan and non-metropolitan) all had lower ratings of child service needs being met compared to the reference area.

- Children who changed carers between Waves 1 and 2 had an increased likelihood of being rated as having their average service needs being very well met in both waves.

8. Barriers to service use

Carers of children with a carer-reported long-term health condition who were unable to access services they needed were asked to provide information about the barriers to access. For all service types, the vast majority of carers reported that there had been no barriers to access services. The original responses related to individual health issues; however, these have been combined due to very low numbers of carers reporting that the study child could not access any particular service. Another variable was also derived, which combined any barriers except where the carer responded that the service was 'not needed'. This variable was used when examining demographic and placement associations with barriers to service access. The tabular results of this section are available on request subject to maintaining confidentiality.

Across both waves, there were relatively few carers with a study child who experienced a long-term health condition and who encountered barriers to services. Figure 8.1 illustrates the responses of carers who have a study child with a long-term health condition and who reported any barriers to services at Wave 1 and/or 2. It shows that long waiting lists were the most common barrier across all age groups.

Figure 8.1 Barriers to service access amongst carers reporting any barriers in Wave 1 and/or 2, multiple choice



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

9. Support for carers

The final section of this report relates to carer responses about professional and informal support.

Since the analysis is based on carers, the sample size is different to the previous results; this is because some carers are caring for more than one child. In these cases, carer responses have only been counted once and the characteristics of the children they are caring for are summarised into age of youngest study child, any Aboriginal study children and any CALD study children. Only carers who completed two waves are included in this analysis. In addition, residential carers were not asked many of these questions so have been excluded from some analysis in this section.

A limitation in this section is that differences in children's legal orders have not been explored. Differences in policy and practice for carers with parental responsibility mean that these carers are not expected to have casework support; however, they have been retained in the analysis to show the overall amount of support and satisfaction of the support provided, regardless of legal order. It is anticipated that this will be explored in more detail in future reports.

The tabular results of this section are available on request subject to maintaining confidentiality.

9.1. Casework support for carers

Foster and relative/kinship carers were asked a range of questions relating to the type of contact they have with their caseworker, as well as their satisfaction with the assistance provided by caseworkers and agencies related to the study child (e.g. early childhood education, counsellors etc.).

The following figures (Figure 9.1, Figure 9.2 and Figure 9.3) show the raw distribution of responses to three questions related to carer's satisfaction with communication with and relationship to caseworkers. In general, carers are satisfied or very satisfied. Foster carers reported higher levels of satisfaction with their communication and relationship with their caseworker.

Figure 9.1 Ability to reach caseworkers when needed—foster and relative/kinship carers, Wave 1

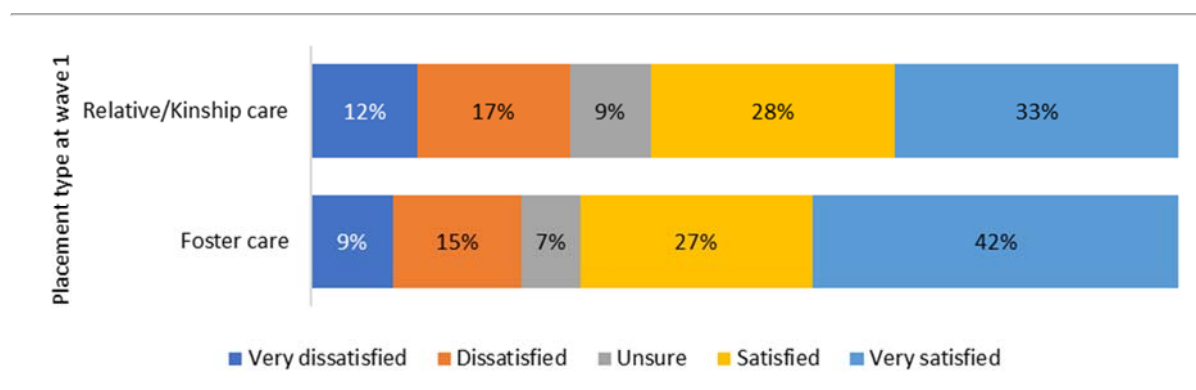


Figure 9.2 Assistance from caseworkers, foster and relative/kinship carers, Wave 1

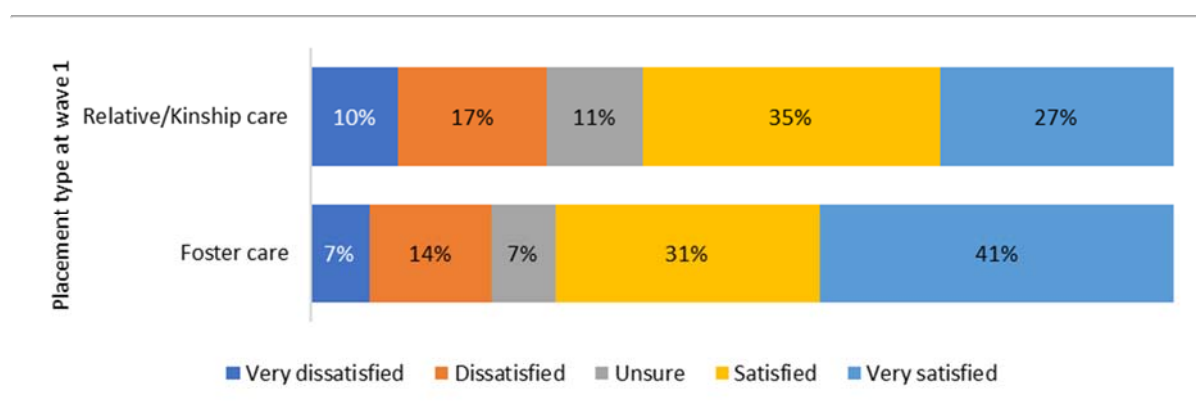
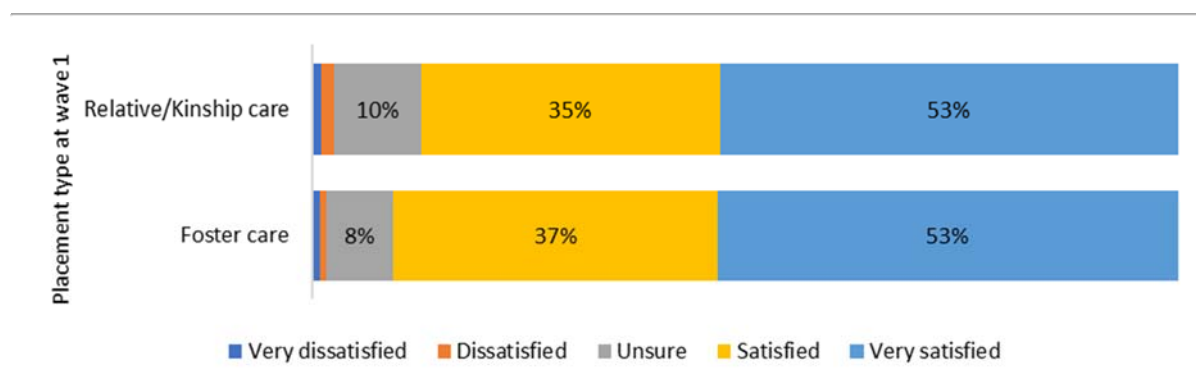


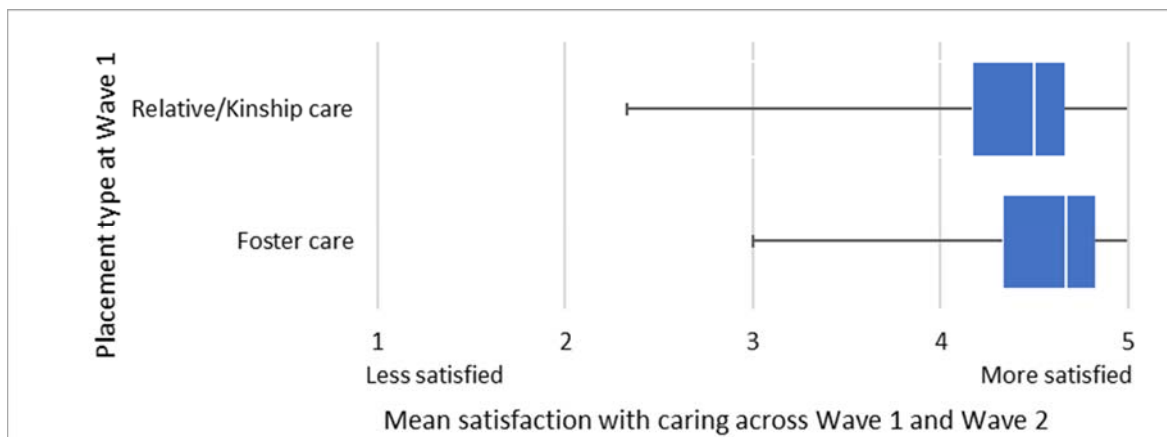
Figure 9.3 Working relationship with other agencies related to study child, foster and relative/kinship carers, Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

These items were grouped into an index and then averaged over both waves to enable an examination of the average satisfaction of carers with their relationship and communication with their caseworker and other agencies related to the study child. The resulting index retained the same scale as the original questions, so ranged between one and five, with a score of one representing lower levels of satisfaction across both waves, and five representing high satisfaction across both waves.

Figure 9.4 Average satisfaction rates for caseworker and associated agencies amongst foster and relative/kinship carers across Wave 1 and Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

To explore the associations between carer demographics and placement characteristics, and average satisfaction across both waves, a univariate analysis of variance was conducted in which carer age group, an indicator of the carer having a spouse, carer cultural background, placement type, location, indicators of whether any study children are Aboriginal or CALD, the number of service needs (as defined in Section 5), the age of the youngest study child and the number of study children were included as independent variables. The primary focus of the analysis was to explore the relationship between placement type and average satisfaction levels.

The results (summary in Table 9.1, full results available on request subject to maintaining confidentiality) indicate that accounting for carer age, spouse, culture, location and study child characteristics, relative/kinship carers had lower average satisfaction with the communication, relationship and assistance from caseworkers and associated agencies compared to foster carers.

Table 9.1 Univariate analysis of regression summary—average carer satisfaction with relationship and assistance from caseworkers and associated agencies across Waves 1 and 2

Parameter	B	95% Confidence Interval		Significance
		Lower Bound	Upper Bound	
Intercept	3.73	3.37	4.09	***
Foster care	0.23	0.10	0.36	**
Southern metro	0.21	0.00	0.41	
Southern non-metro	0.33	0.07	0.58	
Northern metro	0.35	0.10	0.60	**
Northern non-metro	0.36	0.17	0.55	***
Western metro	0.30	0.08	0.52	**
Western non-metro (ref)				

Note: Partial output shown, full output available on request subject to maintaining confidentiality.

Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

* $p < .05$, ** $p < .01$, *** $p < .001$

Additional regression analyses showed that a higher average number of service needs experienced by the study children²⁵ was also significantly associated with lower satisfaction amongst carers, after controlling for carer characteristics and other study children's characteristics.

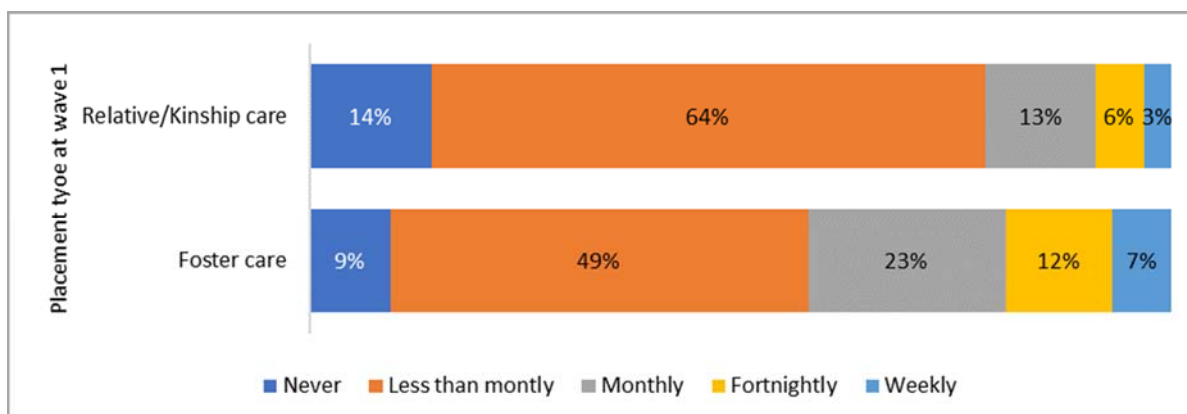
In addition, location of placement was also associated with satisfaction levels; however, post-hoc comparisons found that this was only between northern non-metropolitan and western non-metropolitan areas (northern non-metropolitan had significantly higher satisfaction levels compared to western non-metropolitan).

Foster and relative/kinship carers²⁶ were also asked about the frequency and mode of communication with their caseworkers. The following figures show the response for Wave 1. Most carers had face-to-face contact less than monthly (Figure 9.5), with foster carers reporting higher frequency of contact compared to relative/kinship carers. Over three quarters (78%) of kinship carers reported contact less than monthly or never compared to 58% for foster carers. Phone or email contact rates were lowest for relative/kinship carers with 58% having monthly or less phone/email contact compared to 30% of foster carers. As indicated above, it is possible that these findings are partly an indicator that some kinship carers had full parental responsibility and therefore would not be expected to have contact with the caseworker.

²⁵ The number of service needs was averaged across all study children in the household.

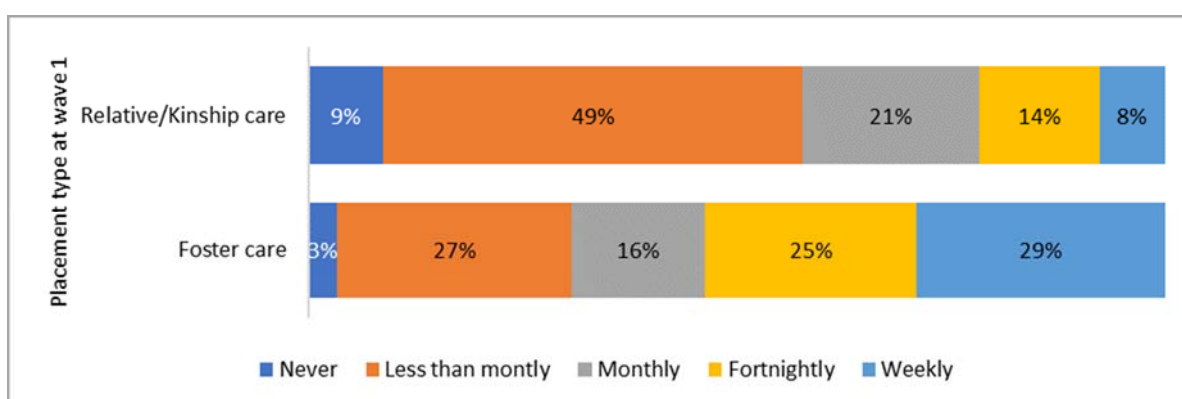
²⁶ Residential carers were also asked about contact with caseworkers; however, there are too few to include in this analysis so they have been excluded.

Figure 9.5 Frequency of face-to-face contact between caseworker and relative/kinship and foster carers Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Figure 9.6 Frequency of phone or email contact between caseworker and relative/kinship and foster carers Wave 1

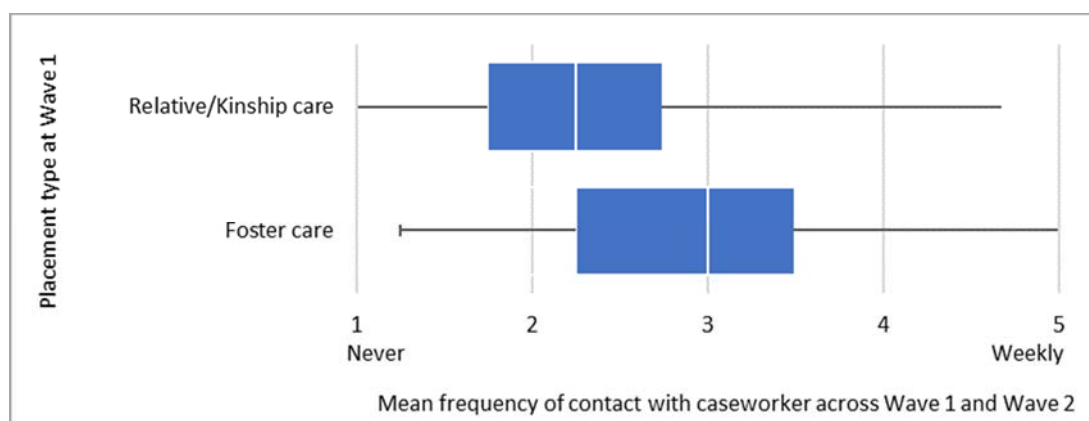


Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

In order to examine the factors that are associated with contact rates, and to determine whether contact rates were different for care type once other variables were controlled, a scale was derived that combined contact rates across Waves 1 and 2²⁷. Figure 9.7 shows the resulting average distribution of responses between relative/kinship carers and foster carers across both waves. As with the Wave 1 responses, the average contact across both waves is higher for foster carers.

²⁷ In Wave 2, this question had additional values relating to those who had contact less than monthly. In order to create a cross-wave scale, the items were harmonised so all items relating to less than monthly contact (except 'never', which remained) were grouped together.

Figure 9.7 Average contact frequency with caseworker across waves 1 and 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

A univariate analysis of variance was conducted to examine the relationship between frequency of contact and placement type while accounting for carer cultural background, location of placement, the number of study children, the age of the youngest study child in the household and the number of needs/issues for the study child/ren.

The results indicated that accounting for the variables listed above, foster carers report significantly more contact with caseworkers across both waves of the survey compared to kinship carers. No other independent variables had significant associations with contact between carer and caseworker.

Table 9.2 Univariate analysis of regression summary—average carer contact with caseworker across Waves 1 and 2

Parameter	B	99% Confidence Interval		Significance
		Lower Bound	Upper Bound	
Intercept	2.27	1.90	2.64	***
Foster care	0.68	0.53	0.83	***

Note: Partial output shown, full output available on request subject to maintaining confidentiality.

Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

* $p < .05$, ** $p < .01$, *** $p < .001$

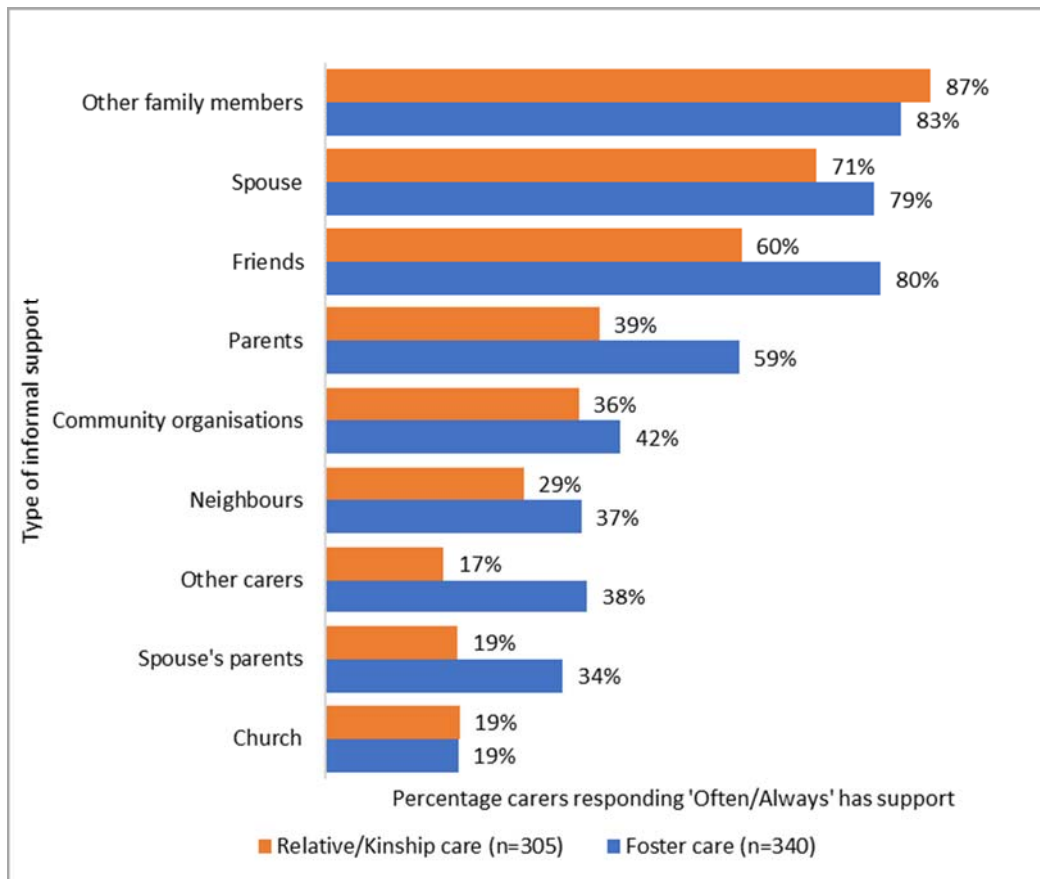
9.2. Informal support for carers

Carers were asked to provide an indication of the frequency with which various informal support networks were utilised. The following analysis provides a description of the types of services 'often' or 'always' used by the carer, and the overall amount of support across both waves.

Figure 9.8 shows that family and friends are the most common types of support used by carers, with an average of 84% of all carers reporting that they often or always get support from other family members. The largest difference between placement types was for friends and carer's own parents, with foster carers reporting a higher frequency of support from these groups. The finding is likely to reflect the relative

ages of foster and kinship carers; many kinship carers are grandparents and therefore unlikely to have parents able to provide support. Kinship carers were slightly more likely than foster carers to be supported by other family members, but in all other categories foster carers were more likely to get support (other than church, where the proportion is the same).

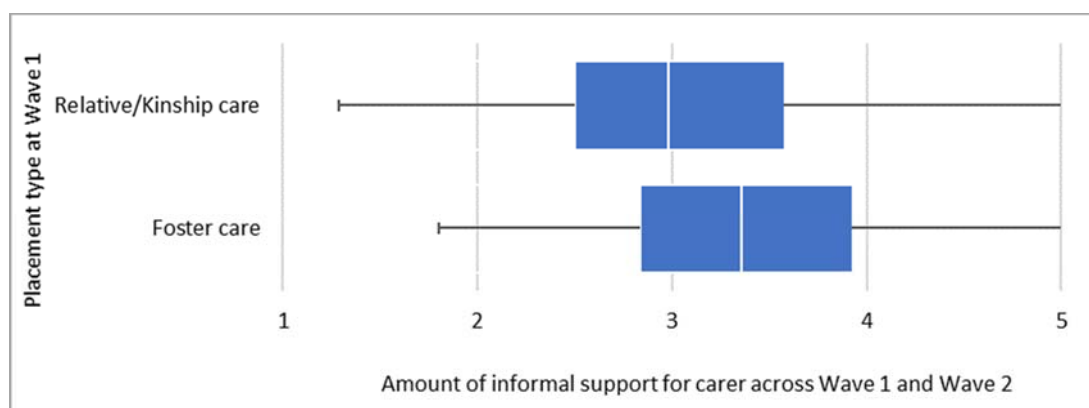
Figure 9.8 Type of informal support often or always used by carer across Wave 1 or 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

In order to explore differences between the amount of informal support experienced by carers, a mean informal support variable was derived that utilised the original scales for each of the support types (one through to five, *never* through to *always*). This was averaged across all support types and across waves to form the final item, which had the same range (one through to five), in which higher numbers represent more informal support. Figure 9.9 shows the distribution for this variable—relative/kinship carers report less informal support compared to foster carers.

Figure 9.9 Amount of informal support for carers, Wave 1 and Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Informal support for carers was analysed using a univariate analysis of variance in which carer and children's characteristics were entered as independent variables (summary in Table 9.3, full results available on request subject to maintaining confidentiality)²⁸. The results confirmed that foster carers experience more informal support than relative/kinship carers once carer age, spouse in household, location of placement, carer cultural background, care of Aboriginal or CALD child, the number of children in care, the age of the youngest child and the number of needs/issues are held statistically constant.

In addition, the location of the placement was also significantly associated with the amount of informal support experienced by carers. Holding the same carer and child characteristics constant, the results indicated that carers living in the southern metropolitan area experienced the lowest rates of informal support. This was followed in order by southern non-metropolitan, northern metropolitan, northern non-metropolitan, western metropolitan and western non-metropolitan. Within these areas, there were significantly better informal support rates between those living in western non-metropolitan and other areas except northern metropolitan. Western metropolitan was significantly lower than western non-metropolitan.

²⁸ This model was checked using a second model that included the mean number of services accessed by study children in the household; however, this did not influence the results.

Table 9.3 Univariate analysis of regression summary-average amount of informal support for carer across waves 1 and 2

Parameter	B	99% Confidence Interval		Significance
		Lower Bound	Upper Bound	
Intercept	3.78	3.33	4.24	***
Foster care	0.25	0.09	0.41	***
Southern metro	-0.77	-1.03	-0.52	***
Southern non-metro	-0.60	-0.90	-0.29	***
Northern metro	-0.40	-0.71	-0.09	**
Northern non-metro	-0.51	-0.74	-0.28	***
Western metro	-0.44	-0.70	-0.17	***
Intercept	3.78	3.33	4.24	***

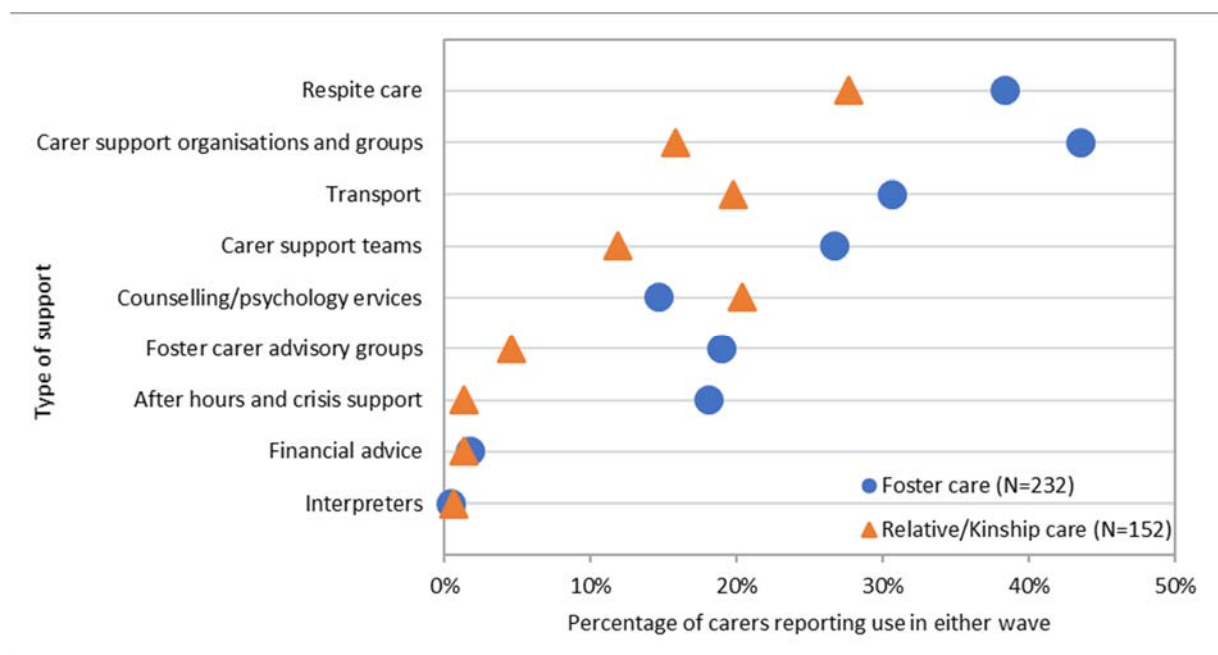
Note: Partial output shown, full output available on request subject to maintaining confidentiality.
Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6
Note: * $p < .05$, ** $p < .01$, *** $p < .001$

9.3. Professional support for carers

Carers were asked whether they have received any professional support services to assist them as carers. The following analysis reports the type and number of these services across both waves of the survey.

Figure 9.10 shows that the most common services accessed by carers are respite care and carer support organisations; however, there are large differences in access between placement types. The largest difference is for carer support organisations and groups, which 44% of foster carers and only 16% of relative/kinship carers reported using. Amongst relative/kinship carers, childcare, respite care and counselling/psychology services were most commonly used, whereas amongst foster carers, carer support organisations, childcare and respite care were most commonly used.

Figure 9.10 Professional services and supports used by carers across Wave 1 or Wave 2

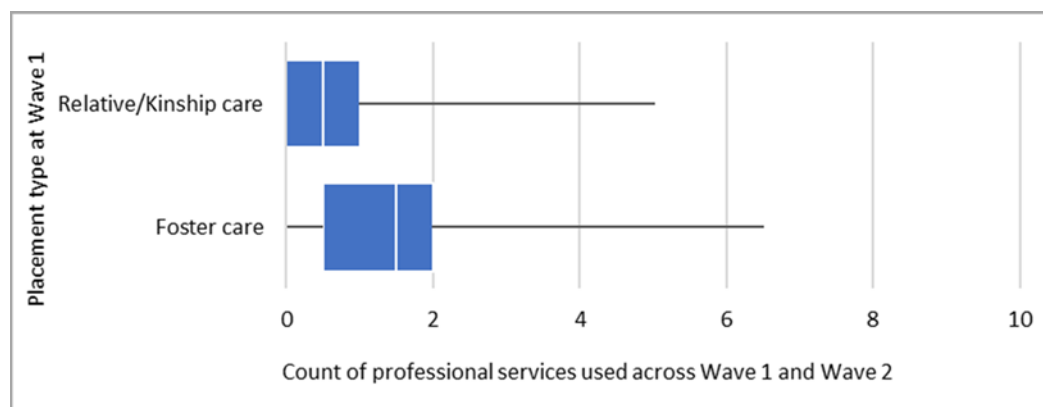


Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Although excluded from the above chart due to age-specific service provision, it is notable that the POCLS Wave 1 baseline statistical report found that at Wave 1, 96% of children aged 4-5 in the POCLS cohort were reportedly attending some type of childcare or preschool (AIFS, Chapin Hall, NSW FACS, 2015).

Figure 9.11 shows the average number of services used by carers across both waves of the survey. This measure was calculated by taking the mean number of professional services reported as being accessed by each carer across both waves of the survey and then rounding the result down to integers. It shows that foster carers use a wider range of services than relative/kinship carers.

Figure 9.11 Average number of professional services used across Wave 1 and Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

This measure was analysed using a Poisson regression (suitable for count variables) to determine whether the differences in the number of services used remained different across placement types while accounting for carer and study child/ren characteristics.

The results of the Poisson analysis (summary below in Table 9.4, full results available on request subject to maintaining confidentiality) confirmed that foster carers were expected to use a wider range of services once carer and child/ren characteristics were accounted for. In addition, carers with a spouse living in the household were expected to utilise fewer services.

Table 9.4 Poisson regression summary—average number of service types accessed by carer across Waves 1 and 2

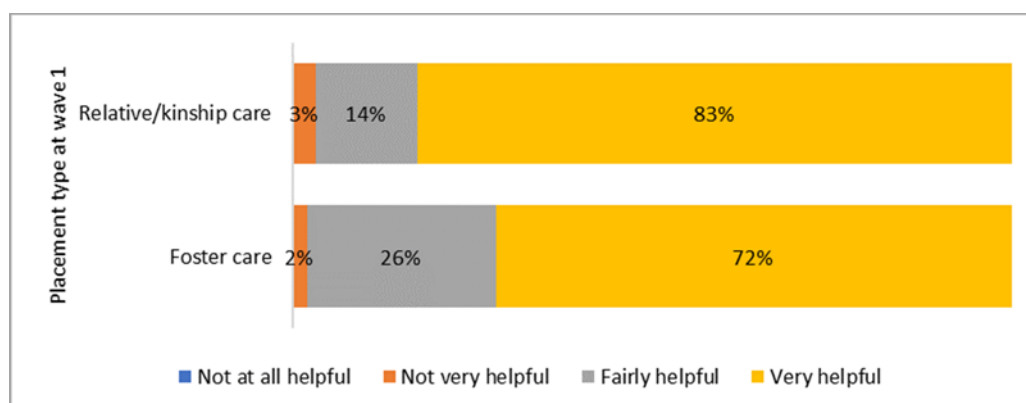
Parameter	B	Significance	Exp(B)	95% Wald Confidence Interval for Exp(B)	
				Lower	Upper
(Intercept)	-0.09		0.92	0.62	1.36
Carer has spouse	-0.24	**	0.79	0.68	0.91
Foster care	0.62	***	1.87	1.61	2.16

Note: Partial output shown, full output available on request subject to maintaining confidentiality.
Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6
Note: * $p < .05$, ** $p < .01$, *** $p < .001$

A second regression was run, including the mean number of service needs across study children in the household and the mean number of services accessed by study children in the household at Wave 1. The amount of service needs and child service access were both associated with an increase in the expected count of services accessed by the carer; however, the overall results did not change. Even accounting for the issue/need and service access 'load' of the household, foster carers are still expected to access more services.

Figure 9.12 illustrates that amongst carers who were able to access services, the services were rated as being very helpful. Very few respondents indicated that services were less than 'very helpful' in either wave.

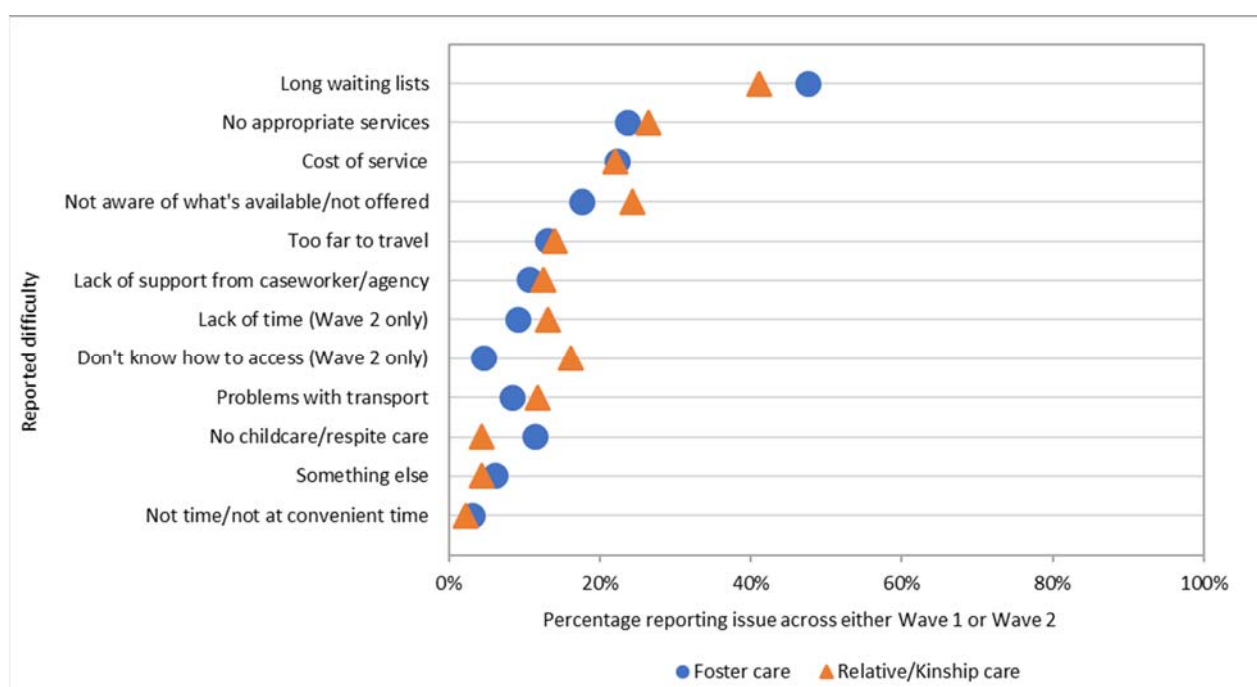
Figure 9.12 Helpfulness of professional services used in Wave 1 and Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Carers who reported that they still required services were then asked to provide information on the types of difficulties encountered. Figure 9.13 shows that, similar to services for children, long waiting lists was the most commonly reported issue by both foster and relative/kinship carers. There were few differences observed between carer types, with the largest differences being that kinship carers reported more often that they do not know how to access the services.

Figure 9.13 Difficulties in obtaining professional support services across Wave 1 and Wave 2



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Figure 9.14 illustrates the percentage of carers who reported using a range of services when the study child was first placed. Carer allowance payment was reported to be accessed by almost all carers. The largest difference between foster carers and relative/kinship carers were those reporting access to a carer support

group—a much lower percentage of relative/kinship carers reported using these groups.

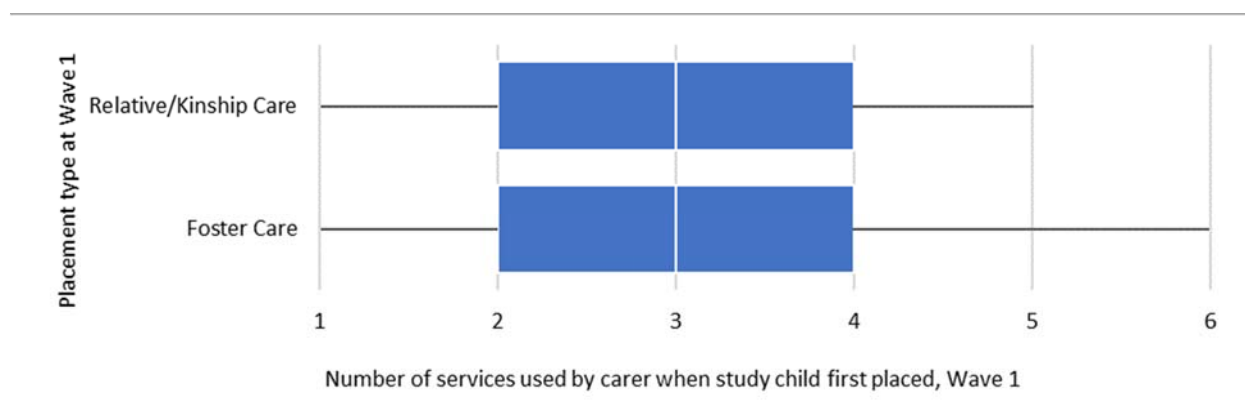
Figure 9.14 Services and supports used when study child first placed



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

The number of services utilised when the study children were first placed is shown below in Figure 9.15. As with the previous results relating to service use, a multivariate Poisson regression analysis confirmed that foster carers utilised a wider range of services after accounting for carer characteristics and child characteristics. No other variables were significant.

Figure 9.15 Number of services used by carer when child first placed, Wave 1

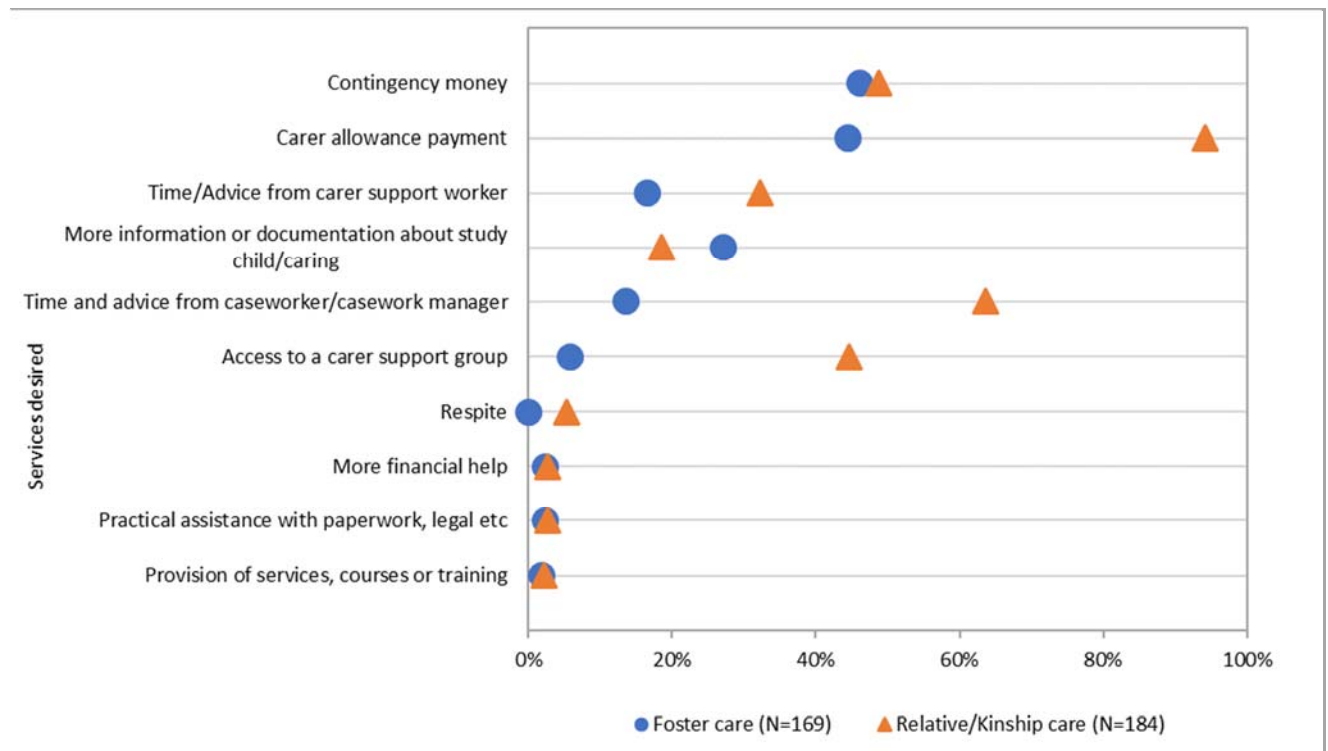


Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

Carers were asked whether there were any services that they required but were not received. The following chart provides a breakdown of responses at Wave 1 amongst carers who reported that services and supports were needed but not received. This represents 60% of relative/kinship carers and 50% of foster carers. The most common overall needed service or support across both carer groups was for

contingency money (for example, additional money to set up the placement to cover furniture, clothes and other items), which was reported as being needed but not received by 46% of foster carers and 52% of relative/kinship carers. Kinship carers were more likely to report not receiving carer allowance payment, time and advice from caseworkers and access to a carer support group compared to foster carers.

Figure 9.16 Services desired but not received by study child-carers reporting a need, Wave 1



Source: Authors' calculation using the POCLS carer and children Wave 1 and Wave 2 survey file V6

9.4. Summary—carer support

- Relative/Kinship carers of the POCLS cohort experience lower amounts of professional, informal and casework support than foster carers. This was also the case when taking into account potential confounding variables using multivariate regression analysis. Some of this difference may be accounted for by differences in legal order—some relative/kinship carers have parental responsibility and are therefore not provided with the same level of professional support as other carers. This will be explored in more detail in upcoming reports.
- Relative/Kinship carers had lower average satisfaction with the communication, relationship and assistance from caseworkers and associated agencies compared to foster carers.
- Carers who cared for children with higher levels of needs/issues also had lower satisfaction with the communication, relationship and assistance from

caseworkers and associated agencies. Overall, carers caring for children with service needs reported lower satisfaction rates than carers of children with no service needs.

- Foster carers report significantly more contact with caseworkers across both waves of the survey compared to kinship carers. No other independent variables had significant associations with contact between carer and caseworker.
- Both types of carers had more contact by email/phone than face to face. Face-to-face contact with relative/kinship carers was lower than foster carers with 78% of these carers reporting contact less than monthly or never compared to 58% for foster carers. There were also differences in frequency of phone/email contact, with 29% of foster carers reporting weekly contact, compared to 8% of relative/kinship carers.
- Relative/Kinship carers also reported lower rates of informal support compared to foster carers, both in the range of supports that often or always provide support to the carer, and the overall amount of informal support. Again, this relationship remained once other potentially confounding variables were included.
- Informal support was highest amongst those living in the western non-metropolitan area, and lowest for carers in the southern metropolitan area.
- Amongst professional services used by carers when the child had first been placed, childcare, respite care and carer support organisations were utilised more than other professional services.
- There were relatively large differences between foster and relative/kinship carers in the types of professional services used; the largest difference was for carer support organisations and groups, which 44% of foster carers and only 16% of relative/kinship carers reported using.
- Amongst relative/kinship carers, childcare, respite care and counselling/psychology services were most commonly used, whereas amongst foster carers, carer support organisations, childcare and respite care were most commonly used.

10. Discussion

Overall, this analysis shows that children in the POCLS cohort have relatively high levels of potential needs for services related to psychological, socio-emotional, physical and cognitive needs/issues during the early part of their care trajectory. Over the two waves of the survey the levels of needs/issues stayed the same or improved for most of the cohort. There were no specific groups of children whose needs/issues showed particular improvement or deterioration over the two waves.

As children age their needs and issues tend to decrease, but even taking age into account, the number of needs for services declined and the overall health of children improved between Wave 1 and Wave 2 of the study. The level of need/issue is also associated with the age the children came into care, with the youngest (9–35 months) and, even more so, the oldest (12–17 years) age groups showing higher levels of needs/issues. This is not the case for long-term health conditions, which the youngest age group were less likely to experience than other age groups. This may indicate that children coming into care at younger ages are able to access preventive health services which can forestall the development of health conditions, but it could also be that some conditions only emerge or are only diagnosed later in life.

Children who moved placement tended to have higher needs/issues related to socio-emotional development. There were mixed results relating to children who changed households between the two waves. Carer ratings of health went down between Wave 1 and Wave 2; however, carers also said that they had their service needs met ‘very well’ in both waves. These findings may be a result of different carers responding in the two waves.

Children who moved households were more likely to have a need for service in both waves compared to those who remained in the same placement. These children were more likely to have an increase in need related to socio-emotional development, but when all needs were combined, there was little difference between the overall need (i.e. number of needs) between those that changed household and those that remained in the same placement. Overall, the analysis did not find that a change of placement was associated with poorer outcomes for children over the two waves. Analysis of further waves will be needed to provide a clearer picture of the impact of placement change on children’s wellbeing.

The findings relating to care type are consistent with the research literature, showing that children in residential care have the highest needs/issues, and those in kinship care have lower levels of needs/issues than those in foster care. This is most likely due to selection—children with very high needs are not usually placed in kinship care. To some extent, this may also be accounted for by the fact that these assessments are provided by the carer, and kinship carers may be less disposed to identify needs or issues in the children in their care than foster carers or residential care staff. Nevertheless, in contrast to the US literature, children in kinship care had similar levels of access to services compared to those in foster care.

Aboriginal and CALD children with similar placement and demographic characteristics do not differ from other Australian children, either in their level of

need/issue or in the change in needs/issues over the two waves. This is an unexpected finding, as the majority of the research literature indicates that these groups are more vulnerable than mainstream children and have poorer outcomes in OOHC.

The differences between different groups of children and their numbers of needs/issues were small. In the multivariate analysis there was no difference with regard to placement type, age at Wave 1, Aboriginal status or household change. In addition, children tended to improve or stayed the same, irrespective of any of these factors. This may therefore be an effect of OOHC itself, or it may be the case that in the general population most needs and issues tend to improve over time as children grow up.

Overall, the children in this cohort appear to have had access to a wide range of services, and service use is broadly associated with the child's level of need. Very few carers reported that their child was unable to access a needed service, and satisfaction with services was generally very high. Long waiting lists was the most cited barrier to accessing services, but this applied to a minority of services.

Unsurprisingly, the age of the child appeared to be the major factor associated with service use, with young children using more services than older groups. As children grew up in care they tended to use fewer services, as would be expected. Aboriginality did not affect service use for children, other than that Aboriginal children aged 6 and older were less likely to attend counselling/psychology services; no other cultural background effects were observed. The services accessed did not vary by placement type (with some exceptions). The service access questions in the POCLS are not able to measure the extent of use of any particular service²⁹, nor the quality of services provided.

The analysis shows that, taking into account a range of demographic variables, as well as the service needs/issues of the children and the children's access to services, foster carers use more professional services than kinship carers. Carers with a spouse used lower numbers of professional services.

An increase in health service use amongst children was associated with an increase in the count of professional service types accessed by carers. This could indicate either that carers with more vulnerable children need more support and therefore access more services, or it could mean that some carers are more likely to access services—both for the children and for themselves.

The analysis indicated that foster carers are able to access more informal supports, as well as professional support services, compared to kinship carers. This is true, even considering that the level of needs/issues of children in foster care is higher than those in kinship care. These findings are consistent with previous literature, which shows that foster carers access services more than kinship carers, but it adds to the literature by showing that kinship carers do not offset the lack of professional

²⁹ When Medical Benefits Scheme and Pharmaceutical Benefits Scheme data are linked to the POCLS, these questions will be able to be answered. For this analysis, only carer reports are used to assess access to services.

support with informal support. This indicates a need for better support for kinship carers, who represent an increasing proportion of the carer workforce.

This difference between foster and kinship carers is particularly apparent in their views regarding casework support—foster carers have much more contact with caseworkers than kinship carers, and are more satisfied with their contact. However, unlike previous research, which indicated that kinship carers are reluctant to engage with caseworkers, the kinship carers in this study were more dissatisfied with the level of casework support they received than foster carers, perhaps indicating a greater desire for more casework contact.

Despite the lower levels of support accessed by kinship carers, the children in their care have similar profiles of service use to those in foster care, indicating that kinship carers are as adept as foster carers at accessing services (other than casework support). Also, some of the factors which would be expected to be associated with service use, such as Aboriginality, appear not to be significant predictors of service use amongst children or carers. The data available for this analysis was not able to differentiate service use by remoteness, which would be expected to affect access to services.

Overall, the findings from this analysis indicate that the POCLS cohort was faring relatively well in their first years of being in OOHC:

- Wellbeing appeared to be improving over the two waves.
- Access to services was generally good.
- Carers do not report significant barriers to services.
- Aboriginal and CALD children seem to be doing as well as others and have similar access to services.

11. Limitations

The results are not representative of every child in OOHC; however, they are representative of children who are the subject of final children's court orders for the first time.

The analysis provides measures of association only and cannot show causal effects.

The data is not weighted, as no weights were available at the time of analysis. This means that the results apply to those who completed the surveys only, and the results may change when weighted to represent all children entering care for the first time.

Residential care was included in the child analysis, as were children who had changed placements. However, the numbers in these groups were very small, and the results may therefore be unreliable or not generalisable. Residential carers were excluded from the carer analysis, as too few had responded across both waves of the survey.

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Appendix Outcome measure derivation and definitions

The following variables were created for use in this analysis as outcomes:

Table A. 1 Outcome variable information

Variable Group	Variable	Categories	Source
Child needs/issues and potential need for services			
	Number of service needs as at Wave 1 interview	Count (0 through 5) of any of the following: Any socio-emotional development issue Any physical development issue Any cognitive development issue Any long-term physical (or 'other') health condition Any long-term psychological health condition	Derived
	Grouped count of service needs as at Wave 1 interview	Grouped count of service needs (0, 1, 2+)	Derived
	Carer-reported general health rating as at Wave 1 interview	1 (very poor) to 6 (excellent)	Carer report
	Any socio-emotional development issue as at Wave 1 interview	Yes/No	Derived ⁺
	Any physical development issue as at Wave 1 interview	Yes/No	Derived ⁺

Variable Group	Variable	Categories	Source
	Any cognitive development issue as at Wave 1 interview	Yes/No	Derived ⁺
	Any long-term physical (or other) health condition as at Wave 1 interview	Yes/No	Derived ⁺
	Any carer-reported long-term psychological health condition as at Wave 1 interview	Yes/No	Derived ⁺
	How well children's need for services met as at Wave 1 interview	1 (very well) to 4 (not at all well)	Carer report
Children change in needs/issues and potential need for services			
	Grouped count of service needs as at Wave 2 interview	Grouped count of service needs (0, 1, 2+)	Derived
	Change in the number of services needed between Wave 1 and Wave 2	-5 to 5 (negative number is a decrease in the number of services needed, positive number is an increase in the number of services needed, 0 is no change).	Derived ⁺
	Change in carers rating of child's general health	-5 to 5 (negative number indicates child's health has deteriorated, positive number indicates it's improved, 0 indicates it's remained the same)	Derived

Variable Group	Variable	Categories	Source
	Change in existence of carer-reported long-term health conditions	Has issue in both waves Improvement (had issue in Wave 1, does not have issue in Wave 2) Deterioration (does not have issue in Wave 1, has issue in Wave 2) Does not have issue in both waves	Derived ⁺
	Change in existence of socio-emotional issues	Has issue in both waves Improvement (had issue in Wave 1, does not have issue in Wave 2) Deterioration (does not have issue in Wave 1, has issue in Wave 2) Does not have issue in both waves	Derived ⁺
	Change in existence of physical development issues	Has issue in both waves Improvement (had issue in Wave 1, does not have issue in Wave 2) Deterioration (does not have issue in Wave 1, has issue in Wave 2) Does not have issue in both waves	Derived ⁺
	Change in existence of cognitive development issues	Has issue in both waves Improvement (had issue in Wave 1, does not have issue in Wave 2) Deterioration (does not have issue in Wave 1, has issue in Wave 2) Does not have issue in both waves	Derived ⁺
Service use			
	Use of a range of health specialists and services during placement as at Wave 1 interview	Yes/No [multiple choice range of items] Service use during current placement. If child changed placements since entry to care, this will only represent time spent with current carer.	Carer report

Variable Group	Variable	Categories	Source
	LTPhysRefW1: Referral made for any physical (or 'other') condition	Yes/No	Derived ⁺
	LTPsychRefW1: Referral made for any psychological condition	Yes/No	Derived ⁺
	LTPhysWellW1: Child responding well to treatment for any physical (or 'other') condition	Yes/No	Derived ⁺
	LTPsychWellW1: Child responding well to treatment for any psychological condition	Yes/No	Derived ⁺
	LTPhysNoW1: Child with any physical (or 'other') condition not resolved	Yes/No	Derived ⁺
	LTPsychNoW1: Child with any psychological condition not resolved	Yes/No	Derived ⁺

Variable Group	Variable	Categories	Source
	Use of a range of health specialists and services during placement as at Wave 2 interview	<p>Yes/No [multiple choice range of items]</p> <p>If in same placement as Wave 1, this refers to use between Wave 1 and Wave 2 interviews, if in different placement, this is since placement commenced.</p> <p>Note that the later comparison of service types means that additional backcoded service types provided in Wave 2 are counted as 'other' to align with Wave 1 categories.</p>	Carer report
	Number of service types attended as at Wave 1	Use during current placement. If child changed placements since entry to care, this will only represent time spent with current carer.	
	Change in the numbers of services attended	<p>-12 to 12</p> <p>(negative number refers to fewer service types attended in Wave 2 compared to Wave 1, positive number indicates more service types attended in Wave 2 compared to Wave 1)</p>	Derived ⁺
Barriers to service use			
	Barriers to service use as at Wave 1 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Carer report
	Reasons for barrier for any physical (or 'other' issue) as at Wave 1 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived

Variable Group	Variable	Categories	Source
	Reasons for barrier for any psychological issue as at Wave 1 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived
	Reasons for barrier for any long-term health issue (phys or psych or other) as at Wave 1 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived
	Barriers to service use as at Wave 2 interview	Yes/No [multiple choice range of items]	Carer report
	Reasons for barrier for any physical (or 'other' issue) as at Wave 2 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived
	Reasons for barrier for any psychological issue as at Wave 2 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived

Variable Group	Variable	Categories	Source
	Reasons for barrier for any long-term health issue (phys or psych or other) as at Wave 2 interview [multiple choice range of items]	Yes/No [multiple choice range of items]	Derived
Carer support*			
	Satisfaction with caring as at Wave 1	1 (low) to 5 (high satisfaction) Mean of: Overall satisfaction with foster or kinship parenting, Satisfaction with opportunities to meet other foster or kinship families, Likelihood to continue being a carer	Derived
	Change in satisfaction with caring between Wave 1 and Wave 2	-5 to 5 (negative number is a decrease in satisfaction, positive number is an increase in satisfaction, 0 is no change)	Derived
	Amount of informal social support for carer as at Wave 1	1 (low) to 5 (high support) Mean of: range of 9 informal supports to carer in raising study child (original questions relate to frequency of support, 'never' through 'always')	Derived
	Change in the average amount of informal social support for carer between Wave 1 and Wave 2	-5 to 5 (negative number is a decrease in satisfaction, positive number is an increase in satisfaction, 0 is no change)	Derived
	Amount of informal support	0 to 9 Count of the number of informal supports who 'often' or 'always' support carer	

Variable Group	Variable	Categories	Source
	Change in amount of informal support between Wave 1 and Wave 2	-9 to 9 (negative number is a decrease in amount of informal support, positive number is an increase in amount of informal support, 0 is no change)	
	Amount of professional support utilised	0 to 11 Count of the number of professional support service types used to support carer	
	Helpfulness of professional support services	1 (very helpful) to 4 (not at all helpful)	
	Satisfaction with assistance from caseworkers and other agencies as at Wave 1	1 to 5 (very satisfied) Mean of: Satisfaction with being able to reach caseworkers when needed, Satisfaction with assistance from caseworkers, Satisfaction with your working relationship with other agencies related to Study Child (early childhood education, counsellors, etc.)	
	Range of professional support services still required to assist carer as at Wave 1 interview	Yes/No [multiple choice range of items]	Carer report
	Range of reasons related to other demands of being a carer or why support was not provided	Yes/No [multiple choice range of items]	Carer report

Notes:

+ Refer to Section 4.4 for information on how these items were derived.

* All carer support variables are created and subsequently analysed at a carer level–this means only one observation per carer and therefore the N amongst the carer analysis is lower than that of the child analysis due to carers with more than one study child.

The following table provides details of the source and categories created for all independent variables used in the analysis.

Table A. 2 Independent variable creation

Item	Categories	Source
Child characteristics		
Child age at Wave 1 interview	9–35 months 3–5 years 6–11 years 12–17 years	Carer/Child Survey
Cultural background of study child	Aboriginal CALD Other Australian Unspecified	Carer/Child Survey
Placement characteristics		
Placement type at Wave 1 interview	Foster care Relative/Kinship care Residential care	Carer/Child Survey
District of interview at Wave 1	[FACSAR districts]	As provided* Admin data linked to Carer/Child Survey
District (metro/non-metro) at Wave 1	[FACSAR districts grouped into metro/non-metro]	As provided* Admin data linked to Carer/Child Survey
Whether children changed household between Wave 1 and Wave 2	Yes/No	If Wave 2 household ID is different to Wave 1 ID, child has changed household

Item	Categories	Source
Carer characteristics		
Age at Wave 1 interview	21–40 years 41–50 years 51–60 years 61+ years	Carer/Child Survey
Whether carer has spouse living in the household	Yes/No	Carer/Child Survey
Cultural background of interviewed carer	Aboriginal CALD Other Australian Unspecified	Carer/Child Survey
Whether the household is an Aboriginal household (based on carer/ spouse Aboriginal status)	Yes/no	Carer/Child Survey

Note:

*‘As provided’ = unchanged from POCLS datafile provided by FACSAR.

