Support needs and placement matching in out-of-home care

A Literature Review
Introduction

In July 2012, the Queensland Child Protection Commission of Inquiry identified placements as “a central feature of child protection services and one of the biggest challenges facing the Queensland child protection system” (Queensland Child Protection Commission of Inquiry, 2013, p.251). The key concern identified by the Commission “is that demand for places is outstripping supply, leading to what many describe as a ‘mismatch’ between the services assessed as suiting an individual and the services ultimately received by the individual” (Queensland Child Protection Commission of Inquiry, 2013, p.251).

This paper examines the national and international research on the support needs of children and young people in out-of-home care and placement matching processes, with the purpose of informing policy, program development and practice.

Children and young people entering out-of-home care, both within Australia and overseas, are presenting with increasingly complex levels of need. Rates of mental health and behavioural disorders are particularly high compared to rates for children and young people in the general community. Placement instability remains a key challenge, particularly for adolescents. These challenges are even greater for a proportion of all children and young people in out-of-home care, who present with complex or extreme levels of need. In theory, placement matching is considered to be important however in general, it occurs in limited and unsystematic ways.

Prior to examining the research on the needs of children in out-of-home care and placement matching, the state of the evidence requires noting, namely:

- little research has been undertaken in Australia and that which does exist, tends to focus on foster care;
- the research rarely compares different models of care or placement types, with a view to the needs of, or outcomes for, distinct groups of children and young people;
- although multiple approaches to placement matching exist, very few of these approaches are evidenced-based or evaluated;
- no research specific to Aboriginal or Torres Strait Islander children or young people has been identified as part of this literature review.

Although the content of this paper is divided into key sections, there are many linkages across research outcomes and findings. For example, placement instability may cause, as well as exacerbate mental health problems, and mental health problems significantly contribute to placement instability.

Behavioural, emotional and mental health problems

The research clearly demonstrates the extent to which children and young people in out-of-home care experience mental health problems, and prevalence rates may be underestimated by child protection workers (particularly where there is an absence of corresponding externalising behavioural disturbances).
Studies of children in out-of-home care consistently describe **high rates** of mental health disorders characterised by behavioural disturbances such as oppositional defiant disorder, conduct disorder and attention difficulties (Octoman et. al., 2014). Kelly and Salmon suggest that “The prevalence of clinically significant emotional and behavioural problems such as non-compliance, aggression, problems with impulsivity and attention, anxiety and depression in children involved in child welfare investigations has been found to be 42-48%” (Kelly & Salmon, 2014, p.536). Further, levels of externalising behaviour are **more than twice** the levels seen in children and young people in the general community, with an average of 42% for children in care (Kelly & Salmon, 2014).

A range of standardised assessment measures and screening tools used in some jurisdictions identify **even greater** levels of mental health and behavioural problems in the out-of-home care population. For example, Octoman et. al., (2014) report that the Child Behaviour Checklist, the Strengths and Difficulties Questionnaire and the Assessment Checklist for Children indicate that **around 60%** of children and young people in care have **clinical levels** of behavioural and mental health disturbance, especially externalising and oppositional behaviour (Octoman et. al., 2014).

In America, “**more than 80%** of children in out-of-home care have an emotional or behavioural disorder or developmental problems” (Barth et. al., 2007, p.46). Depression has also been identified as a **critical issue** among the out-of-home care population. For example, “In the National Survey of Child and Adolescent Well-Being (NSCAW) sample at baseline, **approximately 20%** of the children aged 7 years and older who had been placed out of the home were assessed as being depressed.” (Barth et. al., 2007, p.46). Further, children who display irritable or withdrawn behaviours are at an **elevated risk** for a diagnosis of depression (Barth et. al., 2007).

Factors contributing to developing mental health problems include longer exposure to adverse environments, entering care at an older age, developmental delay, placement instability and lack of a permanent placement (Kelly & Salmon, 2014).

Alternatively, mental health disorders, particularly those characterised by externalising behaviours, are **strongly associated** with risk of placement disruption. “Once children start on a trajectory of placement disruption due to externalising behaviour problems, it is **likely to continue**, with children who have two or more behaviour-related placement disruptions having **only a 5% chance** of achieving placement stability two years later” (Kelly & Salmon, 2014, p.536).

More specifically, the research demonstrates that mental health status, conduct disorder levels, oppositional/defiant behaviours, attention problems and depression are **predictors** of either early or ongoing placement disruption for children and young people in care (Octoman & McLean, 2014; McLean et. al., 2012; Schofield & Simmonds (eds), 2009; Barth et. al., 2007; Osborn et. al., 2008; Osborn & Delfabbro, 2006; Bromfield et. al., 2005).

Kelly and Salmon suggest that “Since children in foster care **often do not** receive any specialist mental health care, it is **critical** that foster care is as stable and reparative as possible” (Kelly & Salmon, 2014, p.537).

**Placement stability and disruption**

A significant amount of out-of-home care research, both national and international, deals with placement stability and disruption. This appears to be related to researchers using placement stability or placement disruption as the **most common** outcome measure for children and young people in care. Although in more recent years, researchers have begun to consider other outcome
measures for children and young people in care (i.e. psychosocial outcomes), findings specific to placement stability and disruption remain significant.

As indicated previously, placement instability may create, or exacerbate, mental health problems (e.g. anxiety, depression, antisocial behaviour) in children and young people (Octoman & McLean, 2014; Parenting Research Centre & the University of Melbourne, 2013; Chor, 2013; Blakey et. al., 2012; Osborn et. al, 2008; Bromfield et. al, 2005), and mental health problems also significantly contribute to placement instability.

Further, placement instability also creates or exacerbates a range of other needs (e.g. social and school difficulties, indiscriminate friendliness, sense of security, lack of reserve with unfamiliar adults) in children and young people (Kelly & Salmon, 2014; Bromfield et. al, 2005; Barber & Delfabbro, 2002; Armsden et. al., 2000).

Perhaps most importantly, the research regarding placement stability and disruption enables child protection workers to predict those children and young people most likely to be at risk of instability, thereby directing preventative case work actions with children and young people or carers, mental health and other needs-based interventions for children and young people, and more appropriate placement matching.

Australian research into placement stability and disruption demonstrates a number of consistent findings (Osborn et. al., 2008; Delfabbro & Barber, 2003; Barber et.al., 2001):

- older children and young people with mental health problems or conduct disorder are the least likely to experience placement stability or to demonstrate improved psychological adjustment in out-of-home care;
- high levels of placement instability are associated with significantly higher scores of conduct disorder, hyperactivity and emotionality, and lower levels of social adjustment, in children and young people;
- children or young people with these characteristics will generally experience unsuccessful transitions to conventional, family-based foster care, and would be more appropriately placed in therapeutic or treatment foster care;
- children and young people who experience sustained periods of placement instability (more than 12 months) become more antisocial, anxious and depressed;
- children who experience neglect, as opposed to other types of abuse, are significantly less likely to experience placement instability and significantly more likely to experience psychological adjustment while in out-of-home care.

The South Australian longitudinal study summarises its key findings, and proposed indicators for guiding potential action with children and young people, as follows (Delfabbro & Barber, 2003):

- “an early risk of placement breakdown is related to the child’s age, level of conduct disorder and mental health status;
- a sustained risk of placement breakdown is related to the child’s age and level of conduct disorder;
- the occurrence of two or more breakdowns due to behaviour in two years strongly differentiates between stable and very unstable children;
• the psychosocial harms associated with placement instability appear to emerge approximately after 12 months." (p17).

Further to the above factors, location is also a predictor of disruption. For example, Delfabbro and colleagues (2000) found that disruption was 3.35 times greater for children in the country (Bromfield et. al., 2005).

The more recent study of 364 children and young people from four Australian states (including Queensland), shows that high levels of placement instability are also associated with certain family histories. "In most cases, a family history of domestic violence, physical abuse, and parental substance abuse dominated over a history of sexual abuse and neglect." (Osborn et. al., 2008, p.847).

Children and young people in this research sample had various diagnosed needs, including a diagnosis of ADHD (33% of sample), mild to severe intellectual disabilities or developmental delays (31% of sample), personality disorders or mental illnesses (16% of sample) and physical disabilities requiring ongoing therapeutic support (13% of sample) (Osborn et. al., 2008).

In addition, close to three quarters of these children and young people fell into the abnormal range for the conduct problems sub-scale and the peer problems sub-scale. Just under half fell into the abnormal range for both the hyperactivity/inattention sub-scale and the emotional problems sub-scale (Osborn et. al., 2008).

While the level and nature of the above diagnoses are not necessarily surprising in a population of children and young people with high levels of placement instability, the findings confirm the "connection between very disrupted family histories, placement instability and psychosocial pathology" (Osborn et. al., 2008, p.856).

The authors note that “most families in the sample had first contact with the relevant Government Department usually four years prior to the child’s eventual entry to care. Given the complexity of many family environments, it is likely that children were usually exposed to four more years of difficult circumstances after the initial child protection notifications had been made. Thus, many children in this sample could have been exposed to disruption, abuse and poverty for over half their lives, before eventually coming into care” (Osborn et. al., 2008, p.857).

There is also some indication that placement breakdown may be avoided, or lessened. For example, during the South Australian foster care study, researchers found that approximately 50% of carers in the study indicated that they either regretted their decision to end the placement, or would have had the child returned to their care, had they received more timely responses from professionals when difficulties arose and been more actively involved in case planning and review processes (Barber & Gilbertson, 2001).

International research associated with placement instability is equally concerning. For example, in the United States, it is not uncommon for children and young people to experience ongoing placement instability once they enter care (Chor, 2013).

Similar to the research findings in Australia, one study conducted in San Diego County over a six month period found that externalising behaviour problems are key predictors of placement movement in out-of-home care, and that placement changes during the first year in care “seem to put children on a trajectory toward further instability” (James et. al., 2004, p.186).

The authors concluded from their research that “much energy should be focused on treating disruptive behaviours in foster care through special training of carers and additional mental health interventions” (James et. al., 2004, p.203).
Another study undertaken in the United States, considered factors influencing placement movements for children and young people with, and without, emotional and behavioural disorders (EBD). This study found that (Barth et. al., 2007):

- children with clinical-level emotional and behavioural disorder scores (as measured by the Child Behaviour Checklist) were 2.5 times as likely to experience four or more placements as their nonclinical peers;

- the presence of depression and not residing with siblings were significant factors in predicting placement movement for children with EBD;

- for children without EBD, the only factor significantly associated with placement moves was age, that is, older children (especially over 11 years).

The research also indicates that placements become more vulnerable to breakdown, as the age of children and young people increases and as behavioural and emotional difficulties increase (Triseliotis, et. al., 2000; Osborn & Delfabbro, 2013). For example, the attrition rate for adolescents can be as high as 60%.

Age and gender are also positively associated with the number of placement changes. For example, male children over 11 years of age experience more placements (Barth et. al., 2007) and boys are four times more likely to experience disruption (Delfabbro et. al., 2000).

**Adolescents in care**

There is consistent evidence that it is more problematic to successfully maintain adolescents (compared to younger children) in foster care, with the disruption rate being very high (Farmer et. al., 2004). For example, young people who present with aggressive behaviour, or with no attachment to an adult prior to the placement, and those who are hyperactive or who show conduct problems are much more difficult to manage, and placements are highly likely to breakdown unless additional help is organised in advance for their placements.

The research does however indicate what helps to make adolescent foster placements succeed.

At the point of pre-placement, the research indicates that:

- “practitioners should avoid making placements when foster carers are reluctant to take a young person or have expressed a general preference for an adolescent of the opposite sex” (Farmer et. al., 2004, p.11);

- careful consideration is required if carers are experiencing strain (e.g. bereavement, relationship difficulties, illness) before the placement commences;

- “much more attention is needed to giving the foster carers full and honest information about young people to be placed”, as placement breakdown occurs more often when social workers are not open with carers regarding the extent of a young person’s difficulties and the plans that have been made for the young person (Farmer et. al., 2004, p.11). The research suggests that carers are able to deal with some very difficult behaviours, as long as they know what they are taking on, children’s problems are not downplayed and social workers respond to carers’ requests for assistance (Farmer et. al., 2004).

**Following placement**, a number of factors contribute to poor placement outcomes for adolescents. These include (Farmer et. al., 2004):
• the carer’s initial reaction to the young person (e.g. whether or not they liked the young person) often continued and affected the course of the placement;

• initial dissatisfaction about the placement, whether experienced by the young person or the carer;

• when the young person had a negative impact on other children in the foster family. When this occurs, workers need to take action to try and improve relationships and lessen the impact of the adolescent.

The researchers also found two factors significant to fewer placement disruptions and more successful placements. The key factors associated with fewer disruptions included the ability of carers to respond to a young person’s emotional age (when this was considerably younger than the young person’s chronological age), and young people were able to discuss their past histories with foster carers (Farmer et. al., 2004).

Factors associated with more successful placements included circumstances where carers had given a moderate level of encouragement to the young person to learn life skills that would assist them once they left care, and carers monitoring the activities of the young person when the young person was outside the home (Farmer et. al., 2004).

Levels of ‘carer strain’ were also found to have a major impact on carers’ capacity to parent adolescents well. Carers responded less sensitively to young people, disliked them more often and showed young people less emotional warmth (Farmer et. al., 2004) when they experienced greater levels of strain. The researchers conclude that social workers should review the stress on carers before and during each placement and for carers experiencing high levels of strain, match them with less demanding adolescents and/or provide carers with increased levels of support.

Children and young people with adverse sexual histories

Despite high levels of concern about how to manage children and young people in out-of-home care who present with adverse sexual histories, little research has been undertaken in this area (Pollock & Farmer, 2005). “What is clear, however, is that children in the out-of-home care system who have adverse sexual histories are likely to be a particularly vulnerable, testing and needy group whose disturbed psychological functioning and behaviour cover a broad spectrum of distress.” (Pollock & Farmer, 2005, p.18).

There is significant research about the long-term psychological and behavioural consequences of sexual abuse, including the following (Pollock & Farmer, 2005):

• psychological – depression, low self-esteem, self-blame, fearfulness and anxiety, post-traumatic stress disorder and dissociative reactions;

• behavioural – self-harm, attempted suicide, age-inappropriate sexual behaviour, the sexual abuse of other children and antisocial behaviour.

In a study of 250 new admissions to care over a six month period, Farmer and Pollock found that children who have been sexually abused and who are in care are “significantly more vulnerable to sexual risks and to emotional, educational and behavioural difficulties than their non-sexually abused counterparts…However at the point of placement, there are rarely markers to alert carers to the multiple deprivations and adversities in their backgrounds and it is therefore likely that this group of children will be denied the specific targeted therapeutic, educational and family support that they need.” (Pollock & Farmer, 2005, p.18). This is particularly the case where the sexual abuse occurred several years earlier.
Of the 250 admissions, some sort of sexual abuse or abusing behaviour had been an issue at some point in their lives for 38% of the children and young people, with sexual abuse or abusing behaviour defined as “professional concern having been noted on file about one or more sexual incidents in a child’s life” (Pollock & Farmer, 2005, p.20). This included professional assessments that abuse or abusing behaviour was probable despite the absence of disclosure, admission of guilt or forensic evidence.

Of the 96 children who met the criteria for sexual abuse or abusing behaviour, 75% had been sexually abused only, 18% had sexually abused another child and had themselves been abused, and 7% were only known to have sexually abused another child (Pollock & Farmer, 2005). Further, only a minority of the 96 children entered care due to their adverse sexual histories, reaffirming the authors’ views that this cohort of children in care is a ‘hidden population’ (Pollock & Farmer, 2005).

The study also considered the adversities (e.g. violence in the home, parental drug and alcohol misuse) in the children’s backgrounds prior to entry to care, compared to children who entered care for reasons other than sexually adverse backgrounds. Compared to the non-sexually abused group, children and young people with sexually adverse backgrounds (Pollock & Farmer, 2005):

- were as likely as the non-sexually abused group to have been registered under the categories of physical abuse, emotional abuse or neglect;
- presented with significantly more prior adversities and concerns regarding behaviour problems than the non-sexually abused group;
- were more likely to have severe educational problems, including non-attendance and exclusion;
- were more likely to have experienced disrupted parenting, including multiple separations from their main parent, parents who had multiple partners and care environments which adversely affected emotional development.

Children and young people who had been sexually abused and/or who presented with sexualised behaviours were found to experience severe educational problems, severe behavioural problems and bullying compared to the children and young people in the non-sexual abuse group. Further, children and young people with adverse sexual histories were more likely to have experienced disrupted parenting, which adversely affected emotional development and attachment (Pollock & Farmer, 2005). Over twice as many sexually abused or abusing children or young people harmed themselves (9%), compared to 4% in the non-sexual abuse group (Pollock & Farmer, 2005).

Overall, the results demonstrated that the sexually abused and abusing children and young people “entering care have significantly more difficulties in their early history than non-sexually abused children” (Pollock & Farmer, 2005, p.26). The subsequent “emotional and behavioural difficulties were potentially likely to have long-term effects on these children’s lives, particularly in terms of their educational attainment and social functioning. They were also likely to have implications for their care and management.”(Pollock & Farmer, 2005, p.26).

The researchers identified four particular areas of difficulty that must be addressed for children and young people in care who have adverse sexual abuse histories (Pollock & Farmer, 2005):

- children and young people need to address the direct consequences or impacts of the sexual abuse itself;
- therapeutic interventions aimed at addressing their multiple separations and rejections and their current behavioural disturbances;
• good educational interventions, which are a vital part of their recovery;
• protection from sexual risks or their own risky behaviour.

Another study which considered the management, care and treatment of sexually abused and/or abusing children in substitute care identified that these children generally fell into 4 distinct groups – each of which required different approaches to case management and placement type (Farmer, 2004). Farmer cautions that these categories are not meant to be rigid but rather, may provide an aid to planning (Farmer, 2004):

• “non-symptomatic young people;
• sexualised young people who have weak interpersonal boundaries;
• young people involved in prostitution;
• young people who sexually abused others in placement, for whom a) sex and aggression were not linked and b) sex and aggression were linked.” (p.381).

The young people’s management was rated across four areas including levels of supervision during the placement, the extent to which carers had successfully modified or re-shaped general or sexual behaviour during the placement, if the young people had any outstanding needs (apart from any need for counselling) that had not been met, and whether young people had received any formal therapeutic intervention from any source to assist them with their behavioural or emotional difficulties during the placement.

The key findings of this study are outlined below, according to each identified category.

Of the 13 young people who showed no problematic sexual behaviours while in the ‘study placement’ (six of whom had shown sexually abusive behaviour previously) (Farmer, 2004):

• over two thirds of these young people were provided with low levels of supervision, fewer than a third had their outstanding needs met and fewer than half of the children received some formal therapeutic intervention during the placement;
• successful attempts were made to modify the general behaviour of almost two-fifths of them;
• the absence of problems in the study placement did not mean that the young people’s problems were resolved but did lead some carers to “sweep the children’s past under the carpet and assume that it would be best if no reference were made to it” (Farmer, 2004, p.382);
• “the wider needs of the young people in this group were often ignored because they were not causing any difficulties. Yet many of them had significant gaps in their education and deep unresolved feelings of loss and rejection with which they needed assistance…because these young people did not display problematic sexual behaviour in the placement, their backgrounds were often forgotten and their needs side-lined.” (Farmer, 2004, p.382).

Of the 13 young people who had weak interpersonal boundaries (many of whom were female and over half of whom were placed in residential care) (Farmer, 2004):

• five had previously sexually abused another child;
• many “had had very little ordinary, good enough parenting and some were markedly emotionally immature. When the very immature children in this group were placed with more mature adolescents they were sometimes drawn into situations where they were at risk from
sexually predatory men. This mix of young people in placements was therefore very important.” (Farmer, 2004, p.383);

- their lack of personal boundaries put them at risk, they placed others at risk through their sexual advances and levels of supervision were very low (which placed them at risk outside their placements);

- few attempts were made to modify their behaviour, the needs of only three of the young people were met, workers and carers tended to normalise their behaviour and failed to address its root causes, and “the management provided...fell far short of what was needed by them” (Farmer, 2004, p.383);

- “most of the sexualised girls in this group were placed in residential care and male residential workers were acutely fearful that they would be the subject of an allegation from them. This made them distant and quite punitive in their management. Residential workers did not see their responsibility for the young people in their care as extending beyond the walls of the children’s home. Even when they knew that children were going out to engage in high-risk behaviour, they would not attempt to stop them, although they might counsel them to desist. If they did not return on time the police would routinely be called. This replicated the home situations of girls who had never been made safe.” (Farmer, 2004, p.384).

Of the three young people who were involved in sexual activity that exploited them during their placement, and the additional one young person who had actively been working as a prostitute (Farmer, 2004):

- the young people were regularly involved with sexually exploitative adults for most of their placements, most had been initiated into prostitution by members of their families and all had become involved in drug and alcohol misuse;

- the levels of supervision provided for all but the one young person in secure care were very low and as a result, they continued to put themselves and others at risk outside the placements;

- carers were unable to intervene effectively to modify young people’s behaviour and the young people’s outstanding needs were not met (although half had received some therapeutic help).

Of the six young people who had sexually abused others in placement but for whom sex and aggression were not linked (Farmer, 2004):

- the management provided usually included tight supervision and monitoring of activities but with one exception, there was no work which focused on the abusing behaviour itself;

- behaviour improved and major needs were adequately met however little work was provided on the extensive problems in the young people’s backgrounds;

- the young people required counselling about their own abuse, as well as about their abusing behaviour and interventions needed to address the “sources of distress for the children as well as their current needs for education and recreational activities.” (Farmer, 2004, p.388);

- there were very real risks that the abusing behaviour would re-emerge after discharge from care, due to the lack of therapeutic intervention to address the abusing behaviour;

- those who demonstrated severe behavioural disturbance, including genital self-harm (two younger children who had experienced prolonged sexual abuse from a very young age) required their behaviour management to be linked to therapeutic work with the young person.
Of the four males who had **sexually abused** others in placement and for whom sex and aggression **were linked** (Farmer, 2004):

- all had previously shown sexually abusing behaviour which involved aggression and coercion or violence to their victims and were considered to be **at high risk** of committing further acts of aggressive sexual assaults;

- all presented **very high risks** to other children, and were **considerably more** behaviourally disturbed than the children who had sexually abused others in placement but for whom sex and aggression were **not** linked;

- the absence of further abuse appeared to be connected to very high levels of supervision, **rather than** any change in the young people themselves;

- attempts were made in most cases to modify their general behaviour and half of them had their outstanding needs met;

- **none** of the young people had received **any direct work** on their abusing or violent behaviour and **very little** work had been undertaken with them in relation to the extensive problems in their backgrounds.

The author concludes that “denial, minimization, normalisation and helplessness **all influence** the management of sexually abused and/or abusing children and that these **mirror the experiences** of children who are sexually abused and their efforts to deal with the accompanying trauma.” (Farmer, 2004, p.34). Further, the author asserts that an appropriate response to the management issues identified in this study **will assist** young people with adverse sexual histories to achieve better outcomes in the future.

### Joint sibling placements in out-of-home care

Research associated with sibling relationships is problematic, as different research studies use different definitions of sibling relationships (e.g. full-siblings, half-siblings, step-siblings). As a result, it is difficult to draw wider conclusions from existing research studies and findings (Schofield & Simmonds (eds), 2009). Despite this, “the role of siblings in placement dynamics has been gaining additional attention.” (Barth et. al., 2007, p.48).

“Recent research on placement with siblings has suggested that this type of placement **may have some of the same salutary influences** on placement disruptions that have been observed for kinship placements.” (Barth et. al., p.48). For example:

- a range of studies “suggest that joint sibling placements are **as stable** or **more stable** than placements of single children or separated siblings.” (Schofield & Simmonds (eds), 2009, p.413);

- adolescents placed individually, following a history of joint sibling placements, were at **greater risk** for disruption than adolescents who were consistently placed with siblings (Barth et. al., 2007);

- **not residing** with siblings **predicted** placement movement among children who had emotional and behavioural disorders (Barth et. al., 2007);

- “girls **separated** from their siblings were reported to have **poorer** mental health and socialisation than girls placed with at least one sibling (Schofield & Simmonds (eds), 2009, p.414).
Further, developmental psychology studies have proven the importance of sibling relationships, including positive contributions towards children's development (Schofield & Simmonds (eds), 2009). For example, there is evidence that (Schofield & Simmonds (eds), 2009):

- siblings can learn important life skills from each other;
- young children develop strong attachments to their siblings, especially in circumstances where older siblings play a role in the children's care;
- older children also become very attached to their younger siblings;
- close sibling relationships can reduce anxiety, and support play and exploration (the same secure base characteristics also found in child-carer attachment relationships).

Alternatively, a range of family factors can negatively influence sibling relationships. The research indicates that poor attachment to parents can lead to intense sibling conflict, parental favouritism can increase sibling conflict and children who have experienced abuse may resent siblings who have not (and vice-versa) (Schofield & Simmonds (eds), 2009).

In addition, the research provides guidance regarding factors which may indicate the need for permanent separation. These factors may include (but are not exhaustive of) intense rivalry and jealousy, exploitation (often based on gender), chronic scapegoating, highly sexualised behaviour between siblings, and acting as triggers to each other's experience of trauma (thereby constantly re-traumatising each other) (Schofield & Simmonds (eds), 2009).

Although there will always be some cases where siblings cannot be placed together in out-of-home care (due to safety or wellbeing issues), “Siblings can be a very valuable resource for each other, both in childhood and throughout life. It is essential that information on a child’s siblings is gathered conscientiously and the possibility of them living together or having contact with each other is carefully assessed and clear decisions are made that are then properly put into effect.” (Schofield & Simmonds (eds), 2009, p.417).

Children and young people with complex and extreme needs

The out-of-home care research clearly demonstrates that children and young people entering out-of-home care, both within Australia and overseas, are presenting with increasingly complex levels of need (Octoman & McLean, 2014; Octoman et. al., 2014; Kelly & Salmon, 2014; Chor, 2013; McLean et. al., 2012; Schofield & Simmonds (eds), 2009; Osborn et. al., 2008; Barth et. al., 2007; Bromfield et. al., 2005; Pollock & Farmer, 2005).

“Children in care experience worse mental health and other outcomes than children who have never been in care, and a significant minority of children in care experience complex psychological and behavioural problems. These children tend to be the same children who tend to experience placement disruption, and who have a family history characterised by substantial trauma.” (Parenting Research Centre & the University of Melbourne, 2013, p.11).

A recent analysis of national and international evidence for out-of-home care indicates that “Ongoing and severe placement disruption appears to affect a relatively small (15-20%) subgroup of children in care. These children tend to be those who had experienced two or more breakdowns due to their behaviour.” (Parenting Research Centre & the University of Melbourne, 2013, p.12).

Similarly, "previous longitudinal research by Barber and Delfabbro (2004) indicates that approximately 15-20% of young people in Australian out-of-home care have significant emotional
and behavioural problems that often condemns them to a life of repeated placement instability and further psychosocial harm." (Osborn & Delfabbro, 2006, p.8).

Reasons for increasing levels of complexity include legislative and policy requirements which restrict removal (from parents) to an option of last resort. By this time, children and young people have experienced substantial histories of ongoing abuse, neglect and emotional trauma, resulting in significant developmental delays and mental health problems (often demonstrated as externalising behaviours) (Schofield & Simmonds (eds), 2009; Triseliotis et. al., 2000; Osborn et. al., 2008; Osborn & Delfabbro, 2006; Farmer et. al., 2004).

Children and young people in care who present with complex and extreme levels of support needs share many characteristics. This is evidenced by the findings of the ‘National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care’.

National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care

The principal aim of the ‘National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care’ “was to extend Barber and Delfabbro’s 2004 findings by conducting a more detailed national study of the needs, social background, and service responses to children” who met the defined criteria for having high support needs (Osborn & Delfabbro, 2006, p.18).

“A second aim was to place a greater emphasis on the utilisation of services both at the entry point into care as well as during placement” (Osborn & Delfabbro, 2006, p.19).

Children and young people in the national study “were aged between four and 18 years... were only selected if they had experienced two or more placement breakdowns in the previous two years or had experienced a placement breakdown during their first four months in care.” (Osborn & Delfabbro, 2006, p.32). Mean age at entry to care was 7.48 years, children had spent (on average) 4.80 years in care and the mean number of previous placements (all types) was just under 11 (Osborn & Delfabbro, 2006).

The Strengths and Difficulties Questionnaire (SDQ) was incorporated in the study “to estimate the proportion of children with placement instability who fell into the abnormal or clinical range on key indicators of psychological and social adjustment, so as to highlight the potential need for specialist therapeutic services for this population.” (Osborn & Delfabbro, 2006, p.18).

This first national comparative study of 364 children and young people with complex and extreme needs provides “a detailed analysis of the social and family background of this population of children, their psychosocial profile, service history, and their placement experiences.” (Osborn & Delfabbro, 2006, p.8). Although the national sample consisted of children and young people from South Australia, Victoria, Queensland and Western Australia, many of the findings were consistent across jurisdictions.

An overview of the key findings is provided below (Osborn & Delfabbro, 2006; Osborn et. al., 2008):

- a high proportion of children and young people experienced multiple problems and the majority had experienced abuse and neglect;
- social backgrounds were similar – approximately three quarters of the total sample came from homes where there was domestic violence or physical abuse, and two thirds of the sample had experienced substance abuse by parents;
• “The majority of children fell into the abnormal range for conduct disorder problems on the Strengths and Difficulties Questionnaire (SDQ). Close to half of the children fell into the abnormal range for hyperactivity and emotionality problems and close to two-thirds of the children fell into the abnormal range for peer functioning problems. Overall, close to 60% of the children and young people fell into the ‘abnormal clinical range’ on the Total Difficulties Score for the SDQ for emotional and behavioural functioning.” (Osborn & Delfabbro, 2006, p.10);

• “this population is estimated to have a fivefold greater prevalence of emotional disorder problems and a six to sevenfold greater prevalence of conduct disorder and peer problems compared to normative populations” (Osborn et al., 2008, p.856);

• the total sample demonstrated relatively high levels of attachment-related problems (i.e. an inability to trust others and to form a close bond with another person, and an inability to regulate appropriate emotional and social responses) – children commonly presented as being excessively demanding or bossy, and showed little guilt or remorse for their actions;

• teenagers with high conduct scores coming into care had an 80% likelihood of placement breakdown due to behaviour within four months, and only a 5% likelihood of being stable two years later;

• most children (89.5%) were noted as having some form of diagnosed psychological health problem that required attention in the past 6 months;

• almost half the children appeared to be highly depressed and anxious;

• many children experienced up to forty placements within two years, clearly indicating that they were unsuitable for conventional out-of-home care placements;

• many children experienced educational problems – approximately three quarters of the children and young people were attending school or a TAFE/apprenticeship program, 34% of the sample had been suspended from school in the previous six months and 12.7% had been excluded;

• the total sample demonstrated poor social functioning – there were no gender or age differences but non-Indigenous children scored significantly poorer on this measure than Indigenous children;

• there were low levels of family contact for these children, and the nature of family contact varied substantially according to age.

The prevalence of domestic violence in the families of the children and young people in this study was of significant concern to researchers, given the close association between domestic violence and the subsequent abuse of children. For example, the research indicates that:

• “children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average” (Osborn & Delfabbro, 2006, p.43);

• “between 53% and 70% of males who engage in physical abuse against their wives in America also frequently abused their children” (Osborn & Delfabbro, 2006, p.43);

• “women who have been hit by their husbands were twice as likely as other women to abuse a child” (Osborn & Delfabbro, 2006, p.43).
The researchers further identified the “adverse consequences of children’s exposure and subsequent reactions to the violence in their home” as significant concerns (Osborn & Delfabbro, 2006, p.43). For example:

- younger children often do not understand the meaning of the abuse and tend to believe they have done something wrong, or are to blame. As a result, children experience feelings of guilt, depression and anxiety. Furthermore, younger children generally do not have adequate verbal skills to express their feelings so that these emotions are often interpreted as challenging behaviours. Such children may also exhibit behaviours such as withdrawal, exhibit regressed behaviours, eating and sleeping difficulties, concentration problems, anxiety and physical complaints." (Osborn & Delfabbro, 2006, p.43);

- “pre-adolescent children typically have better verbal skills and are therefore more likely to externalise negative emotions. Along with symptoms seen in younger children, pre-adolescent children may show signs of low self-esteem, poor peer relationships, delinquent and oppositional behaviour and school problems.” (Osborn & Delfabbro, 2006, p.44);

- adolescents “are at a greater risk of experiencing severe school problems (delinquency, poor attendance and/or drop out) and substance abuse, and these adverse consequences may continue into later life. Long-term problems include higher levels of adult depression and trauma symptoms and increased tolerance for and use of violence in adult relationships…” (Osborn & Delfabbro, 2006, p.44).

Based on the above findings, the researchers conclude the following:

- “The children currently experiencing the highest levels of placement instability have high levels of psychosocial dysfunction, with the vast majority requiring therapeutic support for abnormal levels of conduct disorder and problems with peer relations.” (Osborn et. al., 2008, p.856);

- “Therapeutic interventions involving the treatment of trauma, the establishment of better attachments and social functioning, must therefore be emphasised in addition to interventions that seek to stabilise and control the behaviours contributing to placement breakdowns.” (Osborn & Delfabbro, 2006, p.40).

The views of Australian carers re challenging behaviours

There are two Australian studies regarding carers’ perspectives about challenging behaviours. The first study explores the particular behaviours that carers find challenging. The findings represent the views of 201 foster carers of children aged between 4-12 years, who completed an online survey. The survey items were based on “existing clinical measures, a review of the practice literature, and focus group consultation.” (Octoman et. al., 2014, p.10).

The findings identify four distinct profiles of behaviours considered to be problematic by carers, (Octoman et. al., 2014):

- cognitive difficulties (e.g. language, memory, and attention and learning problems), which make conventional behaviour management techniques less effective. These issues can create problems for children and young people in relation to, planning and organising themselves to sufficiently carry out daily tasks, understanding instructions and expressing themselves, and sustaining attention in a range of circumstances;

- sexual or other high-risk behaviours or activities (e.g. risk and self-harm thoughts or actions, walking off with strangers, absconding from placement, threatening to harm carers or members of their families), which are likely to require intensive and systemic interventions (e.g.
stringent levels of supervision, specialised therapeutic services) that are not easily accommodated within home-based care;

- behaviours of an aggressive, controlling and violent nature (e.g. explosive and dramatic emotional outbursts, lack of social reciprocity, need to control and manipulate others), which are unresponsive to conventional behaviour management techniques. Non-compliance and inability to accept social conventions present significant difficulties for foster carers and there is a need to “support foster carers to build skills in dealing effectively with oppositional and manipulative behaviour while simultaneously building prosocial bonds” (Octoman et. al., 2014, p.16);

- anxiety-based behaviours (e.g. obsessive compulsive behaviour, over-reliance on carers for reassurance and sense of safety), which require carers to implement a range of anxiety management strategies.

“Drug and alcohol use, playing with or lighting fires, self-harm, sexual behaviour towards others, threatening carers’ family members, and stealing are extremely unlikely to be tolerated by carers, especially in the absence of specialised support (Farmer et. al., 2005; Sargent & O’Brien, 2004).” (Octoman et. al., 2014, p.16).

The second study explores what supports foster carers want to assist them in caring for children and young people with challenging behaviours. The findings represent the views of 187 foster carers of children aged between 4-12 years, who completed an online survey. The survey required carers to rank 21 potential supports, from one (not helpful) to five (extremely helpful), according to how helpful they carers felt each item would be (Octoman & McLean, 2014).

The most important support identified by carers included knowledge about children and young people’s behaviours, prior to fostering (irrespective of the type of care – i.e. short-term, long-term and respite, or the length of the carers’ experience), followed by information that prepares and equips carers to manage behaviours. This includes information about how to manage and respond to mental health difficulties and how/why particular behaviours originate (Octoman & McLean, 2014).

Other supports considered to be important by carers include emotional support (i.e. someone to talk to about issues), counselling and therapy for the child, a good relationship with social workers and training in behaviour management.

In terms of the preferred means for accessing support, in-home support and group training were the most endorsed, preferably delivered by carers (either alone or in conjunction with former foster carers or professionals).

Placement matching and decision-making

“One of the main problems associated with emotional and behavioural problems of children in care is foster care drift or placement instability. Many studies have identified the concerning trend of placement instability in foster care systems around the world” (Bromfield et. al., 2005, p.37).

Despite the difficulties and challenges associated with achieving placement stability, there appears to be limited research associated with placement matching and placement decision-making for children and young people requiring an out-of-home care placement, particularly in relation to which carers/care environments are most beneficial and likely to succeed as opposed to those which may be less likely to succeed (Chor, 2013; Schofield & Simmonds (eds), 2009; Barber & Gilbertson, 2001).
Across jurisdictions there are many approaches to placement matching and decision-making, each with their own reported benefits and limitations. No one approach however is advocated as the most effective, many approaches are not supported by research and most have not been evaluated (Chor, 2013; Blakey et. al., 2012). Further, where formal frameworks supporting placement matching and decision-making do exist, sustainability and inconsistent implementation remain key challenges (Chor, 2013; Triseliotis et. al, 2000).

Concerns about placement matching and decision-making are particularly noted in relation to adolescents and children/young people who have adverse sexual histories (Triseliotis et. al., 2000; Chor, 2013; Schofield & Simmonds (eds), 2009; Farmer & Pollock, 1999; Farmer et. al., 2004).

Common research findings
The articles underpinning this literature review identify a range of common research findings that are significant to placement matching and decision-making:

• not all children are suitable for traditional family-based foster care, particularly adolescents who present with certain characteristics (e.g. mental health issues, conduct disorder) – more intensive or residential options are needed for these adolescents (Parenting Research Centre & the University of Melbourne, 2013; Osborn et. al., 2008; Bromfield et. al., 2005; Farmer et. al., 2004; Barber & Delfabbro, 2002; Barber & Gilbertson, 2001);

• foster care is more suited to younger, better functioning children (Bromfield et. al., 2005; Barber & Gilbertson, 2001);

• the perspectives of children and young people are often overlooked despite the availability of some research that when children and young people in care have choice about a placement, placements can be more stable (Chor, 2013; Schofield & Simmonds (eds), 2009; Barth et. al., 2007);

• age and level of conduct disorder at entry to care are predictors of unsuccessful transition to care and ongoing placement instability (Barber & Delfabbro, 2002; Barber & Gilbertson, 2001);

• placement matching and decision-making should commence with a careful assessment of each child’s suitability for placement (Schofield & Simmonds (eds), 2009; Barber & Gilbertson, 2001);

• limited placement matching contributes to greater placement instability, poorer psychosocial outcomes for children and young people, greater educational problems, behavioural needs being overlooked and in some cases, compromised safety from sexual abuse or risks associated with adverse sexual history (Osborn & Delfabbro, 2006; Farmer et. al., 2004; Triseliotis et. al., 2000; Farmer & Pollock, 1999);

• kinship care affords greater levels of placement stability than foster care, thereby protecting children from multiple moves (Blakey et. al., 2012; Schofield & Simmonds (eds), 2009; Barber & Gilbertson, 2001);

• carers see pre-placement information as central to the way they care for the child and it is crucial to understanding behaviour. The provision of full and accurate pre-placement information is also linked to enhanced placement stability and improved outcomes for children and young people (Octoman & McLean, 2014; Pollock & Farmer, 2005; Barber & Gilbertson, 2001; Triseliotis et. al., 2000; Farmer & Pollock, 1999);
• the way placements are made also influence the course of the placement. There is some evidence that placements are more likely to breakdown when (Schofield & Simmonds (eds), 2009):

• they are made quickly, without adequate consultation with children or young people and without adequate consultation with, or the provision of full information to, carers;

• carers’ preferences about the characteristics of children to be placed (e.g. girls only) are ignored.

Additional research findings, some of which are categorised according to placement types, are outlined in the sections below.

Approaches to assessment and decision-making

Australia

Although no Australian research specific to placement matching and decision-making models was identified as part of this literature review, the research findings outlined throughout this paper provide significant but indirect guidance in terms of crucial considerations associated with placement matching and decision-making.

The United States

Jurisdictions across the United States implement multiple approaches to addressing placement stability. These include using specialised caseworkers for placement, placement based on availability, using assessment tools, placement based on the capabilities of foster parents, using a placement matrix system and using specialised placement units (Chor, 2013).

Although 31 states are using the above approaches, very few states are systematically evaluating the effects of each option (Blakey et. al., 2012). Further, some of these options are not supported by research. For example, there can be inconsistency in placement decision-making in circumstances where decision-making is dependent on individual, expert discretion, and placements based on availability alone neglect the views and wishes of the child or young person (Chor, 2013). Further, where the specialised knowledge of placement caseworkers or placement units is used, “it seems unclear as to how such knowledge can produce the best fit between the child and the variety of placements”(Chor, 2013, p.302).

Chor refers to two main placement decision-making models in use in child welfare – Multidisciplinary Team Decision Making and decision support algorithms based on clinical ratings (Chor, 2013). Multidisciplinary Team Decision Making (MTDM) involves multiple stakeholders in the placement decision-making process, based on “the advantages of pooled expertise of team members over individual knowledge in decision-making” (Chor, 2013, p.306).

Participants generally include the child or young person requiring the placement, carers, caseworkers, birth families, community members, family friends and support people, and professionals or other persons who have relevant information about the child requiring placement.

The use of MTDM increases the diversity of perspectives (i.e. pooled expertise and augmented opinions of multiple decision-makers) about children or young people requiring placement, decreases individual discretion in placement decision-making, and enhances the direct participation of children and young people (Chor, 2013). Empirical studies have also demonstrated that (Chor, 2013):

• the participation of a foster/relative carer in MTDM significantly reduced the likelihood of a recommended placement change;
• recommendations for less restrictive placements were significantly more likely, the longer the child or young person was subject to MTDM;

• compared to usual decision-making, the use of MTDM improved access to mental health services for children and young people.

Alternatively, cognitive bias and errors, and external influences (e.g. high workloads) can interfere with decision-making using the MTDM model, and “there are limitations to the expert consensus approach, especially in making decisions at ‘major decision points’ such as placement decisions, which require the highest standards and formal methods” (Chor, 2013, p. 306). Limitations include defining team consensus, finite resources and coordinating large numbers of participants.

A decision support algorithm, in the context of out-of-home care placement decision-making, is “a logical set of criteria that describes the clinical characteristics of children and families that would be best served by the available decision options relevant to the algorithm” (Lyons, 2004 in Chor, 2013, p.309). “Clinical assessment is not only crucial to the team decision-making model, it is also the basis for major decision support algorithms in placement decision-making that makes use of level-of-care criteria.” (Chor, 2013, p.309).

Despite this, not many decision support algorithms are actually based on clinical assessments and placement guidance, and there is little evidence that decision support algorithms based on clinical assessments have been consistently implemented by child protection authorities (Chor, 2013).

Examples of decision support algorithms in use in the United States include Illinois’ Child and Adolescent Needs and Strengths (CANS) Algorithm, Arizona’s Child and Adolescent Level of Care Utilization System (CALOCUS/Child and Adolescent Service Intensity Instrument (CASII), and California’s Level of Care Assessment (LCA).

The CANS Algorithm is implemented as an advisory tool to inform the MTDM model and recommends one of six levels of care of increasing restrictiveness, the CALOCUS/CASII links clinical ratings with one of six standardised levels of care and is used to determine service intensity for children and young people who enter care, and the LCA matches the assessed needs of children and young people in care with specific placement types (Chor, 2013).

Although there is research confirming the validity and/or reliability of each of these algorithms, as well as improved outcomes (in some cases) for children and young people, the effective use of decision support algorithms is impacted by inconsistent or inappropriate use by decision-makers, and implementation and sustainability difficulties are common across relevant jurisdictions (Chor, 2013).

The United Kingdom

Only one study specific to placement matching and decision-making has been located in relation to the United Kingdom but the research primarily focuses on placement matching for children and young people in care in Scotland.

Although the study identifies a number of standard assessment frameworks to inform placement matching and decision-making, the authors note significant inconsistencies in the use of these frameworks and associated resources (Triseliotis et. al., 2000). Specific findings include the following (Triseliotis et. al., 2000):

• authorities were less likely to use a standard assessment framework for emergency fostering but more likely to use it for medium and long-term placements;
• even in relation to medium and long-term placements, an assessment framework was not being used by one in every four authorities;

• workers relied on their own frameworks, exchanging information over the phone (generally after the placement was already made).

Over half of the placements were made on an emergency basis and no meaningful matching occurred. The authors concluded “Based on the overall evidence obtained, it does appear that the assessment of many children was rather unsystematic and so was the collection of background information for matching proposes.” (Triseliotis et. al., 2000, p.164).

This finding further supports a common finding throughout the out-of-home care research that a key source of dissatisfaction for carers is the failure of social workers to provide sufficient information about children’s backgrounds (Octoman & McLean, 2014; Pollock & Farmer, 2005; Triseliotis et. al., 2000; Barber & Gilbertson, 2001; Farmer & Pollock, 1999).

Placement types
The out-of-home care research seems to focus on specific types of care, rather than comparisons between different placement types. Further, “the continuum of care implies a continuum of intensity in treatments and in services. However, how the intensity of placement interacts with the intensity of treatments and services is not entirely clear.” (Chor, 2013, p.319). Regardless of these issues, the available research provides useful guidance in terms of placement matching and decision-making considerations.

Kinship care
In relation to kinship care, “there are now sufficient studies, with a variety of samples and approaches, to make it feasible to use them to develop policy and practice” with a view to “making the fullest possible use of this placement option and supporting it effectively” (Schofield & Simmonds (eds), 2009, p.103).

Despite the evidence associated with kinship care, some social workers remain ambivalent about its use as a placement option, to the extent that “Some practitioners may have to examine their attitudes and beliefs and check how far they are supported by the evidence” (Schofield & Simmonds (eds), 2009, p.103).

The advantages of kinship care, supported by the research, include the following (Schofield & Simmonds (eds), 2009):

• placements last longer than those with non-related carers;

• contact with at least one parent is more likely than in non-kin care;

• children and young people tend to be in contact with members of their extended families other than their approved kinship carers;

• children and young people are often able to remain in their communities and schools;

• children and young people are more likely (than those in foster care) to feel close to carers’ children, and there is less likelihood of tension in relationships with either carers or children.

Further, recent studies in the United Kingdom show that children and young people identify a range of positive experiences and feelings about placement in kinship care, including feeling wanted and part of the family, and being listened to and supported in their education and life plans (Schofield & Simmonds (eds) 2009).
Despite these positive and proven outcomes, social worker ambivalence about kinship care remains a key challenge. Identified concerns include the quality of care, safety risks, the ability of kinship carers to meet emotional needs and to cope with behavioural problems, and complicated or conflictual family relationships.

The research however refutes many of these concerns. For example, although incidences of harm by kinship carers are substantiated in some cases, the proportion is low and no greater than harm to children and young people in non-kin placements. Secondly, although children can be exposed to risk of harm during parental contact, the incidence again appears to be low and research regarding outcomes for children and young people in kinship care is generally positive (Schofield & Simmonds (eds), 2009).

The fact that children and young people placed in kinship care tend to do as well as those placed in non-kin placements is significant, particularly given the extent and nature of pre-placement adversities and the level of emotional and behavioural difficulties commonly exhibited upon entering the placement.

Problematic contact and family contact are however areas in which the research strongly supports social workers’ concerns about kinship care (Schofield & Simmonds (eds), 2009). Seriously strained or conflicted adult relationships between kinship carers and at least one parent suggest that while attention needs to be given to physical risk, “contact planning and intervention need to focus primarily on positively managing relationships and reducing conflict” (Schofield & Simmonds (eds), 2009, p.108).

There is also some evidence supporting concerns about the quality of care in kinship placements however, these concerns also apply only in a minority of cases (Schofield & Simmonds (eds), 2009).

Age, prior difficulties and being a grandparent are all associated with outcomes in kinship care (Schofield & Simmonds (eds), 2009). That is, kinship care placements are more likely to have better outcomes where children are relatively young at placement and present with few difficulties, and carers are grandparents.

Farmer and Moyers (2008) found (with respect to kinship placements) that having a sibling in placement, and the presence of other children, were protective factors, and that “the combination of factors which best predicted disruption was: the child being 10 years or older at placement; low carer commitment; the child being beyond control and [family] contact not being supervised.” (Schofield & Simmonds (eds), 2009, p.109).

**Foster care**

Although children and young people placed with foster carers have different wants and expectations, they all face some common issues. They do not live with family members, they are in a strange house and have to abide by someone else’s rules, their futures are often insecure as they can be moved from the placement against their wishes, their lives are subject to high levels of regulation and their peers are unlikely to see foster children’s situations as ‘normal’ (Schofield & Simmonds (eds), 2009).

Studies that have sought the views of children and young people indicate that they have five main requirements for placement, including normality, family care, respect for their origins, control over their lives and opportunities and enabling skills (Schofield & Simmonds (eds), 2009).

There is also evidence that foster carers with certain characteristics and approaches to parenting, are consistently more successful than other carers (Schofield & Simmonds (eds), 2009; Farmer et. al., 2004; Barber & Gilbertson, 2001).
Foster carer characteristics that have been associated with successful out-of-home care placements consist of the following (Barber & Gilbertson, 2001):

- “non-authoritarian child-rearing styles;
- non-possessiveness towards the foster child;
- rejection of the belief that child development is dependent on heredity;
- tolerance of difficult behaviour and poor academic performance;
- low demand on children for religious observance;
- female carers who, from personal experience, identify with deprived or damaged children.” (p.55).

Alternatively, carer traits associated with poor outcomes include the opposite of the five initial factors outlined above, as well as more highly educated carers (Barber & Gilbertson, 2001).

Successful or ‘authoritative’ carers are also “warm, encouraging, sensitive to their children’s needs, willing to listen and clear over expectations. They are more likely to take part with their foster children in enjoyable joint activities (such as reading a bedtime story or going to a football match) and when they are older encourage them in developing needed skills.” (Schofield & Simmonds (eds), 2009, p.129).

Unsuccessful carers do not present with these characteristics and may be rated as ‘aggressive’ or ‘unresponsive’ (Schofield & Simmonds (eds), 2009).

Many children and young people speak positively about their foster carers and many foster carers are very committed to the children and young people in their care. The research however confirms that foster care is facing many challenges. “It rarely provides very long stays in the same family and it may fail either to change the situations from which foster children come, to offer them a permanent home or bring about much change in their long-term well-being and behaviour.” (Schofield & Simmonds (eds), 2009, p.133).

**Therapeutic foster care**

Multi-dimensional Treatment Foster Care (MTFC) “is an evidence-based approach that involves placing foster children in highly trained and supervised foster homes” (Blakey et. al., 2012, p.370). “MTFC parents participate in 20 hours of pre-service training in treatment foster care, provided by the program supervisor and experienced foster parents”, and “Ongoing supervision and support is provided during telephone calls and in weekly meetings.” (Parenting Research Centre & the University of Melbourne, 2013, p.44).

A recent (2013) analysis of the evidence for out-of-home care found that MTFC was (Parenting Research Centre & the University of Melbourne, 2013):

- well supported by the evidence, for adolescents (MTFC-A) who are not suited to regular foster care (i.e. those who present with conduct disorder, mental health problems and offending);
- supported by the evidence, for pre-schoolers (MTFC-P) aged 2-7 years.

Outcomes for the above adolescents included “lower levels of restrictive care, criminal offences, running away, drug use and psychosocial problems”, whereas outcomes for pre-schoolers
included “increased placement stability, permanence and positive attachment” (Parenting Research Centre & the University of Melbourne, 2013, p.7).

Similarly, Blakey et. al. (2012) reported that “children who received the MTFC intervention experienced both a reduction in both behaviour problems and placement disruptions compared to children in a control group” however MTFC “requires an intensive service delivery model that would be difficult to administer to a high proportion of children in current child welfare systems because of its cost” (Blakey et. al., 2012, p.370).

Lastly, “a recent review located eight foster parent interventions which had an effect on at least one aspect of the foster child’s functioning in a randomised control trial”, including MTFC therapeutic approach for adolescents and pre-schoolers (Kelly & Salmon, 2014, p.537).

The MTFC website indicates that the following staff are necessary to provide an MTFC intervention service incorporating approximately 10 foster care beds (Parenting Research Centre & the University of Melbourne, 2013):

- “full-time program supervisor;
- half-time individual therapist for MTFC-A or hourly playgroup staff for MTFC-P;
- half-time family therapist;
- skills trainer(s) at 20-25 hours a week per 10-bed program;
- .75 FTE foster parent recruiter, trainer, and PDR caller;
- one foster family for each placement (except sibling groups in MTFC-P);
- psychiatry services on an hourly fee basis.” (p.45).

A more dated study which examined international empirical literature, with a view to identifying best practice in foster care, also supported therapeutic foster care (TFC) for “emotionally and behaviourally troubled children and adolescents”, including those with conduct disorder (Barber & Gilbertson, 2001, p. 33). The authors further identified the most important characteristics of TFC (Barber & Gilbertson, 2001):

- “Carers are chosen specifically to deal with the most difficult children in care.
- Carers receive a higher rate of payment than standard foster carers.
- Carers are contracted as employees by the relevant agency.
- Carers are actively involved in case planning as full and equal members of the team.
- Carers undergo longer and more intensive training than do regular foster carers.
- Carers receive ongoing in-service training.
- Normally only one child is assigned to a TFC carer at a time.
- The caseload of the agency support worker is reduced to enable extra support for carers.” (p.56).
Residential care

The use of residential care in recent decades has declined both nationally and internationally. Factors associated with this decline include concerns that residential care imposes more restrictive and less normalised care environments on children and young people (Delfabbro & Osborn, 2005), as well as concerns that the model cannot provide the same quality of care as family-based care (Bromfield et. al., 2005).

Given these concerns, residential care has often been used as a last resort for children and young people whose foster care placements breakdown, or who increasingly present with severe needs the longer they remain in care (Schofield & Simmonds (eds), 2009; Chor, 2013; Delfabbro & Osborn, 2005). However, in the United Kingdom, residential care is also used a first placement option for adolescents who enter care due to complex behavioural problems and family tensions (Schofield & Simmonds (eds), 2009).

The benefits of residential care have traditionally been identified (reportedly without evidence) as creating a framework for emotionally secure relationships or attachments with adults, providing an environment for intensive therapeutic intervention, providing stability and a stimulating setting, and widening cultural and educational horizons (Schofield & Simmonds (eds), 2009).

Alternatively, the difficulties associated with residential care have included “providing unconditional love, constraints on children’s emotional development, poor staff continuity and marginalisation of children’s families and other welfare services (Schofield & Simmonds (eds), 2009, p.211). In addition, it is reported that “benefits rarely carry over or are much reduced after leaving and the long-term effects of residential care have proved difficult to identify (Schofield & Simmonds (eds), 2009, p.211).

A recent (2013) analysis of the evidence for out-of-home care is equally unfavourable with respect to outcomes associated with residential care. The authors indicate that although children with severe psychological and behavioural problems are commonly placed in residential care, “These settings rarely lead to better outcomes for children. Rather, they are associated with some of the worst outcomes seen in out-of-home care.” (Parenting Research Centre & the University of Melbourne, 2013, p.31).

Despite these significant concerns, “in recent years research has provided evidence that residential care may not be as ‘bad’ as previously thought.” (Bromfield et. al., 2005, p.47). For example, international research has provided supporting evidence that health and wellbeing outcomes for children and young people in foster and residential care are broadly comparable (Bromfield et. al., 2005).

In addition, multiple studies of residential care in the last decade have identified occasions where residential care can be helpful, including the following (Schofield & Simmonds (eds), 2009):

- “the young person has difficulties allowing any one adult to get close to them and they can benefit from having available a range of carers;
- a young person has a history of having abused other children;
- a young person feels threatened by the prospect of living in a family or needs respite from it;
- multiple potential adult attachment figures might forestall a young person from emotionally abandoning their own parents;
- when the emotional load of caring for a very disturbed or chaotic young person is best distributed among a number of carers;
when the young person prefers residential care to any form of family care, and would sabotage the latter if it were provided." (p.212).

Residential care also seems to be helpful in the following circumstances:

- “for adolescents whose challenging behaviour at home, school and in the community requires placement in a supportive but emotionally undemanding setting, staffed by experienced people. This should encourage continuities in the young person’s social life, education and employment and those family and peer relationships that he or she wishes to pursue. The difference between this and a foster home is in the roles of staff, the relationship demands made on the young person, the availability of a peer group and the capacity of the establishment to contain the effects of difficult behaviour and prevent status deterioration.” (Schofield & Simmonds (eds), 2009, p.216).

- “when there is a need for specialised treatment, either within the residential setting or outside of a living situation whose style and ethos complement it. For those seeking such placements, the aspects to consider are, the value of the group of residents, the availability of a number of adults and freedom to choose with whom to make relationships, the undemanding emotional nature of the ambience that gives the young person choice and power, an environment that ensures safety, supervision and control and an active stimulating programme.” (Schofield & Simmonds (eds), 2009, p.216).

Although there are no conclusive comparisons between residential care and foster care for adolescents, the research supports the following (Schofield & Simmonds (eds), 2009):

- residential care is very expensive;
- most children and young people in foster care seem to prefer this to residential care;
- some children and young people in residential care prefer this placement type;
- “very well supported foster care is capable of containing some very difficult adolescents without losing foster carers” (Schofield & Simmonds (eds), 2009, p.125).

**Additional placement matching considerations**

**Children and young people with adverse sexual histories**

In their study of 40 looked after “sexually abused and/or abusing young people aged 10 or over”, researchers found that (Farmer & Pollock, 1999):

- consideration was only given to how the young person would fit in with others in the placement setting in fewer than one third of the placements, meaning that the potential risks to the young person and other children in the placement were not addressed. This was the case even although half of the placements were planned and nine young people participated in pre-placement visits;

- no information about the young person’s history of sexual abuse or abusing behaviour was given to carers in just under half of the sample (42%), and some carers were unable to avert incidents of further abuse;

- in the 21 cases where some information was conveyed to carers, crucial details were left out in relation to six young people;
“when the whole histories of the sexually abused young people in the study were examined, it was found that half of them had abused another child at some stage, generally another child in care.” (Farmer & Pollock, 1999, p.377);

in total, information about 18 young people’s sexual abuse and/or sexually abusing behaviour was not provided to carers.

Many reasons were identified for social workers not sharing relevant information with carers. Some social workers had no knowledge of the abuse or the sexualised behaviour. Although details were recorded, they were not easily accessible short of reading the entire case file. In other cases, workers did not wish to ‘label’ the child and thought the information should be kept confidential. Other social workers feared losing a placement if the information or full information was provided to a potential carer. In a number of cases, social works “simply did not realize the risks which these young people might pose to others in the placements to which they were going”. (Farmer & Pollock, 1999, p.386).

It became clear to the researchers that during the placement on which the study focussed, the risks from and to these young people were considerable. Seven of 36 victimised young people sexually abused another child, and three of 17 young people who had already sexually abused a child repeated this behaviour in their placement (Farmer & Pollock, 1999). “Overall, three quarters of the sexually abused children became involved in sexual activities or showed sexual behaviours which put themselves or others at risk during the index placement.” (Farmer & Pollock, 1999, p.387).

The researchers concluded that “if children’s safety in care is to be maximised, then placement planning will need to focus on the risks and vulnerability of both the child to be placed and others already in the setting. It should also ensure that full information is given to the caregivers.” (Farmer & Pollock, 1999, p.377), including “the time of day and circumstances in which it [the abuse] took place, as well as the age, gender and identity of the abuser, and the child’s age when it started and stopped, how the abuser gained compliance and silenced the child and the child’s reaction to disclosure.” (Farmer & Pollock, 1999, p.388).

The second study (mentioned previously in this paper) outlining the management, care and treatment of sexually abused and/or abusing children in substitute care, also identified some information that may be of use when considering placements for these children and young people.

An overview of relevant information from this research is provided below (Farmer, 2004):

- although some young people did not demonstrate adverse sexual behaviours during their current placements, this did not mean that their problems were resolved;
- opportunities for some young people who indicated a readiness to do some direct work on their past abuse were missed, due to the absence of difficulties in the placements (and subsequent fewer contacts between social workers and the young people themselves);
- placement mix was particularly important where young people presented with both weak interpersonal boundaries and considerable levels of emotionally immaturity;
- careful attention was also required in relation to placement mix for young people who had sexually abused others in placement – as “there are few clear predictors of which children
who have been sexually abused or who have sexually abused other children will abuse a child in any particular placement." (Farmer, 2004, p.387);

- carers and social workers **lacked an understanding** of the reasons for young people’s behaviours, that is, connections between young people’s behaviours in placement and their sexualised backgrounds and past experiences of sexual abuse;

- it was **not uncommon** for carers and social workers to **normalise or minimise** very sexualised and risky behaviour, resulting in limited or ineffective interventions with, and/or poorer outcomes for, young people;

- “Residential workers did **not see** their responsibility for the young people in their care as extending **beyond the walls** of the children’s home,” (Farmer, 2004, p. 384), even although active attempts to monitor the young people’s behaviour when outside the placement are very important;

- carers had **to teach** young people to separate physical touch and affection from sexual contact, and young people **often required** nurture appropriate to a much younger child (to prevent young people acting out their need for affection and nurture through sexual contact);

- young people required “active assistance to develop school attendance, work experience and other activities which could bring them rewards, an alternative source of esteem and involvement with a positive peer group.” (Farmer, 2004, p.386);

- young people who had sexually abused others in placement and for whom sex and aggression **were linked** presented **substantial risks** to other children and young people, and demonstrated **considerably more** behaviourally disturbed behaviours than young people who had sexually abused others in placement **but for whom sex and aggression were not linked**;

- young people who had sexually abused others in placement and for whom sex and aggression **were linked** required **very structured** residential placements that provided **therapeutic intervention and consistently high** levels of supervision (within, and external to, the placement). Further, “Their placements would have benefited from consultancy for the caregivers and greater involvement of child and adolescent psychiatrists with a specialized knowledge of this area.” (Farmer, 2004, p.390).

**Joint sibling placements in out-of-home care**

Despite the potential benefits associated with joint sibling placements in out-of-home care, the research indicates that social workers **do not always give adequate priority** to assessing and deciding this issue, in accordance with the needs of each sibling requiring placement and the nature of sibling group dynamics.

For example, Rushton (2001) found that “there was **relatively little use** of any sort of structured procedure informing social workers’ decisions” (Schofield & Simmonds (eds), 2009, p.410), and that there was **no formal** assessment of the children’s needs or relationships with each other in **two thirds** of the cases involving sibling placements (Schofield & Simmonds (eds), 2009).

Similarly, Beckett (1999) showed that “in the **absence** of policy or a corporate response to planning for siblings, the values and commitment of individuals appeared to wield considerable influence” (Schofield & Simmonds (eds), 2009, p. 410).

Finally, “Practice experience suggests that an **anticipated inability** to find permanent new families for sibling groups of four or more children can sometimes lead to a decision to split children **before** family finding starts.” (Schofield & Simmonds (Eds.), 2009, p.406).
An international review (2005) of 17 sibling studies determined that siblings were more likely to be placed separately in the following circumstances." (Schofield & Simmonds (eds), 2009):

- “children were older;
- there was a large age gap between siblings;
- children were of different genders;
- children entered care at different times;
- some of them had special needs;
- placement changes had been more frequent and recent.” (p.405).

The above findings are also consistent with previous research studies, for example (Schofield & Simmonds (eds), 2009):

- Rushton (2001) found that the two most important reasons for separation in placement included entering care at different times and the specific needs of a child or young person;
- Kosonen (1996) found that the most frequent reason for sibling separation was children entering care at different times.

Given the lifelong implications for children and young people, and the apparent lack of informed decision-making by social workers, it is critical that the research findings underpin assessment and decision-making about jointly placing, or separating, siblings in out-of-home care.

An overview of these findings is provided below (Schofield & Simmonds (eds), 2009):

- “It is important that consideration is given to whether siblings, separated on starting to be looked after solely because there was no foster care family able to take them all, should be reunited as soon as a suitable vacancy occurs.” (Schofield & Simmonds (eds), 2009, p.410);
- the longer siblings remain in separate placements, the more difficult it will be for them to maintain their relationships and for a clearer assessment of sibling dynamics to be made;
- it is important to identify who children and young people consider to be their siblings, even if they are not living together, or have never lived together;
- all siblings need to be consulted – not just those currently requiring a placement. This includes siblings who already reside in out-of-home care placements, as well as those who live independently as adults;
- sibling separation is likely to lead to a profound sense of loss and grief where sibling relationships provide some of the secure base characteristics that child-carer attachment relationships provide;
- dysfunctional or abusive patterns of behaviour will exist for some sibling groups (depending on the family context, children’s experience of parenting, and the nature and extent of children’s experience of abuse or neglect);
- sibling bonds can be strengthened and siblings can and do provide comfort and protection towards each other;
• in some cases, sibling relationships can be very difficult to transform and/or there will be clear reasons for sibling separation in placements;

• “wherever possible, consideration must be given to whether children can be helped to form healthier relationships and whether their individual needs can be met together in placement before making permanent decisions for separation” (Schofield & Simmonds (eds), 2009, p.408);

• sibling relationships are complex and individual and comprehensive and careful assessments of whether siblings will be placed together or apart are essential;

• these assessments should involve observing siblings together, ideally on more than one occasion, to assess four key factors central to sibling relationships - “the degree of warmth, the degree of conflict, the degree of rivalry and the degree to which one of the siblings nurtures or dominates the others” (Schofield & Simmonds (eds), 2009, p.408);

• it is important to consider the potential benefits and disadvantages (of joint placement or separation) for the child throughout their entire life, not just in the immediate future;

• separation should only occur after very careful assessment of the needs of each child;

• the decision to separate siblings should not be based on “the vacancies in foster homes or the ages and genders of children whom foster carers can accommodate” (Schofield & Simmonds (eds), 2009, p.410);

• it is critical that the decision-making process is clear and transparent, that a decision is only made after consultation with all stakeholders (including all relevant siblings) and the decision is documented, communicated and explained to all relevant siblings.

The authors conclude that the decision to place or separate siblings on a permanent basis “should be treated with the same seriousness as the decision to separate children permanently from their birth parents” (Schofield & Simmonds (eds), 2009, p.408).

Conclusion

National and international literature underpinning this review confirms the concern identified by the Queensland Child Protection Commission of Inquiry (2013), that demand for out-of-home care placements is outstripping supply, contributing to a mismatch between the services assessed as suiting children and young people in care and the services ultimately received.

Despite demand for placements outstripping supply, the few available research articles relating to placement matching and decision-making suggest that the above-mentioned mismatch is also significantly impacted by the limited and generally unsystematic approach to placement matching across many jurisdictions.

While current research specific to placement matching and decision-making is somewhat limited, the extensive amount of research regarding placement stability and disruption, and the more recent availability of research associated with psychosocial outcomes for children in care (including those with complex and extreme needs), provide important messages and clear direction for future practice.

There is no doubt that children and young people entering out-of-home care, both within Australia and overseas, are presenting with increasingly complex levels of need. The most commonly reported reason is that contemporary out-of-home care is mostly used as an option of last resort, resulting in only those children and young people whose needs are most serious entering care.
Although the proportion of children and young people in care who present with complex or extreme levels of need is approximately 15-20% within Australia, the research relating to placement stability and disruption, children with complex needs, and outcomes for children in out-of-home care identifies the significant prevalence of behavioural, emotional and mental health problems across out-of-home care populations (not just children and young people with complex/extreme needs).

The research also highlights the criticality of providing treatment and other interventions (e.g. educational, social) to children and young people in out-of-home care, even in some cases where a child or young person does not exhibit problematic behaviours (either upon entering out-of-home care, or within a particular placement).

Much more research is required not only in relation to placement matching and decision-making but also in relation to comparing different models of care or placement types, with a view to the needs of, or outcomes for, distinct groups of children and young people. The need for these areas of practice to be subject to future research is illustrated by the following concluding quote:

“While child welfare literature has made tremendous strides on evidence-based treatments and the mutual influence of placement stability and child welfare outcomes such as functioning, permanency, adoption or reunification, there is an overlooked gap in the pivotal role of out-of-home placement decision-making as a precursor to these outcomes.” (Chor, 2013, p. 317).
References


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