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1
Research report

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

Wave 1 Baseline Statistical Report

Prepared by
Australian Institute of Family Studies
Chapin Hall Center for Children University of Chicago
NSW Department of Family and Community Services

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About the information in this report
All the information contained in the Pathways of Care Longitudinal Study Wave 1 Baseline Statistical Report is accurate as of May 2015. The analyses presented are based on an almost final version of the Wave 1 unweighted data collected in face-to-face interviews with children and caregivers, and the FACS administrative data.

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

Pathways of Care Longitudinal Study working group
FACS Analysis and Research: Ms Sharon Burke, Ms Marilyn Chilvers, Ms Toula Kypreos, Ms Marina Paxman, Dr Lucy Tully, Dr Johanna Watson, Mr Albert Zhou. Australian Institute of Family Studies (AIFS) consortium: Professor Judy Cashmore (AO) University of Sydney, Professor Paul Delfabbro University of Adelaide, Dr Daryl Higgins AIFS, Professor Ilan Katz University of NSW, Dr Julie Lahausse AIFS, Mr Mark Sipthorp AIFS, Ms Diana Smart AIFS. Chapin Hall Center for Children University of Chicago: Dr Fred Wulczyn and Ms Xiaomeng Zhou. I-view: Ms Rachelle Brown, Mr Andy Cubie.

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Wave 1 Baseline Statistical Report

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Abbreviations

The Glossary has a definition of terms.

ABS	Australian Bureau of Statistics
ACASI	Audio computer-assisted self interview
ADHC	Ageing, Disability and Home Care (NSW)
AGHE	Australian Guide to Healthy Eating
AH&MRC	Aboriginal Health and Medical Research Council
AIFS	Australian Institute of Family Studies
APCS	Adoption and permanent care service
ASEBA	Achenbach System of Empirically Based Assessment
ASSAD	Australian Secondary Students' Alcohol and Drug Survey
ASQ	Ages and Stages Questionnaire
ATP	Australian Temperament Project
BITSEA	Brief Infant Toddler Social Emotional Assessment
CALD	Culturally and linguistically diverse
CAPI	Computer-assisted person interview
CASI	Computer-assisted self interview
CBCL	Child Behaviour Checklist
CCYP	Commission for Children and Young People (NSW)
CHeReL	Centre for Health Record Linkage
CIW	Corporate Information Warehouse (FACS)
CSBS-ITC Checklist	Communication and Symbolic Behaviour Scales Infant and Toddler
CSC	Community Services Centre (FACS)
DBSES	Difficult Behaviour Self-Efficacy Scale
FACS	NSW Department of Family and Community Services
IA	Initial assessment
IFS	Intensive Family Support
IFP	Intensive Family Preservation
JIRT	Joint Investigation Response Team
KiDS	Key Information and Directory System (FACS)
K-10	Kessler Psychological Distress Scale
LONGSCAN	Longitudinal Studies of Abuse and Neglect (US)

LOTE	Language other than English
LSAC	Longitudinal Study of Australia's Children
MCDI-III	MacArthur-Bates Communicative Developmental Inventories
MOU	Memorandum of Understanding
MR	Matrix Reasoning Test from Wechsler Intelligence Scale for Children
'n'	Number
NGO	Non-government organisation
NHS	National Health Survey
NSCAW	National Survey of Child and Adolescent Well-Being (US)
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OOHC	Out-of-home care
POCLS	Pathways of Care Longitudinal Study
PPVT-IV	Peabody Picture Vocabulary Test
PR	Parental responsibility
PRM	Parental responsibility of the Minister
ROSH	Risk of significant harm
SARA	Safety Assessment, Risk Assessment (and Risk Reassessment)
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment Stage 2
SATI	School Aged Temperament Inventory
SFPI	Satisfaction with Foster Parenting Inventory
SMHWB	Survey of Mental Health and Wellbeing (Australia)
SPR	Sole parental responsibility
UNSW HREC	University of NSW Human Research Ethics Committee
WISC-IV	Wechsler Intelligence Scale for Children
WWCC	Working with children check

Acknowledgements

Many people have contributed to the development and implementation of this study in addition to the Pathways of Care Longitudinal Study (POCLS) working group. In some way the study has been shaped by all of the following:

Children, young people and caregivers: We wish to extend our thanks to all the children, young people carers who participated in Wave 1 interviews. We very much appreciate their time and effort in participating in the study.

I-view interviewers and fieldwork team: I-view has maintained a consistent team of interviewers and fieldwork managers during Wave 1. The interviewers are: Ms Janine Brown, Ms Glenda Carbone, Ms Carolyn Chapman, Ms Lianne Corke, Ms Kelly El Shiekh, Ms Renate Golding, Ms Gina Guajardo, Ms Janette Knight, Ms Nicole Moore, Ms Margaret Reid, Ms Marion Sassen and Ms Beth Tilley. I-view senior staff supporting the Wave 1 fieldwork include Dr Liz Gould, Mr Justin Doyle, Ms Elaine Ledwidge, Ms Jenny Green and Ms Anne Cah.

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Actor and interview audio recordings: Ms Sammy Verma is a young person who grew up in care and played a key role in the production of the study DVD for children and stakeholders. Sammy also did the voiceover for the audio computer-assisted self interview (ACASI) for the child interview.

Artist: Ms Billy Black is a young person who grew up in care and designed the study logo/ banner.

FACS: Ms Maree Walk, Deputy Secretary Programs and Service Design, and staff from OOHC Policy, Aboriginal Services Branch, Multicultural Services Branch, Adoption Branch and Office of the Senior Practitioner who have provided advice on the questions and measures. Library: Mr Alex Brown, Ms Zoe Dallimore and Mr Arran Gore. Student placements: Ms Michelle Thomson and Ms Amy Hutchinson. Ms Merran Butler and Ms Karmela Laing provided editorial assistance.

Previous members of the Pathways of Care Longitudinal Study Working Group: FACS – Dr Margo Barr, Ms Wendy Finnegan, Mr Matthew Gorringe, Dr Robert Johnston, Ms Neriman Kashouli, Dr Stephanie Taplin, Mr Peter Walsh; AIFS – Dr Ben Edwards, Professor Matthew Gray, Mr Jonathon Guy, Dr Walter Forrest and Ms Carol Soloff; and Chapin Hall Center for Children University of Chicago – Dr Linda Collins and Dr Michelle Ernst.

Special acknowledgement: We would like make a special tribute to the contributions to this study by the late Emeritus Professor Jacqueline Goodnow, Macquarie University, who was a member of the Department's Research Advisory Council. Professor Goodnow's leadership at the inception of the study and during the design phase was invaluable and we appreciate the exceptional experience and knowledge she brought to this study.

Foreword by NSW Department of Family and Community Services

There is nothing more important than safeguarding and nurturing our children when the family protective environment breaks down and children are at risk of serious harm – it is vital we understand how to best achieve the child's needs for a better future.

The Pathways of Care Longitudinal Study is a landmark research study in NSW that has enormous potential to inform policy, program and service development to achieve the best outcomes for children and young people in out-of-home care (OOHC).

This report showcases the study's comprehensive baseline data from face-to-face interviews with caregivers of 1,285 children and young people who were entering out-of-home care for the first time in NSW. Research activities and interviews were also conducted with children who were aged three years and older. This study will allow us to reflect on our work – How are children and young people faring in out-of-home care? What are the characteristics of their carers? What are the contact arrangements with the child's birth family? What are the services and support provided to children and carers?

The most important findings from the study will come from future data collections with information about how children and young people change over time and the critical factors that influence their outcomes.

The challenge now is to interpret these baseline results critically and thoughtfully to improve how we work with families and the community and to filter this knowledge into policy and program reform to improve the lives of children and young people.

I commend the efforts of all members of the study team. I would also like to extend my sincere thanks to the children, young people and carers who gave up their valuable time to participate in the first phase of this very important study.

Mr Brad Hazzard
Minister Family and Community Services

Foreword by Australian Institute of Family Studies

I applaud the vision of the NSW Department of Family and Community Services (FACS) in initiating the Pathways of Care Longitudinal Study. It demonstrates the Department's recognition of and major commitment to the importance of research in informing policy and practice.

Knowledge of the pathways children and young people take through out-of-home care is essential to identify the factors that influence their experiences and outcomes. Such information provides the evidence to enable adjustment of policy and improvement of practice in order to reduce risk and enhance the wellbeing of those in the out-of-home care system. To date, there have been few large longitudinal studies in this area and virtually none in Australia. The Pathways of Care Longitudinal Study redresses that.

I am very pleased that the Australian Institute of Family Studies (AIFS) can be a research partner in this landmark study. AIFS heads a consortium of advisors to the study comprising Australia's leading experts in this area – Professor Judy Cashmore (AO), Professor Ilan Katz and Professor Paul Delfabbro. I also acknowledge the valuable contributions of Dr Fred Wulczyn and his colleagues from Chapin Hall Center for Children University of Chicago in advising on the study and of the team at I-view social research as the data collection agency undertaking the fieldwork.

This statistical report is the first of a series of publications that will make use of the data collected during Wave 1 of the study. With the completion of future waves of the study we look forward to the opportunity to work with the Department to analyse the journeys of the children and young people in the light of their characteristics, situations, circumstances and the services and supports they receive. Dissemination of such information is a most valuable resource for those who frame policy, design services and provide supports to young people in out-of-home care.

Of course, in addition to the commitment of the Department, a study of this scope and nature would not be possible without the generous involvement of the children and young people, and their carers and the professionals who support them. Without their willingness to engage with the study and share their experiences, insights and information, this ambitious enterprise would not be possible.

Professor Alan Hayes AM
Director
The Australian Institute of Family Studies

Foreword by Chapin Hall Center for Children University of Chicago

Over the past decade, there has been a profound shift in how public child welfare agencies see their mission. Fundamental concerns with child protection – keeping children safe in the context of a permanent family – have expanded to include the wellbeing of children, especially children living in out-of-home care. When the state takes on parental responsibilities, how well children are doing has to be front and centre.

The shift in emphasis was inevitable. The decision to place children away from their families has an indelible impact on how young people come to see the world around them. Adverse life experiences contribute to why children come into care; high quality foster care has the potential to put children back on a positive life course trajectory.

A deeper awareness of the interplay between child wellbeing and child protection is a testament to the importance of science as a driving force behind policy and practice. The connection between early adversity and adult outcomes, that now seems so obvious, opened the door to a broader, transformative discussion linking safety and permanency to wellbeing and wellbeing to safety and permanency.

The Pathways of Care Longitudinal Study offers the promise of bringing science closer to policy and practice. If one wants to improve the wellbeing of children in out-of-home, the discussion has to start with knowing how well children are doing. Only then can policy-makers and practitioners make informed choices about how to improve services and outcomes.

The Chapin Hall Center for Children University of Chicago is proud to have been a part of this landmark research, from its inception to this Wave 1 report. International collaboration is difficult. The nuances of norms, values, and systems that define how a nation protects its children mean it is difficult to interpret the how and why of child protection. At the same time, it is only through comparison and collaboration that we come to understand whether the choices made are reasonable, given the evidence. We applaud the Department of Family and Community Services, and its partners – I-view, Australian Institute of Family Studies, and others – for the vision and patience needed to see a longitudinal study through each step of the way. We are, of course, happy to have been a part of such an important endeavour.

Mr Bryan Samuels
Executive Director
Chapin Hall Center for Children University of Chicago

Foreword by I-view Social Research

The success of the Pathways of Care Longitudinal Study will be measured by the growth in positive outcomes for children and young people in out-of-home care. This report is the first step in providing detailed empirical information to inform the development of policy and programs to drive such outcomes.

At the foundation of this study is the cooperation of those directly involved in the out-of-home care experience – the children and young people and their carers. There is widespread recognition amongst study participants of the importance, value and scope of the study and we have been impressed by their willingness to share their time and experiences.

I-view Social Research is proud to be partnering with FACS, AIFS, Chapin Hall and the other contributors on this important study. We have endeavoured to recognise, and demonstrate respect for, the wide range of experiences and circumstances of study children and their carers, as well as acknowledging their varied cultural backgrounds. This, together with a flexible approach in accommodating carers' busy schedules, and an innovative approach to data collection, has helped achieve high response rates and robust data.

As an organisation whose mission is to undertake government and social research to help guide policymakers, this project holds a special place in our hearts. Our specialist researchers and fieldwork team value the opportunity to be part of this research; it has been a very rewarding experience for all involved. We particularly want to recognise our interviewers for their dedication to completing interviews with sensitivity to the needs and preferences of study children and their carers.

Since completing Wave 1, interviewers have enjoyed immense satisfaction in revisiting families and following the pathways of study children through both stable and changing placements, restoration and adoption. I-view Social Research looks forward to continuing its involvement in this important study. We are confident this will provide an extensive and rich evidence base to enable the long-term enhancement of the wellbeing of those in the NSW out-of-home care system.

Mr Mark Davis
Managing Director Ipsos Public Affairs
(including I-view Social Research)

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Executive Summary – the Pathways of Care Longitudinal Study

The Pathways of Care Longitudinal Study (POCLS) is the first large scale prospective longitudinal study on out-of-home care (OOHC) in Australia. The study examines the developmental wellbeing of children and young people (hereafter children) in OOHC on final orders under the NSW (NSW) *Children and Young Persons (Care and Protection) Act 1998*. The study population is 4,126 children (aged 0-17 years) in NSW entering OOHC for the first time ever between May 2010 and October 2011. The POCLS will follow in detail the trajectories of a subset of the study population, those children who received final care and protection orders by April 2013 including children in long-term foster care or relative/kinship care, residential care, adoption, restoration[1] and those who re-enter OOHC. In May 2011, multi-wave face-to-face interviews commenced with children and caregivers to collect detailed information on the characteristics, needs, experiences and outcomes of the study children. Other data sources for the POCLS are online surveys of childcare workers, teachers and caseworkers; and administrative data through record linkage. This study will contribute towards building a strong evidence base to inform policy, practice, decision making and training to improve the outcomes of children who have been exposed to childhood abuse and neglect.

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[1] The POCLS sample who were restored to their birth family before being invited to participate in the Wave 1 caregiver interview were not included in Wave 1 data collection but invited to Wave 2. All other children, who received final orders by April 2013, were invited to participate in the POCLS primary data collection.

The NSW Department of Family and Community Services (FACS) is funding and leading the study, with a team of experts contracted to provide advice on the study design and undertake data collection and analysis. The current POCLS research team is as follows:

- a team of researchers at FACS Analysis and Research including Ms Sharon Burke, Ms Marilyn Chilvers (Chief Investigator), Ms Toula Kypreos, Ms Marina Paxman (Project Manager), Dr Lucy Tully, Dr Johanna Watson and Mr Albert Zhou
- a consortium of Australian researchers at the Australian Institute of Family Studies (AIFS) including Dr Daryl Higgins, Dr Julie Lahausse, Mr Mark Sipthorp, Ms Diana Smart (Project Manager) and their consortium: Professor Judy Cashmore AO, Socio-Legal Research and Policy, Law School, University of Sydney; Professor Paul Delfabbro, School of Psychology, University of Adelaide; and Professor Ilan Katz, Social Policy Research Centre, University of NSW
- Dr Fred Wulczyn (Project Manager) and Ms Xiaomeng Zhou at Chapin Hall Center for Children University of Chicago
- Ms Rachelle Brown and Mr Andy Cubie (Project Manager) at I-view, an independent social research data collection agency.

About this report

This baseline statistical report presents an overview of the study design and key findings over a broad range of areas that have emerged from the Wave 1 data collection. Given the large size of the POCLS database, the report cannot present all of the data items collected. The aim of this report is to provide a baseline picture of the children's wellbeing across major areas of life, service provision and support, children's contact with their birth family and the characteristics of the current caregiving household.

The Wave 1 analyses provide information about children and their caregivers shortly after the children received final orders under the *Children and Young Persons (Care and Protection) Act 1998* in NSW from the Children's Court. On average, the Wave 1 interview occurred 17 months (ranging from 4–39 months) after the child's first ever entry to OOHC (usually on interim orders), and most of the children had been living with their current caregivers at the time of the interview for one year or more.

This baseline statistical report presents comparisons by age across all domains while comparisons by type of placement (foster, relative/kinship and residential care) and cultural identity (Aboriginal, Culturally and Linguistically Diverse (CALD) and other Australian) are presented for selected questions only. The analyses presented are based on an almost final version of the Wave 1 unweighted data and are descriptive only. They provide evidence of associations using bivariate analysis methods and do not indicate causality nor do the associations take into account other underlying confounding factors that could contribute to the relationship. Tests of statistical significance have not been routinely undertaken so findings should be interpreted with this in mind.

The POCLS design has some features that are important to note when considering the policy and practice implications.

Firstly, the POCLS final care and protection orders cohort (n=2,828) includes a wide range of aspects of parental responsibility from all aspects to the Minister, shared aspects with the Minister and another person, and no aspects with the Minister for children in full parental responsibility to a relative. Thus caution is needed when interpreting analyses relating to relative/kinship care at the overall level; for example, the level of appropriate case management and support could be less if full parental responsibility has been delegated to a relative.

Secondly, the POCLS sample of children who were restored to their birth family before the Wave 1 interview were not included in Wave 1 data collection for practical (e.g., recruitment) and ethical (e.g., sensitivity) reasons. However, these children and their birth parents will be invited to take part in an interview from Wave 2. Therefore, the key findings in this baseline statistical report do not describe children who were in OOHC on final orders for a short period of time before being restored.

Finally, the POCLS sample of children entered OOHC for the first time ever and their outcomes may differ from children of a similar age who have been in OOHC for a longer period of time, or who have had a number of re-entries into OOHC. This is particularly relevant for the older group of children in the POCLS, as lower numbers of children enter care for the first time ever at an older age (at Wave 1, only 10% of the POCLS sample on final orders were aged 12–17 years when compared with around 34% of all children aged 12–17 years in OOHC (Department of Family and Community Services, 2014). Caution is required in generalising the findings at this early stage of the study as the sample children in these older age groups may have had longer exposure to abuse and neglect than children entering care at younger ages.

Study design, key research questions and key findings

Chapter 2 – Introduction to the Pathways of Care Longitudinal Study

Chapter 2 provides an overview of the study design, sample population, measures and questions and the characteristics of the Wave 1 interviewed cohort. The POCLS population cohort (n=4,126) are all children who entered OOHC for the first time in NSW between 1 May 2010 and 31 October 2011. From this larger group, a subset of children who went on to receive final care and protection orders (n=2,828) in the Children's Court by 30 April 2013 were eligible for a face-to-face interview.

Participation in the study involves completing a 90-minute face-to-face interview at the caregiver's home or somewhere convenient. Children over three years are also invited to participate in activities and a short interview depending on their age and maturity. A Wave 1 interview was completed for 1,285 of the 1,789 children whose caregivers agreed to participate in the study. The most common reason caregivers gave for not wanting to participate in the study and/or interview at Wave 1 was lack of time. The Wave 1 data collection took place between May 2011 and August 2013 in 897 caregiving households.

The caregiver of every child who agreed to have their contact details securely transferred to the independent data collection agency during the sample recruitment period (n=1,789) will be invited to participate in subsequent waves of data collection. The interval between waves is approximately 18 months.

Chapter 3 – Eligibility for and participation in the Pathways of Care Longitudinal Study

Chapter 3 provides information about the eligibility for and participation in the POCLS. As the POCLS focuses on the developmental wellbeing of children placed on final care and protection orders, a subset of all children who enter OOHC, it is important to understand who, among all the children who enter OOHC, reaches the point of having a final care and protection order before study findings are generalised to subsequent cohorts of children. The issue of generalisation is also sensitive to whether the subset of children interviewed differs from the overall final care and protection orders cohort. Although the findings are still preliminary, the data described in this report begin to address selection into the study.

Generally, the findings suggest that children with more contact with the child protection system were both more likely to receive final care and protection orders and participate in the interviews. The connection between contact and participation is more or less expected. Children on final care and protection orders most often come from situations wherein the likelihood of restoration is low; hence the need for a long-term final care and protection order. Children in these situations tend to stay in care longer and the underlying difficulty may be reflected in the risk of harm, or risk of significant harm, prior to entry into OOHC. These factors will be examined in upcoming analyses.

Chapter 4 – Establishing children's placements

Chapter 4 describes how children's current placements were established and begins to address aspects of the Key Research Question: '*What are the placement characteristics and placement stability of the children, and how do these influence their outcomes?*'. These data were collected as part of the Wave 1 interview.

The majority of the POCLS children had been living with the current caregiver household for more than a year at the time the Wave 1 interview was conducted. Just over half of the POCLS children were living with caregivers with whom they were not related. Approximately two-thirds of the children were placed with the expectation that the placement would be a long-term arrangement until the child turned 18 years (note, children restored before the Wave 1 interview will be invited to participate in the study from Wave 2). Contact with the caregiving family prior to placement was quite common. Most caregivers had needed to make some changes to their household in preparation for the child's placement. Many children identified with their cultural background and most caregivers reported receiving support from others in helping children maintain these links. Most children had settled quickly when placed with the caregiver household and were very well settled at the time the Wave 1 interview was conducted.

Chapter 5 – Wellbeing of children and young people

Chapter 5 investigates the developmental wellbeing of children in the first years of OOHC and begins to address aspects of the Key Research Question: '*What is the physical health, socio-emotional wellbeing and cognitive/learning ability of the children entering OOHC compared with other children in the community?*'. Establishing a Wave 1 baseline measure of children's wellbeing will enable investigation of their progress over time and the factors that facilitate or hinder ongoing development.

Three major areas of children's functioning were examined: physical health, social-emotional adjustment, and cognitive/language development. As well as investigating how the total sample of children was faring, the wellbeing of children of differing ages, from differing cultural backgrounds, and from differing placement types was explored. This information was gathered as part of the Wave 1 data collection.

Overall, most children seemed to be progressing well in terms of their physical health and were similar to children in the general population. In the area of socio-emotional wellbeing, the POCLS children showed higher levels of behaviour problems from 3 years of age than usually found in the general population, particularly of the externalising type (e.g., aggression, hyperactivity). Rates of socio-emotional difficulties were highest among 12–17 year olds. Finally, children aged 9 months to 5 years were generally developing normally in terms of developmental milestones, but there were some signs of slower than average language development. While the majority of children were in the normal range on cognitive abilities and language development, rates of difficulties in these areas were higher among children aged 6 years or older than would be expected by normative comparisons. Children in residential care appeared to be experiencing poorer wellbeing than children in other placement types. Looking at how children are faring across the 3 domains of children's functioning examined showed that approximately half (49%) of the children did not show any problems, 30% showed problems in 1 developmental domain, 16% showed problems in 2 developmental domains, while 5% showed problems across all 3 developmental domains.

Chapter 6 – Children's childcare and educational experiences

Chapter 6 describes children's childcare and educational experiences and addresses aspects of the Key Research Question: '*In what ways do the characteristics of the child, carer, home/family and community affect the children's and young people's developmental pathways, and how do these differ from similarly situated children in the general population?*'. The information is sourced from the Wave 1 POCLS interview.

Many of the POCLS children who were not yet of school age attended some form of childcare, most commonly at a childcare centre except at age 4–5 years when preschool was more common. School age children often had to change schools when they entered OOHC. For many, this was an additional change to the school changes already experienced. Approximately one-tenth of children had repeated a school grade at some stage, while approximately one-third were receiving special services or remedial help at school. Just over one-quarter of caregivers of 6–11 year olds and 30% of caregivers of 12-17 year olds reported that an OOHC education plan was in place for the child. School absenteeism was relatively common, most frequently due to health reasons. Most caregivers were monitoring and supporting their child's school progress. A sizable minority were concerned about the child's learning progress and felt that the child was experiencing problems at school. On the other hand, many caregivers thought children looked forward to going to school and believed that schools were meeting children's needs. Most 7–11 year olds appeared to have positive perceptions of their school life but a larger proportion of 12–17 year olds did not (e.g., close to half of 12–17 year olds 'rarely/never' or only 'sometimes' enjoyed being at school). There were several differences between children from differing cultural backgrounds and placement types; one of the most prominent findings was that children in residential care, while a very small group overall, appeared to have multiple problems and were not faring as well as children in foster and relative/kinship care at school.

Chapter 7 – Caregiver parenting practices and children's relationships

Chapter 7 examines caregiver parenting practices and perceptions of the child's relationships with the caregiving family and birth family and begins to the address aspects of the Key Research Questions: '*What are the placement characteristics and placement stability of the children, and how do these influence their outcomes?*' and '*How does contact between the children in OOHC and their birth parents, siblings, and/or extended family influence their outcomes?*'. Children's views of relationships were also obtained. Data were collected during the Wave 1 interview on how children and young people were getting on with caregiving and birth families in their early years of being in OOHC, which is believed to be an important factor not only in regard to placement stability, but also child happiness and wellbeing.

A generally positive picture emerged of the family relationships experienced by children in the early years of OOHC. The majority of children had close relationships with the caregiver interviewed and other children in the caregiving household, and most caregivers interviewed reported knowing the study child well. In addition, most children aged 6–17 years had close relationships with peers and significant others. Although approximately half had a good relationship with their birth siblings, fewer had a good relationship with their mother or father. Several differences were evident for children's family relationships when examined by age group (e.g., closer carer and family relationships among younger children) and placement type (e.g., more positive family and social relationships among those in relative/kinship care in comparison to other placement types).

Chapter 8 – Service provision and support

Chapter 8 describes service provision and support for children and caregivers. It addresses aspects of the Key Research Question: '*What are the placement, service intervention and case planning pathways for the children during their time in OOHC?*'. The provision of services is one of the most crucial ways that governments can assist vulnerable children to recover from abuse or neglect and make a successful adjustment to OOHC. This can range from the provision of medical services to case planning and caseworker support. This information was collected as part of the Wave 1 interview.

Children and caregivers had accessed a broad range of services, supports and information sources. Overall, caregivers felt their needs and those of the study child had been well met by the services accessed. However, a number of service needs remained. Caregivers identified a range of barriers that prevented access to services for the child and themselves, with the most common being long waiting lists. Generally, carers were satisfied with their access to caseworkers and the assistance that had been provided. The perspectives of children aged 7 years and older tended to be less positive however, with these children less likely to report being satisfied with caseworker support (e.g., with how often their caseworker talked to them by themselves). A higher proportion of foster carers reported access to services and caseworker support than relative/kinship carers.

Chapter 9 – Characteristics of the caregiver, household and neighbourhood

Chapter 9 summarises the characteristics of caregivers, their household and neighbourhood and addresses aspects of the Key Research Question: '*In what ways do the characteristics of the child, carer, home/family and community affect the children's and young people's developmental pathways, and how do these differ from similarly situated children in the general population?*'. This information was collected during the Wave 1 data collection.

Overall, the socio-economic status of the POCLS caregiving households tended to be lower than that of the Australian population at large, when considering key factors such as annual household income. Despite these findings, however, on-the-whole, caregivers felt they were relatively comfortable financially (i.e., not struggling to make ends meet), and they were also generally satisfied with the households and neighbourhoods in which their families were living.

The socio-economic profiles of caregiving households differed to some extent according to placement type, with relative/kinship households appearing more financially disadvantaged than foster care households. Relative/kinship carers interviewed tended to be older than foster carers, with a higher proportion aged over 60 years. Relative/kinship carers interviewed also reported slightly worse physical and mental health, slightly higher levels of household smoking and slightly less positive relationships with their partners by comparison with foster carers. Overall, the proportion of cares interviewed who identified as Aboriginal was much higher than the general Australian adult population, with relative/kinship carers more likely than foster carers to be Aboriginal and/or Torres Strait Islander.

Nevertheless, while the POCLS households were somewhat financially disadvantaged in comparison to the general Australian population (a finding that was more characteristic of relative/kinship care households by comparison with foster care households), the majority of children appeared to be placed in households where the incidences of financial hardship and psychological distress, as well as potentially harmful behaviours such as heavy alcohol consumption and smoking inside the household, were infrequent.

Conclusion

This report aims to provide key baseline data for the POCLS. However, there are some caveats to be aware of when interpreting the findings presented in each of the chapters and these are outlined above. Hence, caution is likely to be required in generalising some of the findings.

This report forms one part of a suite of reports on the Wave 1 baseline data. Further analysis is planned which will examine in-depth several of the key issues identified in this baseline statistical report including:

- children's interaction with the NSW child protection system including risk of significant reports, response to risk of significant harm and OOHC
- connections between children and young people's child protection histories and their wellbeing
- contact with birth families and its links to child wellbeing
- children's wellbeing in differing types of placements
- the circumstances and wellbeing of Aboriginal children
- services and supports appropriately meeting the needs of specific cohorts of children.

An analysis of non-response bias for these data is being undertaken and will inform the weighting (if any) to be applied to the data for further analyses.

Longitudinal statistical reports will be produced following each wave of data collection. The longitudinal multivariate analyses will examine differences in outcomes for children based on a number of factors. The longitudinal analyses will provide a picture of how children are faring over time and identify factors that help differentiate between those on a positive trajectory and those continuing to experience challenges in relation to their development and wellbeing.

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Introduction to the Pathways of Care Longitudinal Study

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The NSW Department of Family and Community Services (FACS) is funding and leading the Pathways of Care Longitudinal Study (POCLS), with a team of experts contracted to provide advice on the study design and undertake data collection and analysis. The POCLS is the first large-scale prospective longitudinal study on out-of-home care (OOHC) in Australia. The study will follow children and young people (from here on, 'children' refers to children and young people) aged 0–17 years entering OOHC for the first time ever under the *Children and Young Persons (Care and Protection) Act 1998* in NSW. This study will contribute towards building a strong evidence base to inform policy, practice, decision making and training to improve the outcomes of children who have been exposed to childhood abuse and neglect. This first statistical report for the POCLS presents the Wave 1 baseline data and will be followed by longitudinal analyses on children's experiences and outcomes as subsequent waves of data collection occur.

The study has a broad scope and collects detailed information about the characteristics and circumstances of children on entry to OOHC, the experiences of children in OOHC, their developmental wellbeing and needs, and safety. The developmental domains of interest are the children's physical health, social-emotional wellbeing and cognitive/learning ability. The POCLS will follow children regardless of their pathways through OOHC (e.g., placement changes, restoration, adoption or ageing out) to examine the factors that predispose children to poorer outcomes and which factors are protective.

The sample is drawn from a population cohort of all children entering OOHC in NSW for the first time ever between May 2010 and October 2011. The cohort thus includes children of all ages, all placement types, as well as all geographic locations in NSW. Caregivers of children who went on to receive final care and protection orders by April 2013 were then invited to participate in a face-to-face interview for Wave 1 of the study. The first wave of data collection took place between May 2011 and August 2013 with caregivers of 1,285 children participating in a face-to-face interview. Children aged three years and over also completed activities and an interview (see Table 2.8). This study will include at least three waves of face-to-face interviews, conducted 18 months apart.

This chapter presents a brief background to the NSW child protection and OOHC policy context; and the study's objectives, key research questions, conceptual overview, population cohorts, data collection, Wave 1 interviewed cohort and analyses presented in this report.

2.1 NSW child protection system

The *Children and Young Persons (Care and Protection) Act 1998* governs the child protection system in NSW. The Act specifies how children and young people under the age of 18 years at risk of significant harm (ROSH), or being harmed, should be protected. This includes guidelines around reporting, assessments and the provision of services that range from early intervention to OOHC. Children enter OOHC for a variety of reasons, including exposure to ROSH from physical, sexual or emotional abuse and neglect, or because their parents' ability to care for them has been severely compromised by factors such as poor mental health, drug and alcohol misuse or domestic violence. An overview of the NSW continuum of services for children at risk of harm is provided in Appendix 1.

The change of legislation from 24 January 2010 means that reports to the Child Protection Helpline need to meet the threshold of ROSH as opposed to 'risk of harm'. This change was introduced so that children and young people who need the protection of statutory intervention can receive this from FACS, while children and families who need other forms of support and assistance can receive this from a range of government and community organisations without being reported to FACS (NSW Department of Family and Community Services, 2014).

Helpline caseworkers record the issues associated with ROSH reports. Table 2.1 presents the number of ROSH reports by all reported issues recorded for each report. When a child and young person concern report is received, it is first classified according to the issue that is considered the most significant. Physical abuse, neglect, emotional abuse and domestic violence were the top four reported issues across all three years. There was some variation in the order of the issues between the years. In 2012/13, physical abuse and neglect were present in around 30% of all ROSH reports, with domestic violence and sexual abuse the next most frequently reported issues (NSW Department of Family and Community Services, 2014).

Table 2.1: ROSH reports by reported issue (all issues), NSW, 2010/11 to 2012/13[1]

Reported issue – all issues[2]	2010/11		2011/12		2012/13	
	Number	% of total reports	Number	% of total reports	Number	% of total reports
Physical abuse	31,939	32.3	32,580	32.8	32,990	31.5
Neglect	30,868	31.2	29,575	29.8	29,951	28.6
Domestic violence	19,836	20.1	18,653	18.8	19,008	18.1
Sexual abuse	14,600	14.8	15,839	16.0	18,410	17.6
Drug/alcohol use by carer	18,847	19.1	17,904	18.0	17,602	16.8
Emotional abuse	21,182	21.4	18,023	18.2	16,951	16.2
Carer: mental health	11,212	11.3	9,673	9.7	8,346	8.0
Prenatal report[3]	..[4]	.. [4]	.. [4]	.. [4]	3,539	3.4
Child inappropriate sexual behaviour	2,197	2.2	2,396	2.4	3,069	2.9
Drug/alcohol use by child or young person	3,092	3.1	2,546	2.6	2,928	2.8
Suicide risk for child	2,527	2.6	2,363	2.4	2,882	2.7
Carer: other issues	2,160	2.2	1,691	1.7	1,488	1.4
Runaway child	973	1.0	859	0.9	850	0.8
Total reports[5]	98,845	.. [4]	99,283	.. [4]	104,817	.. [4]

1 For the period from 24 January 2010 to 29 November 2012, up to four reported issues may be recorded. Since 30 November 2012, up to three reported issues maybe recorded.
2 A classification of all issues relating to risk of harm reports is presented in Appendix 2.
3 Prenatal reporting is defined under Section 27 of the Children and Young Persons (Care and Protection) Act 1998, which provides for reports to be made for unborn children where there are concerns that the child may be at risk of significant harm after his or her birth. Prior to 2012/13, prenatal reports were captured under the 'Carer: other issues' category.
4 '..' – not applicable.
5 As a report can have multiple reported issues recorded, the categories presented are not mutually exclusive and do not add up to the total number of reports.
Source: KiDS – CIW annual data. Published in the NSW Department of Family and Community Services Annual Statistical Report, 2012/13.

NSW out-of-home care policy context

OOHC is a last resort for keeping children safe and provides: *emergency placements* in unplanned situations; *short-term placements* following child protection intervention; and *long-term placements* including foster care, relative/kinship care, residential care and independent living, or adoption (NSW Department of Family and Community Services, 2014).

In NSW, the needs of most children placed in OOHC will be best met through placement with relative and kin carers or, when this is not possible, with unrelated foster carers or adoptive parents. For a very small number of children, placement in a residential care service may best meet their needs for a period of time. The placement of Aboriginal children is guided by the 'Aboriginal Child Placement Principle', which gives priority to placing an Aboriginal child or young person with a member of his or her extended family or kinship group. This principle sets a priority hierarchy of placements, starting with family and kin and may, in part, contribute to the increasing use of kinship/relative placement in the past decade. The existence of the principle serves to acknowledge the importance of the child or young person's identity and maintain their connections with family, culture and community. Aboriginal kinship care includes carers from the Aboriginal community even if they are not part of the child's extended family.

The provision of services for children in statutory OOHC is currently provided by both government and non-government organisations (NGOs). The provision of services for children in supported care (e.g., orders allocating full parental responsibility to a relative) is provided by FACS only. FACS and NGOs recruit and authorise foster carers and relative/kinship carers. Caregivers are provided with ongoing support such as training, peer support and financial assistance. Children and caregivers, who are referred by FACS caseworkers, are provided with psychological support as appropriate by the FACS Psychological Service. Some specialised services provide an intensive level of services for children with high needs, significant disabilities, or large sibling groups. While in OOHC, relationships that children have with their birth families and communities are maintained when it is safe to do so (NSW Department of Family and Community Services, 2014).

NSW is in a period of reform to improve OOHC following the release of *Keep Them Safe*, the Government's response to the Wood Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008). Predominately, this involves the transfer of case management of all children in statutory OOHC to NGOs. At 30 June 2013, the proportion of all children in statutory care who were placed with NGOs was 41%, up from 26% in the previous year. FACS is also working to deliver on the NSW 2021 target to reduce the rate of children in statutory care by:

- focusing on and improving early intervention services for the most vulnerable families and communities
- increasing the capacity and responsibility of families to care for their children
- working with NGOs to provide more flexible and innovative responses
- making decisions about permanent care arrangements earlier to provide more stability for children where children are unable to be restored to their parents. This includes looking at ways to make adoption by carers easier and quicker (NSW Department of Family and Community Services, 2014).

Current legislative reforms to the child protection system in NSW, which are being progressed under a *Safe Home for Life*, aim to improve the outcomes of children at ROSH by focusing on:

- building parenting capacity and increasing parental responsibility
- providing greater permanency for children and young people in care
- delivering a modern, responsive and child-focused system.

The safety, welfare and wellbeing of children and young people can be improved by giving them a long-term, nurturing, stable and secure environment which in turn gives them greater opportunity to fulfil their potential. From 29 October 2014, the *Children and Young Persons (Care and Protection) Act 1998* has recognised this with changes made to the legislation which now sets out guiding principles for the permanent placement of a child or young person. The order of preference for the permanent placement of a child or young person is:

- family preservation or restoration
- guardianship
- open adoption (for non-Aboriginal children)
- parental responsibility to the Minister.

Practice standards in statutory OOHC are fundamental to maintaining consistent and quality care to children. The *National Standards for Out-of-Home Care* have 13 standards that focus on the key factors that directly influence better outcomes for children in OOHC (Department of Families, Housing, Community Services and Indigenous Affairs, 2011). The *NSW Standards for Statutory Out-of-Home Care* were introduced in 1998 to establish minimum requirements for the accreditation of agencies providing case management for children in OOHC. In 2010, the standards were updated to provide a greater focus on the rights of children, and in 2013 they were updated again to reflect legislative changes (NSW Office of the Children's Guardian, 2013).

In NSW, 18,300 children were in OOHC at 30 June 2013, of whom 68% were in statutory care and 32% in supported care (see Glossary for definitions of care). The main placement types were relative/kinship care (53%) and foster care (39%), with only a small number of children in residential care (3%). Aboriginal children are over-represented in OOHC in NSW and at 30 June 2013 made up 35% of the OOHC population. During 2012/13, 3,210 children and young people entered OOHC, and for 81% of these children this was their first-ever entry into OOHC – this is a slight increase compared with 2010/11 (NSW Department of Family and Community Services, 2014).

2.2 Study objectives, key research questions and conceptual overview

The overall aim of this study is to collect detailed information about the life course development of children who enter OOHC for the first time and the factors that influence their development, and to use that knowledge to enhance the OOHC service system and casework practice and thereby improve outcomes for children in care.

The objectives of the POCLS are:

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

Table 2.2 presents the key research questions for the study across the waves of data collection. The Wave 1 baseline statistical report begins to address aspects of these key research questions. However, the majority of the key research questions will require longitudinal data to address them.

Table 2.2: The key research questions to be addressed in the POCLS

1 What are the backgrounds and characteristics of the children entering OOHC, including their demographics, child protection history, reasons for entering care and duration of the legal order?

2 What is the physical health, socio-emotional wellbeing and cognitive/learning ability of the children entering OOHC compared with other children in the community?

3 How are the Aboriginal Child Placement Principles used in placement decision making for Aboriginal children entering OOHC?

4 What are the placement, service intervention and case planning pathways for the children during their time in OOHC?

5 What are the developmental pathways of the children during their time in OOHC, post restoration, post adoption and on leaving care at 18 years?

6 How safe are the children during their time in OOHC, post restoration, post adoption and on leaving care?

7 How prepared are children for restoration, adoption or the transition out of care at 18 years?

8 What are the placement characteristics and placement stability of the children, and how do these influence their outcomes?

9 In what ways are service interventions related to the outcomes for the children, and how is this affected by their developmental status when they entered care?

10 In what ways do the characteristics of the child, carer, home/family and community affect the children's and young people's developmental pathways, and how do these differ from similarly situated children in the general population?

11 How does contact between the children in OOHC and their birth parents, siblings and/or extended family influence their outcomes?

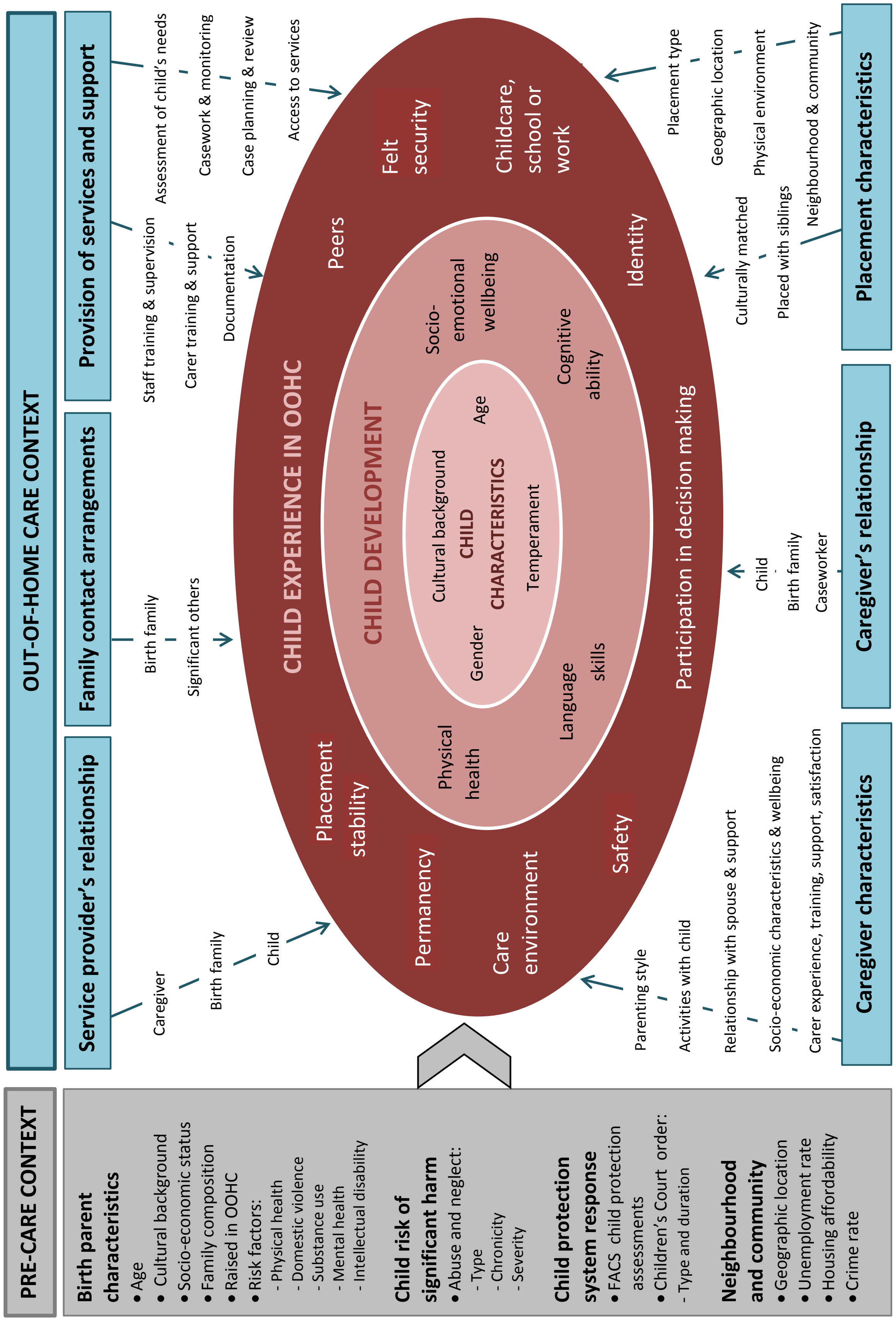
12 How well do the administrative data capture relevant information about the process and quality of care for assessments, case planning, permanency planning and child outcomes; and how can they be improved?

This study aims to measure the key factors associated with children's experiences and wellbeing as described in the research literature and the NSW Standards for Statutory OOHC. In order to capture the complexity of the factors associated with developmental outcomes for children in OOHC, a conceptual overview was developed based on Bronfenbrenner's (1979) socio-ecological model of child development. As shown in Figure 2.1, these factors include:

- family background and pre-care context including birth family characteristics, parental risk factors, and type and chronicity of abuse and/or neglect
- decisions made by the Children's Court and FACS, as the statutory child protection agency, on entry into OOHC
- the OOHC service system, including a number of factors that may improve or worsen a child or young person's experiences and developmental outcomes while in OOHC.

The risk and protective factors in OOHC include: placement characteristics (e.g., type of placement, if placed with siblings, neighbourhood); carer characteristics (e.g., socio-economic status, health, parenting style, social support); the services and supports provided to the child or young person and their carers; and contact with birth family. Figure 2.1 illustrates how these factors may relate to each other to influence a child or young person's experience of OOHC and shape their developmental outcomes.

Figure 2.1: Conceptual overview of factors influencing outcomes of children and young people in OOHC



[1] Informed by Bronfenbrenner (1979)

2.3 Pathways of Care Longitudinal Study population cohorts

The sampling unit for the POCLS is the study child. The sample was drawn from FACS administrative data stored in the Key Information Directory System (KiDS), which holds comprehensive data on children reported at ROSH in NSW.

The study population cohort is all children aged 0–17 years entering OOHC for the first time ever under the *Children and Young Persons (Care and Protection) Act 1998* across NSW within an 18-month period between May 2010 and October 2011 (n=4,126). The sample frame of first-time entries into OOHC provides the opportunity to understand the developmental pathways of children placed in OOHC, while preventing the confounding influence of past OOHC experiences.

The study population cohort (n=4,126) includes three subset cohorts:

- **no final care and protection orders cohort** (n=1,298) is a subset of children who entered care for the first time ever but did not receive final care and protection orders by April 2013 (many would have been assessed as being able to return to their parents' care with appropriate services and supports; others may have received final orders after April 2013). This subset of the study population cohort was not eligible for face-to-face interviews in the POCLS
- **final care and protection orders cohort** (n=2,828) is a subset of children who entered care for the first time ever between May 2010 and October 2011 and who went on to receive final care and protection orders from the Children's Court by April 2013, allocating to the Minister full aspects of parental responsibility (PR), shared aspects of PR, or no aspects of PR (e.g., full aspects of PR to a relative and thus in supported care). Children in this subset of the study population cohort are eligible to participate in a face-to-face interview for the POCLS regardless of their pathways in OOHC
- **final orders interviewed cohort** is a subset of children in the final care and protection orders cohort where children and their current caregiver completed a face-to-face interview at each wave of data collection.

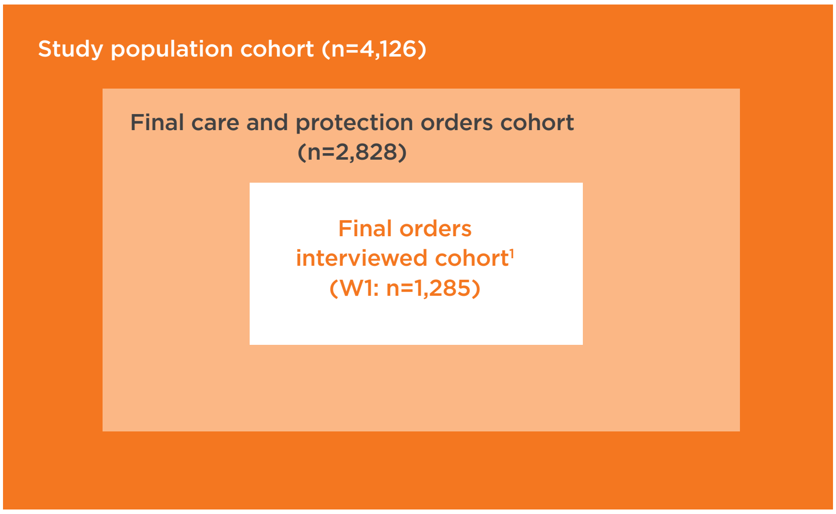
FACS attempted to contact the caregiver of every child in the final care and protection orders cohort to inform them of the POCLS and seek permission to pass on their contact details to the data collection agency – which would in turn invite them to participate in an interview at each wave. The final care and protection orders cohort included children who had been restored to their birth family (n=516) before FACS attempted to contact the caregiver. In these cases, FACS attempted to contact the birth parent(s) to inform them of the POCLS and seek permission to pass on their contact details to the data collection agency.

A total of 1,789 children (including 192 children who returned to their birth families) agreed to have their contact details passed on to the data collection agency (this group is referred to as the interview sample pool).

At each wave of data collection, the current caregiver of the 1,789 children in the interview sample pool will be invited to participate in an interview regardless of whether they completed an interview in the previous wave(s). Exceptions to this rule are the children restored before the Wave 1 interview (n=192). These children were not included in Wave 1 data collection for practical reasons (e.g., recruitment) and ethical reasons (e.g., sensitivity). However, these children and their birth parents will be invited to take part in a POCLS interview from Wave 2.

This study will focus on comparing three key cohorts of children and young people in OOHC (as shown in Figure 2.2) across the waves of data collection conducted approximately 18 months apart. At Wave 1, 1,285 study children in the final care and protection orders cohort, and their caregivers living in 897 households, participated in an interview. Caregivers of 1,027 study children (excluding 516 children who were restored at Wave 1) were invited but did not wish to participate in an interview. Chapter 3 examines study eligibility for and participation in the POCLS.

Figure 2.2: POCLS key study cohorts



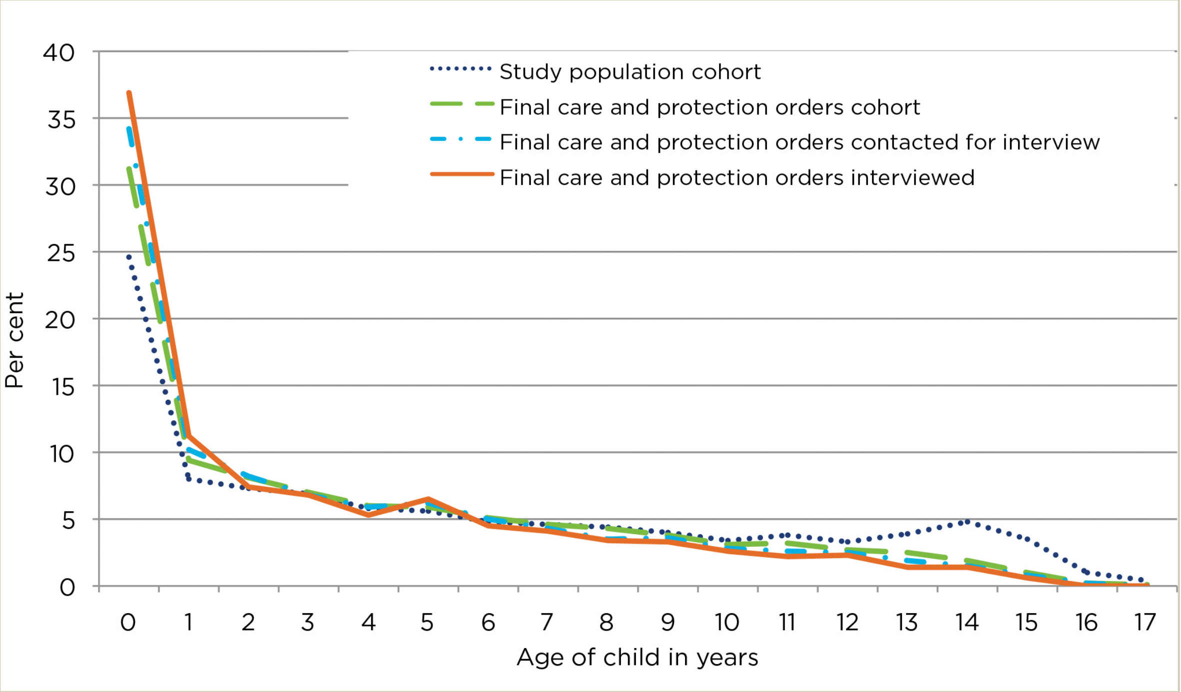
1 Note that the number of interviews completed will differ at each wave.

Characteristics of the study children on entry to OOHC

Child age

Infants (i.e. less than 12 months old) and children up to the age of 2 years are especially vulnerable due to their age, and the system's response to ROSH reports about them is prioritised. As a result, it is not surprising that this age group comprised the largest group to enter the study population cohort (40%), with most of these (62%) being under 12 months of age. For children aged 12 months or more, the proportion entering OOHC fell sharply (Figure 2.3). For 5 year olds, the proportion was 6%, and for 15 year olds it was 4%. More children aged under 2 years entering OOHC for the first time went on to receive final orders. This is reflected in the larger proportion of this age being eligible to be interviewed and, in turn, those who were in the interviewed cohort. Thus, children aged between birth and 2 years made up 40% of the study population cohort and 55% of those interviewed on final orders (Table 2.2). Results for children aged 12–17 years in the interviewed cohort relate to a small group of 74 children aged between 12 and 15 years and with an average age of 13 years (based on the age of the child at first entry into OOHC). There were 58 children aged 16 or 17 years in the population cohort, with only nine receiving final orders and none remaining in the interviewed cohort.

Figure 2.3: Children entering OOHC for the first time by study cohorts, percentage distribution



Child gender

There are similar numbers of males and females who enter OOHC for the first time in the study population cohort. These proportions remain relatively steady across cohorts.

Child cultural background

In the population cohort, 32% of the children are Aboriginal and 68% are non-Aboriginal (Table 2.3). Of the non-Aboriginal children, there were a number from culturally and linguistically diverse (CALD) backgrounds (10% of the total sample). These proportions remain relatively stable for the final orders cohorts generally.

Districts in which children resided

Children entering OOHC for the first time varied across the 15 FACS districts, with Hunter New England, South Western Sydney and Western NSW accounting for around 40% of the children entering OOHC for the first time in NSW in the study population cohort. Far West and Northern Sydney had the fewest first time entries to OOHC (1% and 2% respectively). Similar distributions can be found across the cohorts of children on final care and protection orders.

Table 2.3: Characteristics of the study cohorts at the time of entry to OOHC (May 2010–October 2011)

	Study population cohort (all children entering OOHC for the first time ever)		**Final care and protection orders cohort**[1] (up to April 2013)		**Final care and protection orders interview sample pool** (caregivers who agreed to be invited to an interview at each wave)		**Final care and protection orders Wave 1 interviewed cohort**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Age at first entry to OOHC								
0–2 years	1,649	40.0	1,377	48.7	941	52.6	713	55.5
3–5 years	752	18.2	533	18.8	337	18.8	239	18.6
6–11 years	1,031	25.0	680	24.0	388	21.7	259	20.2
12–17 years	693	16.8	238	8.4	123	6.9	74	5.8
Sex								
Male	2,059	49.9	1,452	51.3	881	49.2	637	49.6
Female	2,066	50.1	1,376	48.7	908	50.8	648	50.4
Cultural background								
Aboriginal[3]	1,323	32.1	927	32.8	614	34.3	451	35.1
CALD[4]	429	10.4	298	10.5	171	9.6	114	8.9
Other Australian	2,373	57.5	1,603	56.7	1,004	56.1	720	56.0
Placement type at entry to OOHC								
Foster care	2,372	57.5	1,816	64.2	1,131	63.2	816	63.5
Kinship/relative care	1,186	28.8	719	25.4	474	26.5	328	25.5
Residential care	38	0.9	22	0.8	8	0.4	3	0.2
Other[5]	529	12.8	270	9.5	175	9.8	137	10.7
District								
Hunter New England	750	18.2	507	17.9	339	18.9	266	20.7
South Western Sydney	515	12.5	379	13.4	229	12.8	149	11.6
Western NSW	395	9.6	256	9.1	183	10.2	141	11.0
Western Sydney	355	8.6	266	9.4	173	9.7	114	8.9
Nepean Blue Mountains	300	7.3	226	8.0	132	7.4	85	6.6
Illawarra Shoalhaven	242	5.9	171	6.0	98	5.5	65	5.1
Murrumbidgee	240	5.8	155	5.5	107	6.0	86	6.7
Central Coast	223	5.4	180	6.4	132	7.4	94	7.3
Northern NSW	223	5.4	121	4.3	78	4.4	63	4.9
South Eastern Sydney	218	5.3	144	5.1	87	4.9	66	5.1
Sydney	203	4.9	151	5.3	78	4.4	49	3.8
Mid North Coast	197	4.8	125	4.4	69	3.9	51	4.0
Southern NSW	112	2.7	66	2.3	50	2.8	38	3.0
Northern Sydney	81	2.0	47	1.7	20	1.1	10	0.8
Far West	45	1.1	29	1.0	12	0.7	7	0.5
Statewide Services	16	0.4	3	0.1	1	0.1	0	0.0
Total[2]	4,126	100.0	2,828	100.0	1,789	100.0	1,285	100.0

1 The final care and protection orders cohort (n=2,828) includes 2,312 carers and 516 children restored to their birth parents. The final care and protection orders interview sample pool (1,789) includes 1,597 carers and 192 children restored to their birth parents. At Wave 1, children restored to their birth parents (n=192) were not invited to an interview.

2 One child in the population cohort has been overlooked, with administrative data not included for processing. 57 children in the population cohort entered OOHC for respite purposes only.

3 Aboriginal status in this table is based on the Aboriginal status in the administrative data only so as to facilitate comparisons across cohorts. Aboriginal children and carers for the final care and protection orders interviewed cohort, as reported in elsewhere in this report, also take into consideration of a participant's primary cultural background and language spoken at home.

4 The CALD data were collected and verified for the final orders interviewed cohort only (n=1,285). FACS administrative data system collected limited information on CALD status only.

5 'Other' includes independent living and supported accommodation.

Child's first placement on entry to OOHC

When children enter OOHC for the first time, they are commonly placed in foster care (57% in the study population cohort – see Table 2.3). For those who went on to receive final orders and were then interviewed for this study, the proportion placed in foster care on entry to OOHC was slightly higher (around 64%). Fewer children on first entry to OOHC were placed with a kinship/relative carer (29% in the population cohort compared with a quarter in both the final order cohorts). Together, foster care and kinship/relative care account for more than 85% of all first placements. In contrast, only a very small proportion of children were ever placed in residential care for their first ever placement.

Children on final orders restored before the Wave 1 interview

The final care and protection orders cohort will include children who take many pathways in OOHC; for example, long-term OOHC, adoption, restoration and ageing out of OOHC. Almost one fifth (18%) of the children in the final orders cohort were in OOHC for a short period of time and restored to their birth family before FACS conducted the Wave 1 interview. Table 2.4 shows the characteristics of the children in the final orders cohort and restored before the Wave 1 interview compared with the children on longer-term orders. Birth parents who agreed to participate in the study were not invited to participate in a Wave 1 interview for practical reasons (e.g., recruitment) and ethical reasons (e.g., sensitivity). However, these children and their birth parents will be invited to take part in a POCLS interview from Wave 2.

Table 2.4: The POCLS final care and protection orders cohort by children remaining in OOHC and children restored before the Wave 1 interview

	Final care and protection orders cohort[1] (by April 2013)						Interview sample pool (caregivers in the final care and protection orders cohort who agreed to be invited to an interview at each wave)					
	Children with carers		Children restored to birth parents		Total		Children with carers		Children restored to birth parents		Total	
At first entry to care	n	%	n	%	n	%	n	%	n	%	n	%
Age of child												
0–35 mths	1,155	50.0	222	43.0	1,377	48.7	857	53.7	84	43.8	941	52.6
3–6 years	557	24.1	121	23.4	678	24.0	382	23.9	44	22.9	426	23.8
7–11 years	418	18.1	117	22.7	535	18.9	257	16.1	42	21.9	299	16.7
12–17 yrs	182	7.9	56	10.9	238	8.4	101	6.3	22	11.4	123	6.9
Gender												
Male	1,184	51.2	268	51.9	1,452	51.3	793	49.7	88	45.8	881	49.2
Female	1,128	48.8	248	48.1	1,376	48.7	804	50.3	104	54.2	908	50.8
Cultural background												
Aboriginal[3]	806	34.9	121	23.4	927	32.8	574	35.9	40	20.8	614	34.3
CALD[4]	233	10.1	65	12.6	298	10.5	142	8.9	29	15.1	171	9.6
All other children	1,273	55.1	330	64.0	1,603	56.7	881	55.2	123	64.1	1,004	56.1
Total[2]	2,312	100.0	516	100.0	2,828	100.0	1,597	100.0	192	100.0	1,789	100.0

1 The final care and protection orders cohort (n=2,828) includes 2,312 carers and 516 children restored to their birth parents. The final care and protection orders interview sample pool (1,789) includes 1,597 carers and 192 children restored to their birth parents. At Wave 1, children restored to their birth parents (n=192) were not invited to an interview.

2 One child in the population cohort has been overlooked, with administrative data not included for processing. 57 children in the population cohort entered OOHC for respite purposes only.

3 Aboriginal status in this table is based on the Aboriginal status in the administrative data only so as to facilitate comparisons across cohorts. Aboriginal children and carers for the final orders interviewed cohort, as reported in elsewhere in this report, also take into consideration of a participant's primary cultural background and language spoken at home.

4 The CALD data were collected and verified for the final orders interviewed cohort only (n=1285). FACS administrative data system collected limited information on CALD status only.

It is crucial to have a good understanding of how children come into contact with the child protection system, their experiences prior to and in OOHC, and how these and other factors come together to shape child development and placement trajectories over time. This will be examined further as this study progresses.

2.4 Pathways of Care Longitudinal Study data collection

The POCLS has a multi-informant approach and includes first-hand reports from children, caregivers (including foster carers, relative/kinship carers, adoptive parents, birth parents and residential care workers), caseworkers, childcare workers and teachers. Record linkage to retrospective child protection, OOHC placements, health, education and juvenile offending administrative data for the study population cohort will also be part of the POCLS data collection as shown in Appendix 3. These data sources will be integrated into a study analysis database to provide comprehensive longitudinal data.

FACS administrative data for the study population cohort (n=4,126) providing retrospective records at the child level on child protection reports, legal status and OOHC placements was extensively processed by Chapin Hall Center for Children University of Chicago to enable longitudinal analysis at entry.

From Wave 1, detailed face-to-face interviews with children and caregivers were conducted. The measures and questions included in the interviews are described in the section below.

From Wave 2, online questionnaires with childcare workers and teachers will be administered with the caregiver's consent (potential sample size n=1,789). A caseworker online questionnaire will be administered in Wave 3 to the final care and protection orders cohort (n=2,828). As the Wave 2 and 3 components of the study are not relevant to this Wave 1 Baseline Statistical Report, they are not described further in this report (for details, please see an article on the POCLS design by Paxman, et al, 2014).

Child and caregiver questionnaires

The POCLS includes at least three waves of data collection for children and caregivers using interviewer-administered measures for children aged 3 years and older plus face-to-face interviews with children aged 7 years and older. Table 2.5 lists the question modules included in the child and caregiver questionnaires. Table 2.6 provides a summary of the measures and questions used to examine children's wellbeing, and the characteristics of the caregivers and placements. Table 2.6 also provides information about the mode of administration for each measure, the study age range, and the availability of norms and/or use in other studies.

The interviews are conducted by trained interviewers from I-view, an independent data collection agency that specialises in social research data collection. I-view also manages the online surveys for childcare workers, teachers and caseworkers.

The questionnaire for caregivers (including foster carers, relative/kinship carers, birth parents, adoptive parents and residential care workers) includes a mix of standardised measures and validated questions (Tables 2.5 and 2.6). The standardised measures and questions used by other studies, such as the Longitudinal Study of Australian Children (LSAC), will allow researchers to compare the POCLS sample with the general population, as will other measures that have norms available.

The caregiver questionnaire is programmed into a computer-assisted person interview (CAPI) and a computer-assisted self interview (CASI) system. This means that all of the questions are recorded directly onto the computer at the time of interview, with some questions asked by interviewers (via CAPI), and other questions (especially sensitive questions) completed by the caregiver directly onto the computer (via CASI).

A short questionnaire for children aged 7–11 years has been programmed into a CAPI, and for 12–17 year olds into an audio computer-assisted self interview (ACASI) set up on an iPad. The ACASI system has a number of special features to make it enjoyable for young people, including a space theme and choice over the order of question modules, and the voice recording is by a young person who grew up in care.

To ensure that caregivers had sufficient knowledge about the child, the study child had to have lived with the caregiver for a minimum of one month before data collection could take place. Caregivers of children from birth onwards were recruited into the study; however, interviews were not conducted until the child was aged 9 months old, to ensure that the measures of infant development were reliable.

The questionnaires at each wave are modified for caregivers of sibling groups (where more than one child is participating in the POCLS) and for residential care workers. From Wave 2, the questionnaires will also be modified for adoptive parents (where the child is adopted) and birth parents (where the child has been restored).

Table 2.5: Child and caregiver questionnaire modules and mode of data collection

Caregiver question modules	Collection mode[1]
Introduction to the child and caregivers	CAPI
Setting up the placement and casework	CAPI
Child physical health (including height, weight, diet, sleep)	CAPI
NSW Heath Blue Book	Scan[2]
Child cognitive and language development	CAPI/CASI
Child socio-emotional development	CAPI
Child temperament	CAPI
Child behaviours	CASI
Services and support for child	CAPI
Child education	CAPI
Child work and further education	CAPI
Family activities, social skills, peer relationships	CAPI
Birth family contact	CAPI
Child cultural background and cultural activities	CAPI
Caregiver experience and training	CAPI
Caregiver own support network	CAPI
Caseworker support and services	CAPI
Caregiver relationship with child	CASI
Parenting – monitoring, hostility and warmth	CAPI
Caregiver difficult behaviour self-efficacy	CASI
Caregiver physical health	CAPI/CASI
Caregiver mental health	CASI
Caregiver relationship with partner	CASI
Caregiver satisfaction with foster/kinship caring	CAPI
Caregiver neighbourhood social cohesion	CAPI
Caregiver socio-demographic characteristics	CAPI
Caregiver household grid	CAPI
Child/young person question modules[3]	**Collection mode**
Child cognitive and language development	Direct assessment
Felt security	Direct assessment
Child school and friends	CAPI/ACASI
Child health	CAPI/ACASI
Child feelings	CAPI/ACASI
Child caregivers	CAPI/ACASI
Child caseworker and support	CAPI/ACASI
Child other comments	CAPI/ACASI

1 CAPI=computer-assisted person interview; CASI=computer-assisted self interview; ACASI=audio computer-assisted self interview.

2 To collect data from NSW Health Blue Book, these were scanned by interviewers at Wave 1 using a hand held scanner, and then de-identified by I-view.

3 Direct assessments of children from age 3 years and interviews with children from age 7-17 years were completed if willing.

POCLS data collection timelines

The study population cohort entered OOHC between May 2010 and October 2011, and a subset of this cohort, who received final care and protection orders by April 2013, were eligible for a face-to-face interview. This timeframe gave every child entering OOHC in October 2011 at least 18 months to receive final orders.

During February 2011 to July 2013, FACS undertook to recruit as many of the 2,828 children as possible to participate in a face-to-face interview.

The interval between waves of data collection is approximately 18 months. Wave 1 data collection spanned between May 2011 and August 2013. Wave 2 data collection ended in March 2015. Wave 3 data collection is underway at the time of publication of this report and is due to end in June 2016.

Ethics approval

Ethics approval for the POCLS has been granted by the University of New South Wales Human Research Ethics Committee (UNSW HREC) (Approval number HC10335) and the Aboriginal Health and Medical Research Council (AH&MRC) of NSW Ethics Committee (Approval Number 766/10).

Table 2.6: The questions and measures used in the POCLS interviews to examine children's wellbeing and caregiver and placement characteristics, including the respondent type, the age range, and availability of norms or whether used in other studies

Domain	Questions and standardised measures	Respondent type	Study age range	Used in other studies/norms available
Children's wellbeing				
Physical health and development	Ages and Stages Questionnaire (ASQ3; Squires & Bricker, 2009)	Caregiver	9 months[1] –5 years	US norms
	Additional questions about health conditions, services received, immunisation, diet, weight, sleep	Caregiver	All	Project developed and used by other studies such as LSAC, ATP
Socio-emotional development	Abbreviated Temperament Scales adapted from the Revised Infant Temperament Questionnaire (Carey & McDevitt, 1978), the Toddler Temperament Questionnaire (Fullard, McDevitt & Carey, 1978) and the Childhood Temperament Questionnaire (Thomas & Chess, 1977)	Caregiver	9 months –7 years	LSAC, ATP
	School Aged Temperament Inventory (SATI; McClowry,1995) – short form	Caregiver	8–17 years	LSAC, ATP
	Brief Infant Toddler Social Emotional Assessment (BITSEA; Briggs-Gowan et al, 2004)	Caregiver	12–35 months	LSAC US norms
	Child Behaviour Checklist 1.5–5 and 6–18 (CBCL; Achenbach & Rescorla, 2000; 2001)	Caregiver	3–17 years	NSCAW, LONGSCAN, US and Australian norms
	Ages and Stages Questionnaire (ASQ3; Squires & Bricker, 2009)	Caregiver	9 months[1] –5 years	US norms
	School Problems Scale (Prior, Sanson, Smart & Oberklaid, 2000)	Young person	12–17 years	ATP
	School Bonding Scale (O'Donnell, Hawkins & Abbott, 1995)	Young person	12–17 years	ATP, Seattle Social Development Project

Domain	Questions and standardised measures	Respondent type	Study age range	Used in other studies/norms available
Socio-emotional development	Short Mood & Feeling Questionnaire 13-item scale (Angold et al, 1995) and additional questions on mood[2]	Young person	12–17 years	LSAC,ATP, ASSAD
	Self Report Delinquency Scale 10-item scale adapted from (Moffitt & Silva,1988)[2]	Young person	10–12 years	ATP
	Felt security activity to show who they feel close to (adapted from the Kvebaek Family Sculpture Technique; Cromwell, Fournier & Kvebaek, 1980).	Child/Young person	7 years plus	Cashmore & Parkinson (2014) in family law study
	Additional questions for caregivers about services and supports for child emotional and behavioural problems, problems at school, child psychotropic medication	Caregiver	All	Project developed and used by other studies such as LSAC, ATP
	Additional questions for children and young people about peer relationships, friendships, school, health, caregivers and caseworkers	Child/Young person	7 years plus	Project developed and used by other studies such as LSAC, ATP
Cognitive and language development	Communication and Symbolic Behaviour Scale Infant and Toddler Checklist (CSBS ITC; Wetherby & Prizant, 2003)	Caregiver	9[1]–23 months	LSAC US norms
	MacArthur-Bates Communicative Developmental Inventories (MCDI-III; Fenson et al, 2007)	Caregiver	30–35 months	LSAC US norms
	MacArthur Communicative Development Inventories—Short form (Fenson et al, 2000)	Caregiver	24–29 months	US norms
	Peabody Picture Vocabulary Test (PPVT-IV; Dunn & Dunn, 2007)	Interviewer administered	3–17 years	Many studies; US norms

Domain	Questions and standardised measures	Respondent type	Study age range	Used in other studies/norms available
Cognitive and language development	Matrix Reasoning Test from Wechsler Intelligence Scale for Children (WISC-IV; Wechsler, 2003)	Interviewer administered	6–16 years	LSAC
	Additional questions about current schooling (usual grades at school, changes in schools, repeated years, school problems); for children aged 15 and older, questions on work and further education, life skills and plans for leaving care	Caregiver	All	Project developed and used by other studies such as LSAC, ATP
Caregiver and placement characteristics				
Psychological distress	Kessler K10 (Kessler et al, 2003)	Caregiver	All	LSAC, NSW Health Survey, Australian norms
Social cohesion	Social Cohesion and Trust Scale (Sampson, Raudenbush & Earls, 1997)	Caregiver	All	LSAC
Parenting practices/style/ self-efficacy	Parenting – Warmth (Paterson & Sanson, 1999)	Caregiver	All	LSAC
	Parenting – Hostility (Institut de la Statistique du Québec, 2000)	Caregiver	All	LSAC
	Parenting – Monitoring (Goldberg et al, 2001)	Caregiver	12–17 years	LSAC
	Difficult Behaviour Self-Efficacy Scale (DBSES; Hastings & Brown, 2002)	Caregiver	All	Study by Whenan, Oxlad & Lushington (2009)
	Emotional Responsiveness Scale from the Parenting Style Inventory II, adapted version (PSI-II: Darling & Toyokawa, 1997)	Young person	7–17 years	LSAC
	Additional questions for child about relationship with caregiver	Child/young person	All	Project developed and used by other studies such as LSAC, ATP
Satisfaction with support from services	Satisfaction with Foster Parenting Inventory (SFPI) – Social Service Support Satisfaction Scale (Stockdale et al, 1997)	Caregiver	All	–

Domain	Questions and standardised measures	Respondent type	Study age range	Used in other studies/norms available
	Additional questions for caregiver about socio-demographic characteristics; relationship with partner; relationship with study child; caregiver experience and training; family activities; support network; caregiver physical health; cultural background and cultural activities	Caregiver	All	Project developed and used by other studies such as LSAC, ATP

1 While children will be recruited from birth onwards, an interview with their caregiver will not be conducted until the child reaches 9 months of age, to ensure that the measures of infant development are reliable.
2 These measures were added at Wave 2.

Note: ASSAD=Australian Secondary Students' Alcohol and Drug Survey; ATP=Australian Temperament Project; LSAC=Longitudinal Study of Australian Children; LONGSCAN=Longitudinal Studies of Abuse and Neglect (US); NSCAW=National Survey of Child and Adolescent Well-Being (US).

2.5 Wave 1 interviewed cohort

A brief summary of the Wave 1 interviewed cohort will provide context to the data presented in Chapters 4–9.

The overall response rate for the Wave 1 interview was 56% and is calculated as the number of children in the final care and protection orders cohort remaining in OOHC for whom a Wave 1 face-to-face interview was completed (1,285) as a proportion of the number of all children in the final care and protection orders cohort not restored at the time of the Wave 1 interview (2,312). As described above, children restored by the time of the Wave 1 interview were not invited to participate in the POCLS until Wave 2.

The number of households that took part in the Wave 1 interview was 897, as many foster carers, relative/kinship carers and residential care workers had more than one study child in their care. A total of 1,285 interviews were completed by caregivers, and children aged 3 years and older also participated in the data collection (Table 2.7). Typically, the carer interview occurred 17.4 months after the child's first ever entry to OOHC, ranging from 4 to 39 months. Table 2.7 below shows the characteristics of the children at the time of the Wave 1 interview, including their age, gender, cultural background, placement type and number of households (note, Table 2.3 and Table 2.4 show sample characteristics at an earlier stage – on first entry to OOHC). The definitions of age groups, cultural background and placement type presented in Chapter 4–9 are outlined in Appendix 4.

At the time of the Wave 1 interview, 51% of children were placed in foster care, 47% were placed in relative/kinship care and 2% were placed in residential care. These distributions are similar to the placements of children and young people in OOHC in NSW in a similar time period of 2012/13: 39% foster care, 53% relative/kinship care and 3% residential care (NSW Department of Family and Community Services, 2014).

Of the children whose caregivers completed a Wave 1 interview, just under half (44%) were aged under 3 years at the time of interview. The sample was evenly divided into female and male, and just less than 1 in 10 were from a culturally diverse background. Over one third (36.5%) of children were Aboriginal, close to the 35% of the overall proportion of Aboriginal children and young people in OOHC in NSW (NSW Department of Family and Community Services, 2014).

Table 2.7: Characteristics of the children completing the Wave 1 interview (n=1,285)

	Number of children	
At the time of interview	n	%
Age of child		
9–35 months	567	44.1
3–5 years	265	20.6
6–11 years	329	25.6
12–17 years	124	9.6
Gender		
Male	637	49.6
Female	648	50.4
Cultural background		
Aboriginal[1]	469	36.5
Culturally diverse[2]	112	8.7
Other Australian	640	49.8
Unspecified	64	5.0
Number of study children by placement type (n=1,285)		
Foster care	661	51.4
Relative/Kinship care	598	46.5
Residential care	26	2.0
Number of households (n=897)		
Foster care	476	53.1
Relative/Kinship care	398	44.4
Residential care	23	2.6

1 Aboriginal status in this table is based on the Aboriginal status in the FACS administrative data.
2 Culturally diverse background is derived from the primary cultural background in FACS administrative data.

Several major child development al stages are covered in the study. Table 2.8 shows the number of children responding to the various data collection components of the interview.

Table 2.8: Number of children completing the Wave 1 activities and ACASI/CAPI interview[1]

	Number of respondents	Wave 1 sample size	Total %
Peabody Picture Vocabulary Test (children 3–17 years)	656	718	91.4
Matrix Reasoning Test (children 6–16 years)	403	447	90.2
Felt security activity (children 7–17)	331	377	87.8
Interview – CAPI (children 7–11 years)	173	253	68.4
Interview – ACASI (children 12–17 years)	92	124	74.2

1 Children aged 9–35 months did not participate in the activities or interview.

2.6 About this report

This baseline statistical report presents an overview of the study design and key findings over a broad range of areas that have emerged from the Wave 1 data collection. Given the large size of the POCLS database, the report cannot present all of the data items collected. The aim of this report is to provide a baseline picture of the children's wellbeing across major areas of life, childcare and educational experiences, contact with their birth family, perceptions of caregiving, parenting practices and children's relationships, service provision and support, and the characteristics of the current caregiving household and neighbourhood. Chapter 3 examines eligibility for and participation in the POCLS and is based on analysis of FACS administrative data for the study population cohort (n=4,126). Although the findings are still preliminary, the data described in this chapter begins to address selection into the study. Chapters 4–9 describe children's and caregivers' circumstances, wellbeing and early experiences of OOHC once final care and protection orders have been made. Chapters 4–9 are based on the first wave of primary data collected by face-to-face interviews with children and caregivers described above.

Data analysis undertaken in this report

The analyses presented are descriptive only and are based on an unweighted data file (September 2014). Hence, minor differences may be found between the results described here and subsequent analyses conducted with the finalised weighted version of the Wave 1 dataset[1]. The analyses provide evidence of associations using bivariate analysis only and do not indicate causality. Tests of statistical significance have not been routinely undertaken, so findings should be interpreted with this in mind.

This baseline statistical report routinely presents comparisons by age, while comparisons by type of placement (foster, relative/kinship and residential care) and cultural identity (Aboriginal, culturally and linguistically diverse (CALD) and other Australian) are presented for selected measures only. This is because the observed relationship between each of the factors, and the questions of interest in each case, are likely to be affected by the significant correlation between placement type and cultural identity. For example, Aboriginal children are much more likely to be placed with relatives or kin than are other children in accordance with the Aboriginal Placement Principle.

The sample sizes available for analysis varied considerably and sometimes were relatively small. Where the sample sizes were lower than 20, the results are not interpreted further.

The POCLS design has some features that are important to note when considering the policy and practice implications.

Firstly, the POCLS final care and protection orders cohort (n=2,828) includes a wide range of aspects of parental responsibility from all aspects to the Minister, shared aspects with the Minister and another person, and no aspects with the Minister for children in full parental responsibility to a relative. Thus, caution is needed when interpreting analyses relating to placement type conducted at the overall level,

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[1] An analysis of non-response bias for the Wave 1 data is being undertaken and will inform the weighting (if any) to be applied to the data for further analyses.

particularly for children in relative/kinship care that includes study children with all aspects of parental responsibility to the Minister and study children with all aspects of parental responsibility to a relative.

Secondly, the POCLS sample who were restored to their birth family before the Wave 1 interview were not included in Wave 1 data collection for practical reasons (e.g., recruitment to the POCLS) and ethical reasons (e.g., sensitivity). However, these children and their birth parents will be invited to take part in an interview from Wave 2. Therefore, the key findings in this baseline statistical report do not describe children who were in OOHC on final orders for a short period of time before being restored.

Finally, the POCLS sample entered OOHC for the first time ever, and their outcomes may differ from children of a similar age who have been in OOHC for a longer period of time, or who have had a number of re-entries into OOHC. This is particularly relevant for the older group of children in the POCLS, as lower numbers of children enter care for the first time ever at an older age (at Wave 1, only 10% of the sample were aged 12–17 years). Caution is required in generalising the findings at this early stage of the study, as the older age groups may have had longer exposure to abuse and neglect than children entering care at younger ages.

2.7 Next steps

Longitudinal analysis

The baseline reports will be followed by a series of longitudinal multivariate analyses examining differences in outcomes for all children, and specific cohorts of children, to answer the study's key research questions. Longitudinal statistical reports will also be produced following Wave 2 and Wave 3 data collections and will provide a picture of how children are faring over time and identify factors that help differentiate between those on a positive trajectory and those continuing to experience challenges in relation to their development and wellbeing.

Other additional data collections from Wave 2 include children who were restored to their birth parents or adopted by their carers; a childcare worker and teacher survey; a caseworker survey and record linkage.

Technical papers on non-response analysis and weighting the data will be published and available on the study webpage.

The POCLS Clearinghouse

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

3

Eligibility for and participation in the Pathways of Care Longitudinal Study

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This study looks at the sample children who are part of the Pathways of Care Longitudinal Study (POCLS). The study is designed to deepen what the NSW Department of Family and Community Services (FACS) knows about the wellbeing of children in out-of-home care (OOHC) and the factors that influence their outcomes. The study design calls for children placed on final care and protection orders (hereafter final orders) to be followed over roughly five years and three waves of data collection. Data collection links administrative data with data collected from carers, childcare workers or teachers, caseworkers and the children themselves.

The broad contours of the study sample are as follows. To be considered eligible for the study, a child or young person would have had to enter OOHC for the first time between May 2010 and October 2011. This group of children is known as the population cohort. Of children in that group (n=4,126), children who were placed on a final order were then considered study eligible (n=2,828)[1]. From the final orders/

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[1] In the analysis of the administrative data which follows, the count of cases is 2,826 rather than 2,828. This is because one child in the population cohort, who was study eligible and interviewed, had been overlooked and was not included in the administrative data. In addition, the number of not eligible children in the following analysis (1,242) includes one child who was incorrectly classified.

study eligible cohort, FACS recruited caregivers to participate in an interview (n=1,789). Of that group, 1,285 completed the Wave I interview[2].

In this overview, we examine two key points in the process of selection into the study: selection from the population cohort into the final orders/study eligible cohort and from the final orders/study eligible cohort into the group of children for whom an interview with carers was completed. With respect to the former, selection into the final orders/study eligible cohort speaks to differential experiences in OOHC. In NSW, a significant portion of children entering OOHC leave after a relatively brief placement. Because study eligibility is conditional on whether the child was placed on a final order, the POCLS focuses on children who have been and likely will be in OOHC for some time. Selection from the final orders/study eligible cohort into the group of children whose carers were interviewed speaks to a slightly different issue. In surveys of this type, for reasons having to do with caregiver willingness to participate, trouble coordinating interview schedules, and myriad other reasons, one cannot expect a 100% response rate. Therefore, it is important to understand who completed interviews in the likely event that interviews involved a non-random subset of the final orders/study eligible cohort, which could influence how the study findings generalise to the larger population of study eligible children.

3.1 Study eligibility

As described in Chapter 2, children who entered OOHC for the first time between May 2010 and October 2011 were candidates for study eligibility (i.e., an interview) once they received final orders transferring parental responsibility to the Minister by the Children's Court. As a general matter, final orders are correlated with length of stay because final orders are issued after a judgment about restoration has been made. Children with final orders may yet be returned to their parents, but the likelihood of restoration goes down with the issuance of the final order. The POCLS focuses on children with final orders to better understand what happens developmentally to children for whom FACS has taken on long-term responsibility.

Table 3.1 presents select characteristics of the children admitted to OOHC for the first time between May 2010 and October 2011 by final order/study eligibility status. Caregivers of study eligible children were later invited to an interview. Overall, 69% of the children admitted during the study window became eligible (e.g., received final orders).

As expected, final orders/study eligibility and length of time in OOHC are inversely related. Among children in care for less than one month, only 21% received a permanent care and protection order. In contrast, 88% of the children in care for 24 months or more received final orders.

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[2] We could have but did not, for this round of the analysis, consider whether and how the population of study eligible children differed from those children whose caregivers agreed to be recruited. Children restored at the time of the Wave 1 interview were not invited to participate in the Wave 1 interview for practical and ethical reasons, but joined the study at Wave 2. Finally, the number of children reported in this study differs slightly from numbers reported elsewhere because the data set used for this study relies on linked placement and child protective services records. Children with only respite placement records (n=57) were dropped from the analysis.

Males were slightly more likely to receive final orders after admission than females. Final orders were much higher among young children – 88% of all infants were eligible for the study, whereas only 29% of the children aged 13 to 17 years became eligible.

Aboriginal children were about as likely to receive final orders and thus be eligible for the study as were non-Aboriginal children.

Most children placed in NSW are placed in family settings including both foster and relative/kinship care. Eligibility tended to be lower among children placed in non-family settings (e.g., residential care). Among children placed in relative/kinship care, final orders were less common among children placed in Aboriginal relative/kinship care (61%).

Table 3.1: The POCLS sample by study eligibility status and selected child characteristics

Characteristic	Not eligible n	Eligible n	Total n	Not eligible %	Eligible %	Total %
Time in care						
Less than 1 month	525	143	668	79	21	100
1–2 months	79	50	129	61	39	100
2–3 months	65	29	94	69	31	100
4–6 months	95	119	214	44	56	100
7–12 months	134	498	632	21	79	100
13–24 months	283	1,539	1,822	16	84	100
Over 24 months	61	448	509	12	88	100
Gender						
Female	668	1,375	2,043	33	67	100
Male	574	1,451	2,025	28	72	100
Age at placement						
Infants	116	883	999	12	88	100
1–5 years	390	1,147	1,537	25	75	100
6–12 years	339	634	973	35	65	100
13–17 years	397	162	559	71	29	100
Aboriginal status						
Non-Aboriginal	861	1,900	2,761	31	69	100
Aboriginal	381	926	1,307	29	71	100
Placement setting						
Foster care	499	1,481	1,980	25	75	100
Relative/Kinship: Non-Aboriginal	382	996	1,378	28	72	100
Relative/Kinship: Aboriginal	169	265	434	39	61	100
Residential care	37	45	82	45	55	100
Other	155	39	194	80	20	100
Total	1,242	2,826	4,068	31	69	100

Note: In this table and others that follow in this chapter, we use a different age categorisation and slightly different categorisation of Aboriginal status. With respect to age, we were interested specifically in identifying how the participation of older children compared with infants, as infants are the largest group of children entering OOHC. With regard to Aboriginal status, these data are based on the administrative data maintained by FACS. Other sections of the Wave I report used data collected during the interviews to identify Aboriginal status more precisely.

3.2 Completed interviews

In this section, we examine interview status relative to final orders/study eligibility. Caregivers of children on final orders were recruited to participate in the POCLS, with some agreeing to be interviewed and others refusing to participate. The interviewed cohort consists of those children whose caregivers participated in the Wave 1 interview. Overall, as a proportion of the final orders/study eligible cohort, interviews were completed with about 45% of the children with a final order.

As with final orders/study eligibility, interview status (interviewed/not interviewed) varied with characteristics of the children (Table 3.2). Notably, interviews were strongly correlated with length of stay (restoration cases were excluded from an interview at Wave 1[3]). Caregivers with children who had been in OOHC for more than one year were much more likely to complete the interview (above 50%). Among children in OOHC for less than one year, completion rates were below 30%.

Gender was not a determining factor in whether an interview was completed. Age, however, was strongly associated with completion. More than half of the children who entered OOHC as infants had a completed interview, while among 13 to 17 year olds, only 27% completed the interview.

Table 3.2: The POCLS sample by interview status and selected child characteristics

Characteristic	Not interviewed n	Interviewed n	Total n	Not interviewed n	Interviewed %	Total %
Time in care						
Less than 1 month	105	38	143	73	27	100
1–2 months	46	4	50	92	8	100
2–3 months	27	2	29	93	7	100
4–6 months	108	11	119	91	9	100
7–12 months	363	135	498	73	27	100
13–24 months	708	831	1,539	46	54	100
Over 24 months	185	263	448	41	59	100
Gender						
Female	728	647	1,375	53	47	100
Male	814	637	1,451	56	44	100
Age at placement						
Infants	409	474	883	46	54	100
1–5 years	626	521	1,147	55	45	100
6–12 years	389	245	634	61	39	100
13–17 years	118	44	162	73	27	100

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[3] Children who had been restored prior to the start of Wave I interviews will be invited to participate in subsequent waves.

Characteristic	Not interviewed n	Interviewed n	Total n	Not interviewed n	Interviewed %	Total %
Aboriginal status						
Non-Aboriginal	1,066	834	1,900	56	44	100
Aboriginal	476	450	926	51	49	100
Placement setting						
Foster care	785	696	1,481	53	47	100
Relative/Kinship: Non-Aboriginal	538	458	996	54	46	100
Relative/Kinship: Aboriginal	160	105	265	60	40	100
Residential care	29	16	45	64	36	100
Other	30	9	39	77	23	100
Total	1,542	1,284	2,826	55	45	100

Aboriginal status did not influence interview rates, but placement type was important. Foster carers and non-Aboriginal relative/kinship carers were among the most likely to complete an interview. Children in other settings were less likely to complete the interview.

Multivariate models

Tables 3.3 and 3.4 show the results of preliminary multilevel models for eligibility/final orders and interview completion. Although consistent with what has already been reported, the models clarify important relationships.

Table 3.4 shows that with respect to eligibility/final orders, gender was not important, as already noted. Age, however, was an important factor, even after accounting for other child characteristics. Relative to children of other ages, infants were much more likely to receive final orders. Aboriginal status did not influence the likelihood that a child would receive final orders. However, children placed in Aboriginal relative/kinship care were less likely to become study eligible when compared to children in foster care.

Table 3.3: Coefficients of multilevel logit models of children's study eligibility

Variable name	Category	Log odds	Standard error	Probability value	Odds ratio
Intercept		3.6899	0.2097	<.0001	
Gender	Female	-0.1022	0.0790	0.1956	0.903
	Male	0			1.000
Age	1–5 years	-1.3717	0.1304	<.0001	0.254
	6–12 years	-2.0255	0.1355	<.0001	0.132
	13–17 years	-3.2782	0.1643	<.0001	0.038
	Infants	0			1.000
Aboriginal status	Non-Aboriginal	0.0151	0.1018	0.8818	1.015
	Aboriginal	0			1.000
Placement type	Residential care	0.1384	0.2676	0.6049	1.148
	Relative/ Kinship: Non-Aboriginal	-0.0454	0.0906	0.6161	0.956
	Relative/ Kinship: Aboriginal	-0.6066	0.1438	<.0001	0.545
	Other	-1.5052	0.2263	<.0001	0.222
	Foster care	0			1.000

Notes: The model also controls for child protection history. The results (not shown here) indicated that children with more contact with the child protection system were more likely to receive final orders.

Multilevel results for interview status are reported in Table 3.4. These data show that although the differences are not, strictly speaking, statistically significant, interviews with caregivers of female children were somewhat more likely. Age was a significant factor. Caregivers of older children, especially teenagers, were less likely to be interviewed when compared to those of infants.

Caregivers of non-Aboriginal children, when compared with caregivers of Aboriginal children, were somewhat less likely to be interviewed. Children placed in Aboriginal relative/kinship care were less likely to be interviewed when compared with children in foster care.

Table 3.4: Coefficients of multilevel logit models of eligible children who are interviewed vs. not interviewed

Variable name	Category	Log Odds estimate	Standard error	Probability value	Odds ratio
Intercept		0.4966	0.1851	0.0083	
Gender	Female	0.1244	0.0782	0.1118	1.132
	Male	0			1.000
Age	1–5 years	-0.5014	0.1083	<.0001	0.606
	6–12 years	-0.8778	0.1249	<.0001	0.416
	13–17 years	-1.3192	0.2183	<.0001	0.267
	Infants	0			1.000
Aboriginal status	Non-Aboriginal	-0.1564	0.0948	0.0992	0.855
	Aboriginal	0			1.000
Placement type	Residential care	0.2463	0.3497	0.4813	1.279
	Relative/ Kinship: Non-Aboriginal	0.0613	0.0865	0.4787	1.063
	Relative/ Kinship: Aboriginal	-0.4244	0.1548	0.0062	0.654
	Other	-0.8035	0.4053	0.0475	0.448
	Foster care	0			1.000

Notes: The model also controls for child protection history. The results (not shown here) indicated that children with more contact with the child protection system were more likely to participate in the interview.

3.3 Child protection history

The characteristics and backgrounds of the children involved in the POCLS will be further analysed and presented in a separate report. The children's demographic backgrounds, as well as their child protection history and early experiences in OOHC, will be examined to inform our understanding of how these children came into contact with the child protection system, their experiences prior to and in OOHC and how these and other factors come together to shape their growth and placement trajectories over time. More detailed analysis of these data and data from subsequent waves will help achieve this understanding.

3.4 Conclusion

The POCLS focuses on the developmental wellbeing of children placed on final orders. As a subset of all children who enter OOHC, it is important to understand who, among all the children who enter OOHC, reaches the point of having a final order before study findings are generalised to subsequent cohorts of children. The issue of generalisation is also sensitive to whether the subset of children interviewed differs from the overall final orders/study eligible cohort. Although the findings presented in this chapter are tentative, we can as a result expect to find that children in these circumstances will have developmental outcomes at Wave 1 that are generally lower than what one might find in the population of OOHC children who leave placement quickly. This is likely the case with older children who were living at home for longer periods prior to coming into OOHC. While the findings are preliminary, the results point to how one might improve the OOHC available to children across the range of placement experiences but especially for children on long-term care and protection orders.

4

Establishing children's placements

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This chapter examines how the current out-of-home care (OOHC) placement for children in the Pathways of Care Longitudinal Study (POCLS) at Wave 1 was established. It describes the information provided to the current caregivers about the study child, preparations made by the caregiver for the child's arrival, the extent to which the child's cultural background had been maintained, as well as the degree to which the child had settled into the household. Chapter 9 examines differing aspects of children's placements focusing on the current caregiver demographics, household characteristics and neighbourhood context. The POCLS Wave 1 interview took place, on average, 17 months after the child first entered OOHC and provides baseline data relevant to Key Research Question 8: '*What are the placement characteristics and placement stability of the children, and how do these influence their outcomes?*'[1].

Placement characteristics and stability can significantly influence outcomes for children in OOHC. Placement instability in the early years of OOHC has been shown to have a negative effect on children's long-term outcomes and wellbeing. Webster, Barth and Needle (2000), for example, reported that two or more placement changes during the first year of OOHC were associated with greater placement instability in the long term. A high number of OOHC placements is associated with compromised developmental outcomes across a range of domains (e.g., Newton, Litrownik & Landsverk, 2000; Wulczyn & Chen, 2010). These findings point to the importance of establishing enduring and nurturing placements for children upon their entry into care.

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[1] Please see Chapter 2 for a description of the data analysis undertaken in this report.

It is not just the frequency of placement changes, however, but also their timing that may be important. For example, in the Philadelphia Children's Stability and Well-being longitudinal study of 400 children in foster care, placement stability is defined not only by the number of times a child moves, but also by the timeframes within which stability is achieved. In the first 18 months of a child's placement in OOHC, Noonan, Rubin, Mekonnen, Zlotnik and O'Reilly (2009) identified three categories: (a) *early stability*, where a child achieves a stable placement within 45 days of entering care; (b) *later stability*, where a child achieves a stable placement beyond 45 days but within nine months of entering care; and (c) *instability*, where a child does not achieve a stable placement. If early instability is due to the unsuitability of the placement in meeting the child's needs, but a good match is subsequently found and a period of significant stability ensues, positive outcomes may still be achieved.

Placement instability is related to a number of factors, including the presence of child behavioural or emotional problems (Redding, Fried & Bitner, 2000), older child age (Chamberlain, Price, Reid, Landsverk, Fisher & Stoolmiller, 2006), and the type of care experienced, with children in relative/kinship care found to be less likely to experience placement instability than those in foster care (Chamberlain et al, 2006). While it can be difficult to disentangle the direction of associations, for example whether child behavioural or emotional problems increase the risk of placement instability or placement instability increases the risk of child problems, the review by Jones and colleagues (2011) suggested that placement stability was a mediator of the relationship between child emotional and behaviour problems and long-term outcomes.

The duration of POCLS children's current placement at the time of the Wave 1 interview is likely to reflect the study design. As described in Chapter 2, the Wave 1 data were collected over 27 months, with interviews staggered based on the child's age, with the early stages of the Wave 1 data collection exclusively for children aged 9–35 months.

The most prevalent length of time children aged 9–35 months had been in their current placement at the Wave 1 interview was 6–11 months (38%) compared with 12–17 year olds, for whom it was 18 months or longer (42%). Overall, the most common length of time POCLS children had been residing in their current placement at the time of the Wave 1 interview was 12–17 months. Placement length and stability will be examined in depth in subsequent reports.

4.1 Setting up the child's current placement

One third of the caregivers reported that they had no contact with the child before the placement commenced, while 40% reported more than one overnight stay, and 37% reported that the child had more than a one-day visit before the placement commenced. Younger children tended to have experienced fewer overnight visits than older children. For example, 58% of caregivers of 6–11 year olds and 48% of caregivers of 12–17 year olds reported more than one overnight stay, compared with 24% of those caring for children aged 9–35 months. As might be expected, a higher percentage of children in foster and residential care had no contact with the caregiver prior to the placement, compared with children in relative/kinship care (65% and 55% respectively compared with 8% of children in relative/kinship care).

One quarter of caregivers reported that the child was already living with them at the time of official placement, while almost half (47%) reported that the placement was long term (Table 4.1). Just over a quarter of children were in emergency or respite placements when they were officially placed with the caregivers, and these children continued to reside in these placements at the time of the Wave 1 interview. In terms of age variations, fewer 12–17 year olds (17%) had been living with the current caregiver when they were officially placed compared with the younger age groups. A smaller percentage of children aged 9–35 months (24%) were in emergency or respite placements when they were officially placed with the current caregiver, compared with children aged 3–5 years (32%) and children aged 12–17 years (33%).

Overall, two thirds (67%) of caregivers interviewed at Wave 1 reported that they were told that the placement would last until the child turned 18 years[2]. Initially some caregivers were told that the placement would only be for a few days or weeks (5%), a few months (5%) or a few years (3%), and then children remained in these placements for longer periods. For 20% of caregivers, no timeframe was given at the start of the placement in relation to the expected placement length. There appear to be minimal differences in placement timeframes across age groups.

Just over half (53%) of the caregivers interviewed reported that they were unrelated to the child. Children were most commonly living with grandparents (29%) when placed with relatives, while a further 13% were with aunts and/or uncles. There appear to be some age differences, with a slightly higher proportion of the two youngest age groups being placed with unrelated caregivers (57% of 9–35 month olds and 53% of 3–5 year olds) compared with the two older age groups (47% of both 6–11 and 12–17 year olds). A higher proportion of 3–5 and 6–11 year olds were placed with a grandparent (30% and 35%) compared with 12–17 year olds (21%). Placement with an aunt or uncle was more common among 12–17 year olds (24%) than younger children (12–13%).

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[2] As explained in Chapter 2, POCLS children restored before the Wave 1 interview was scheduled were not included in the Wave 1 data collection.

Table 4.1: Caregiver reports on various aspects of establishing the placement, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total[1]	
	n	%	n	%	n	%	n	%	n	%
Type of contact with child prior to placement[1]										
More than one overnight stay	135	23.8	125	47.2	192	58.4	60	48.4	512	39.8
Only one overnight stay	30	5.3	13	4.9	6	1.8	1	0.8	50	3.9
More than one day visit	226	39.9	88	33.2	111	33.7	45	36.3	470	36.6
Only one day visit	51	9.0	15	5.7	15	4.6	8	6.5	89	6.9
No contact	208	36.7	87	32.8	88	26.7	42	33.9	425	33.1
Total	567		265		329		124		1,285	
Status of the placement when child officially placed										
Planned long-term placement	283	50.4	109	41.6	146	44.9	60	50.0	598	47.2
Emergency or respite placement	133	23.7	83	31.7	92	28.3	40	33.3	348	27.4
Child already living with caregiver when matter went to Court	145	25.8	70	26.7	87	26.8	20	16.7	322	25.4
Total	561		262		325		120		1,268	
How long caregivers told child would be staying										
Few days	4	0.7	4	1.6	2	0.6	4	3.3	14	1.1
Few weeks	21	3.8	8	3.2	14	4.4	2	1.7	45	3.6
Few months	31	5.7	12	4.8	13	4.1	4	3.3	60	4.9
Few years	15	2.7	8	3.2	11	3.5	5	4.1	39	3.2
Until child turns 18 years	361	66.1	167	66.3	221	69.9	81	66.9	830	67.2
No timeframe given	114	20.9	53	21.0	55	17.4	25	20.7	247	20.0
Total	546		252		316		121		1,235	
Caregiver's relationship to the child[2]										
Unrelated	321	56.6	139	52.5	155	47.1	46	46.9	661	52.5
Grandparent	153	27.0	80	30.2	114	34.7	21	21.4	368	29.2
Aunt/Uncle	71	12.5	32	12.1	41	12.5	23	23.5	167	13.3
Other relative[3]	22	3.9	14	5.3	19	5.8	8	8.2	63	5.0
Total	567		265		329		98		1,259	

1 Column percentages do not add up to 100%, as children could have both daytime and overnight stays. Children in residential care are not included in this table (n=26).

2 The 'caregiver' refers to the caregiver of the study child who was interviewed for Wave 1 of the POCLS, but it cannot be assumed that the other caregiver has the same relationship to the study child in cases where there was a second caregiver in the household.

3 This includes siblings, cousins, great grandparents, great aunts/uncles, step-parents, step-grandparents.

Table 4.2 shows that the most common changes that caregivers made to their household to prepare for the child's arrival were a modification to caregivers' routines, the purchase of furniture/equipment, and the rearrangement of bedrooms, with 57–60% of all caregivers reporting they had needed to make these changes. A change to the family's routine was also relatively common, with this required in approximately 40% of households.

There appear to be only minor differences in caregivers' reports of the changes needed to accommodate children aged 9 months to 11 years. However, caregivers of children aged 12–17 years were considerably less likely to report that any of these changes were needed, with differences particularly evident in changes to their own or the family's routine, and purchase of furniture/equipment or a larger car.

Table 4.2: Caregiver reports of changes made to the household to prepare for the child's arrival, by child age[1]

	9-35 months		3-5 years		6-11 years		12-17 years		Total[2]	
	n	%	n	%	n	%	n	%	n	%
Change in caregiver's routine	360	63.5	158	59.6	187	56.8	44	44.9	749	59.5
Purchase furniture or equipment	342	60.3	161	60.8	198	60.2	48	49.0	749	59.5
Rearrange bedrooms	325	57.3	153	57.7	191	58.1	51	52.0	720	57.2
Change in family routine	257	45.3	120	45.3	134	40.7	21	21.4	532	42.3
Purchase/hire car safety seat or a pram[3]	295	52.0	115	43.4	31	9.4	0	0.0	441	35.0
Childproof the house[4]	235	41.4	63	23.8	0	0.0	0	0.0	298	23.7
Purchase a larger car/ additional car	114	20.1	58	21.9	73	22.2	8	8.2	253	20.1
Other reason - Stopped or reduced work/ study[5]	39	6.9	11	4.2	13	4.0	1	1.0	64	5.1
Other reason - Moved or extended house[5]	13	2.3	15	5.7	9	2.7	6	6.1	43	3.4
Total	**567**		**265**		**329**		**98**		**1,259**	

1 Residential care workers (n=26) were not asked this question.

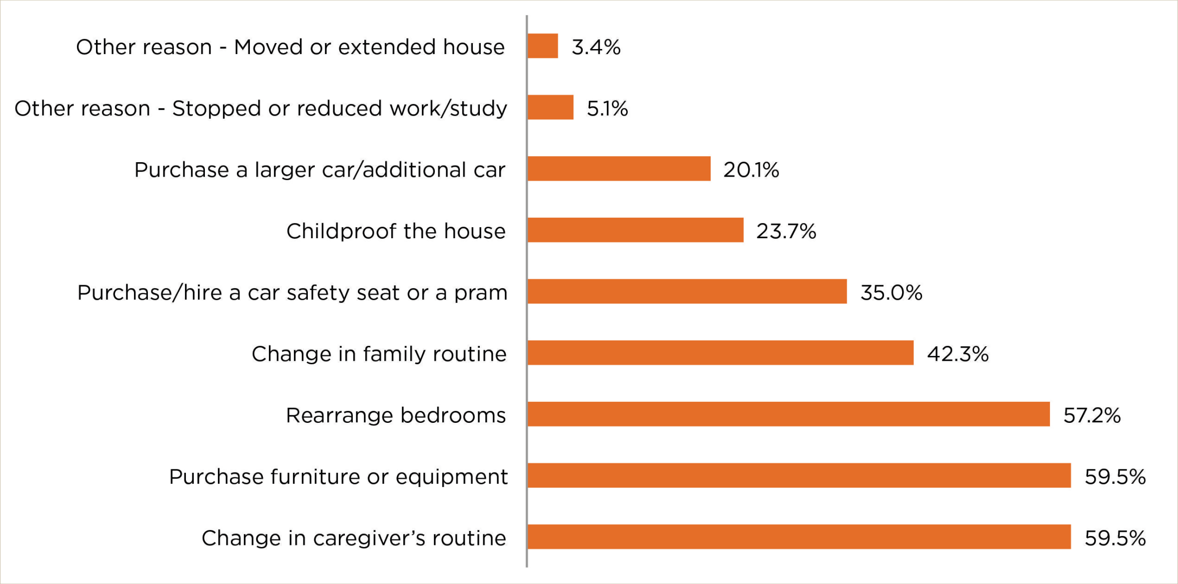
2 Column percentages do not add up to 100%, as more than one type of change may have been made.

3 Only asked if the child was 9 months to 7 years.

4 Only asked if the child was 9 months to 5 years.

5 These responses were coded from *Other (specify)* responses.

Figure 4.1: Caregiver reports of changes made to the household to prepare for the child's arrival



1 Residential care workers (n=26) were not asked this question.
2 Percentages do not add up to 100%, as more than one type of change may have been made.
3 'Purchase/hire a car safety seat or a pram' only asked if the child was 9 months to 7 years.
4 'Childproof the house' only asked if the child was 9 months to 5 years.
5 'Moved or extended house' and 'stopped or reduced work' was coded from *Other (specify)* responses.

A higher percentage of relative/kinship carers appeared to make changes on all the aspects measured when compared with foster carers (Table 4.3). For example, two thirds (66–67%) of relative/kinship carers had made changes to their own routines or had purchased furniture/equipment, compared with just over half (53–54%) of foster carers.

Table 4.3: Caregiver reports of changes made to the household to prepare for the child's arrival, by placement type[1]

	Foster care[2]		Relative/Kinship care[2]	
	n	%	n	%
Change in caregiver's routine	348	52.6	401	67.1
Purchase furniture/equipment	354	53.6	395	66.1
Rearrange bedrooms	357	54.0	363	60.7
Change in family routine	268	40.5	264	44.1
Purchase/hire car safety seat or a pram[3]	230	34.8	211	35.3
Childproof the house[4]	150	22.7	149	24.9
Purchase a larger car/additional car	123	18.6	130	21.7
Other reason - Stopped or reduced work/study[5]	28	4.2	36	6.0
Other reason - Moved or extended house[5]	3	0.5	40	6.7
Total	**661**		**598**	

1 Residential care workers (n=26) were not asked this question.
2 Column percentages do not add up to 100%, as more than one type of change may have been made.
3 Only asked if the child was 9 months to 7 years.
4 Only asked if the child was 9 months to 5 years.
5 These responses were coded from Other (specify) responses.

4.2 Information and support provided at the start of the placement

The proportion of caregivers who were provided with official documents since the start of the placement is shown in Table 4.4. The majority (89%) of all caregivers reported receiving the Confirmation of the Placement, 65% had received the child's Court Order, 48% had received a Placement Agreement, and 34% had received a Placement Information Sheet. The proportion of caregivers receiving documentation and information tended to increase as child age increased, with the exception of the Confirmation of Placement, for which it was lower for caregivers of children aged 12–17 years by comparison with caregivers of younger children.

In terms of other forms of support provided when the child first came to live with them, caregivers most commonly reported receiving the carer allowance payment (93%), time and advice from their child's caseworker or manager (64%), and access to a carer support group (53%). Findings were generally consistent across age groups with the exceptions of access to a carer support group (highest among carers of 9–35 month olds and lowest among carers of 3–5 year olds), and the provision of contingency money (which decreased as child age increased).

Across all caregivers, over half (58%) reported needing at least one type of further support when the child was first placed with them. There were age differences, however, with more caregivers of 3–5 and 6–11 year olds and fewer caregivers of 9–35 month and 12–17 year olds feeling that they had needed additional support. Looking next at specific needs, caregivers of children aged 3 years and over were more likely to indicate that they would have liked to receive contingency money

(31–35% of caregivers of children aged 3 to 17 years compared with 25% of carers of 9–35 month olds). While the proportion of caregivers reporting such needs was not high, a larger percentage of caregivers of 3–5 year olds than caregivers of other age groups would have liked time and advice from their child's caseworker or manager, access to a carer support group, and time and advice from carer support workers.

Across the whole sample, the most common issues that caregivers had learnt about the child but had not been aware of at the start of the placement were emotional and behavioural issues (29%); physical health issues (26%); and learning needs (20%). Caregivers of older age groups more frequently reported that they had learnt about the child's emotional and behavioural issues, learning needs, social/living skills and peer relationships, and personal identity than caregivers of younger age groups. For example, 36% of caregivers of 12–17 year olds identified learning needs, compared to 30% and 24% of caregivers of 6–11 year olds and 3–5 year olds respectively. Similarly, a greater proportion of caregivers of the oldest age group had learnt more about the children's social/living skills and peer relationships (34%) compared with only 5% of the youngest age group. The main exception to this trend was the child's physical health, where proportionately fewer caregivers of the older age groups had learnt about this issue than caregivers of younger age groups (e.g., 17% of carers of 12–17 year olds compared with 31% of carers of 9–35 month olds).

Table 4.4: Caregiver reports of information and support received/not received, and learnings about the child, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total[1]	
	n	%	n	%	n	%	n	%	n	%
Information provided to carer										
Confirmation of Placement	492	89.0	236	91.5	285	89.1	91	79.8	1,104	88.7
Child's Court Order	331	60.2	166	63.4	221	69.5	91	75.8	809	64.7
Placement Agreement	250	46.5	116	47.5	146	48.8	54	50.0	566	47.6
Placement Information Sheet	162	31.6	75	32.3	117	38.7	41	39.1	395	34.3
Total	512–553		232–262		299–320		105–120		1,151–1,250	
Other forms of support										
Carer allowance payment	531	93.7	246	93.2	304	92.7	91	92.9	1,172	93.2
Time and advice from study child's caseworker or managers	360	63.9	165	63.0	209	63.5	61	63.5	795	63.6
Access to a carer support group	322	57.1	126	47.9	166	50.8	49	52.1	663	53.1
Contingency money	286	50.6	125	47.2	148	45.1	42	42.9	601	47.9
Time and advice from carer support workers	219	39.3	88	33.9	115	35.2	36	40.0	458	37.1
Other	25	4.4	7	2.7	5	1.5	1	1.0	38	3.0
Total	558–567		260–265		327–329		90–97		1,235–1,257	

	9–35 months		3–5 years		6–11 years		12–17 years		Total[1]	
	n	%	n	%	n	%	n	%	n	%
Support they would have liked but did not get										
Carer allowance payment	23	4.1	15	5.7	19	5.8	5	5.2	62	4.9
Time and advice from study child's caseworker or managers	139	24.5	74	28.1	82	25.1	21	21.7	316	25.2
Access to a carer support group	72	12.7	45	17.1	41	12.5	7	7.2	165	13.2
Contingency money	140	24.7	85	32.3	115	35.2	30	30.9	370	29.5
Time and advice from carer support workers	63	11.1	40	15.2	39	11.9	8	8.3	150	12.0
Other	109	19.2	46	17.4	67	20.5	16	16.5	238	19.0
At least one of supports listed	302	53.3	163	61.7	207	63.3	54	55.7	726	57.9
Total	567		263–265		327–329		97		1,254–1,255	
Learnt about child since placement										
Emotional and behavioural issues	85	15.0	97	36.6	140	42.6	49	39.5	371	28.9
Physical health issues e.g., allergies, asthma	173	30.6	78	29.4	67	20.4	21	16.9	339	26.4
Learning needs	53	9.4	64	24.2	97	29.5	44	35.5	258	20.1
Social/living skills and peer relationships	30	5.3	57	21.5	93	28.3	42	33.9	222	17.3
Personal identity	18	3.2	16	6.1	27	8.2	16	13.1	77	6.0
Cultural identity and background	20	4.5	14	5.3	17	5.2	9	7.3	60	5.2
Legal issues	58	10.3	21	7.9	14	4.3	10	8.1	103	8.0
Other	18	3.2	11	4.2	7	2.1	6	4.8	42	3.3
Total	442–566		263–265		329		123–124		1,158–1,284	

[1] Column percentages do not add up to 100%, as more than one type of information, support or learning may have been applicable.

Among caregivers who were provided with information at the commencement of the placement, between 34% and 61% reported receiving an explanation of the various types of information from their caseworkers or relevant professionals (Table 4.5). According to caregiver reports, explanations had more frequently been provided for the family contact plan (61%), the child's Lifestory Book (58%), and the child's case plan (55%), but less frequently for the cultural care plan (34%). The proportion of caregivers who thought the case plan met their child's needs 'very well' or 'fairly well' was 87% (see Chapter 8, Figure 8.1).

Table 4.5: Caregiver reports of whether caseworker or relevant professional has explained the information provided

	Yes		No		Total	
	n	%	n	%	n	%
Case plan	633	54.7	524	45.3	1,157	100.0
Health plan	578	50.0	577	50.0	1,155	100.0
Family contact plan	715	60.6	465	39.4	1,180	100.0
Lifestory Book	700	57.8	512	42.2	1,212	100.0
Cultural care plan (if child is Aboriginal)	136	33.6	269	66.4	405	100.0

Children aged 12–17 years were also asked whether they had been involved in developing their case plan, and whether they had been given a copy of the plan (not tabulated). Of the sub-sample who answered these questions (n=53, 43% of all 12–17 year olds), 55% reported being involved in developing their plan, and 28% had been given a copy.

Finally, across all caregivers, 74% were very satisfied or satisfied with being given enough information about the study child at the start of the placement (Table 4.6). There was a small variation (71–78%) between caregivers of children of different age groups.

Table 4.6: Caregiver reports of satisfaction with having enough information about the child at the start of the placement, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Very satisfied	203	35.8	101	38.1	133	40.4	48	38.7	485	37.7
Satisfied	210	37.0	88	33.2	114	34.7	49	39.5	461	35.9
Unsure	42	7.4	14	5.3	16	4.9	9	7.3	81	6.3
Dissatisfied	87	15.3	43	16.2	50	15.2	11	8.9	191	14.9
Very dissatisfied	25	4.4	19	7.2	16	4.9	7	5.6	67	5.2
Total	567	100.0	265	100.0	329	100.0	124	100.0	1,285	100.0

4.3 Promoting the child's identity and connection with their culture

As Table 4.7 shows, the great majority (85%) of children possessed photographs of their birth family and, for close to half (46%), a Lifestory Book had been created or updated. In terms of actions taken for Aboriginal children and children from culturally diverse backgrounds, the continued use of the child's birth name was most frequent, with this occurring for 89% of children. Other commonly reported actions to maintain the child's identity were use of the child's birth language (53%), the child's cultural identity and heritage being discussed, and consumption of food appropriate to the child's culture and religion (both 44%). Approximately one third of children had been given the opportunity to socialise with their birth family's cultural community or attend cultural or religious festivals/events. Only 7% of caregivers reported that none of these actions were undertaken to connect the child with their cultural background.

The likelihood of children having photographs of their birth family tended to correspond to the child's age, with older children more likely to have photographs. It appears that a Lifestory Book had been created or updated more often for younger than for older children (48% of 9–35 month olds and 49% of 3–5 year olds, compared with 45% of 6–11 year olds and 38% of 12–17 year olds).

A higher percentage of caregivers of children aged 3 years or older had discussed with the child their cultural identity and heritage than caregivers of 9–35 month olds, which seems age appropriate. According to caregiver reports, proportionately fewer 12–17 year olds socialised with their birth family's cultural community, or attended key cultural and religious festivals and celebrations compared with other age groups, although this may be a function of the small sample of 12–17 year olds. Practice of the birth family's religion occurred more frequently among children aged 6–11 years than other age groups. A higher percentage of 6–11 year olds (28%) and 12–17 year olds (23%) were being helped to maintain an understanding of their religion compared with younger children aged 9 months to 5 years (14–16%). Overall, it seemed that the cultural connections of children aged 6–11 years were more frequently being maintained than those of other age groups.

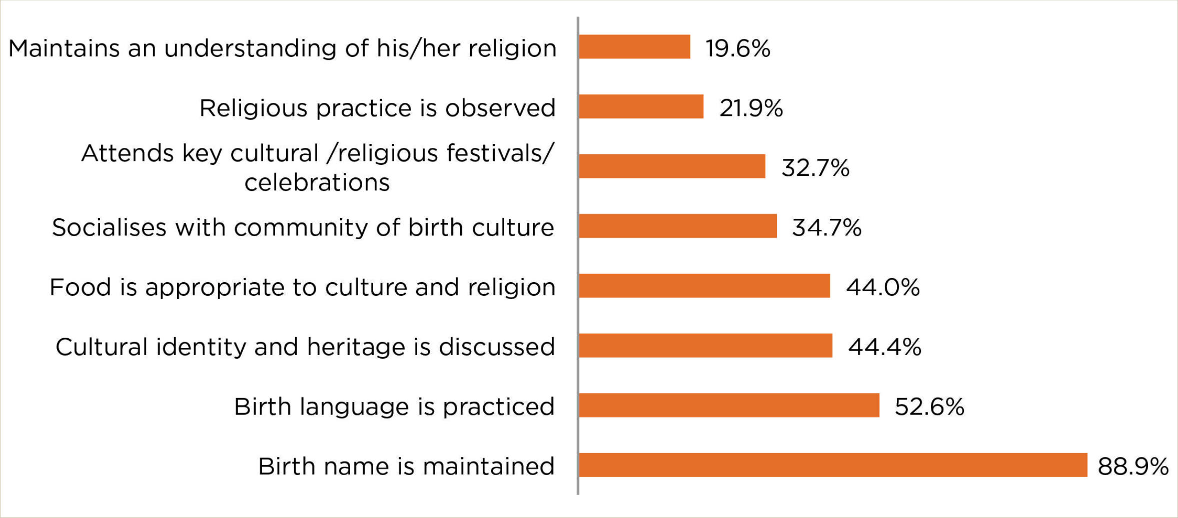
Table 4.7: Caregiver reports of maintenance of the child's cultural background, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		Total[2]	
	n	%	n	%	n	%	n	%	n	%
Since child placed										
Child has photos of birth family	451	79.5	231	87.2	294	89.4	111	91.0	1,087	84.7
Total	567		265		329		122		1,283	
Lifestory Book created/ updated	272	48.3	128	48.5	147	44.8	45	37.5	592	46.4
Total	563		264		328		120		1,275	
Actions taken										
Birth name is maintained	254	86.4	139	89.1	194	91.1	76	91.6	663	88.9
Birth language is practised	152	51.7	83	53.2	110	51.6	47	56.6	392	52.6
Cultural identity and heritage is discussed	109	37.1	70	44.9	118	55.4	34	41.0	331	44.4
Food is appropriate to culture and religion	129	43.9	62	39.7	97	45.5	40	48.2	328	44.0
Socialises with community of birth culture	112	38.1	47	30.1	78	36.6	22	26.5	259	34.7
Attends key cultural and religious festivals and celebrations	94	32.0	52	33.3	78	36.6	20	24.1	244	32.7
Religious practice is observed	50	17.0	32	20.5	66	31.0	15	18.1	163	21.9
Maintains an understanding of his/ her religion	47	16.0	21	13.5	59	27.7	19	22.9	146	19.6
No connection to his/ her cultural background	23	7.7	11	7.1	13	6.1	4	4.8	51	6.8
Total	294		156		213		83		746	

1 All caregivers were asked about presence of photos and a Lifestory Book; only caregivers of Aboriginal children and culturally diverse children were asked about actions taken to maintain the child's cultural background.

2 Column percentages do not add up to 100%, as more than one type of action may have been taken.

Figure 4.2: Caregiver reports of actions taken to maintain the child's cultural background since the child was placed[1]



1 Percentages do not add up to 100%, as more than one type of action may have been taken.

Differences between Aboriginal children and children from culturally diverse backgrounds are shown in Table 4.8. Similarly high percentages of children in these two placement types had photographs of their birth families (as did 85% of all other Australian children; not shown in Table 4.8). Fewer children from culturally diverse backgrounds had had a Lifestory Book created and updated for them (41%, compared with 50% of Aboriginal children and 46% of other Australian children).

In terms of actions taken by carers to maintain children's cultural connections, there was a consistent trend for this to have been undertaken more often for children from culturally diverse backgrounds than for Aboriginal children, with differences particularly evident on observing the child's religious practice (63% compared with 13%) and maintaining the child's understanding of his/her religion (55% compared with 13%), opportunities to socialise with the child's birth family community (59% compared with 39%), and preparation of food appropriate to the child's culture or religion (69% compared to 42%). However, slightly fewer Aboriginal children reportedly had no connection to their cultural background (5%) than children from culturally diverse backgrounds (9%).

Table 4.8: Caregiver reports of maintenance of the child's cultural background, by child's cultural background[1]

	Aboriginal children[2]		Culturally diverse children[2]	
	n	%	n	%
Since child placed				
Child has photos of birth family	390	83.2	92	82.9
Total	469		111	
Lifestory Book created/updated	234	50.3	45	40.5
Total	465		111	
Actions taken				
Birth name is maintained	387	90.6	87	88.8
Birth language is practised	223	52.2	59	60.2
Cultural identity and heritage is discussed	223	52.2	68	69.4
Food is appropriate to culture and religion	178	41.7	68	69.4
Socialises with community of birth culture	167	39.1	58	59.2
Attends key cultural and religious festivals and celebrations	165	38.6	50	51.0
Maintains an understanding of his/her religion	57	13.4	54	55.1
Religious practice is observed	55	12.9	62	63.3
No connection to his/her cultural background	20	4.7	9	9.2
Total	427		98	

1 All caregivers were asked about presence of photos and Lifestory Books; only carers of Aboriginal and culturally diverse children were asked about actions taken to maintain the child's cultural background.
2 Column percentages do not add up to 100%, as more than one type of action may have been undertaken.

Table 4.9 shows that caregivers responded quite positively regarding their ability to support children in maintaining their cultural links, with 69% perceiving that they did this 'very well' and 25% reporting 'fairly well'.

According to caregivers, slightly more than one third of 5 to 17 year old children 'very much' identified with their birth family's cultural background, and a further 26% identified 'a fair amount'. In general, higher proportions of older children identified strongly with their cultural background when compared to younger children. Nevertheless, 21% of all caregivers indicated that the child 'did not at all' identify with their birth family's cultural background.

Approximately 60% of caregivers of children with an Aboriginal cultural plan in place reported receiving support from other family members in keeping up the child's cultural links and carrying out the cultural plan (these questions are not applicable for non-Aboriginal children). The next most frequent sources of help were the child's community, and an Aboriginal or multicultural worker or organisation (both 25%). In approximately one fifth of cases, birth family members had helped. However, 13% of caregivers reported that they had no sources of help in maintaining cultural ties and implementing the cultural plan. There appeared to be some age-specific differences (although sample sizes became quite small for some age groups, and hence findings may be of low reliability), but there was no clear pattern of age differences.

Table 4.9: Caregiver reports of support for the child's cultural ties, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
How well caregiver can support child to maintain cultural links[1]										
Very well	222	72.1	101	71.1	123	65.4	44	63.9	490	69.2
Fairly well	72	23.4	32	22.5	49	26.1	24	34.3	177	25.0
Not very well	10	3.3	7	4.9	14	7.5	2	2.9	33	4.7
Not at all well	4	1.3	2	1.4	2	1.1	0	0.0	8	1.1
Total	308		142		188		70		708	
Extent to which child identifies with birth family's cultural background[2]										
Very much	-	-	10	25.0	78	39.4	26	35.1	114	36.5
A fair amount	-	-	9	22.5	48	24.2	25	33.8	82	26.3
Not very much	-	-	6	15.0	31	15.7	13	17.6	50	16.0
Not at all	-	-	15	37.5	41	20.7	10	13.5	66	21.2
Total			40		198		74		312	
Others helping child to link to culture and carry out cultural plan[3,4,5]										
Caregiver's family members helping	40	66.2	10	45.5	20	51.3	5	-	75	58.6
Child's community helping	15	25.0	4	18.2	12	30.8	3	-	33	25.2
Aboriginal or multicultural worker or organisation	19	30.2	4	18.2	9	23.1	1	-	32	25.0
Child's birth family members helping	13	21.7	5	22.7	8	20.5	2	-	28	21.9
Someone else	1	0.2	1	4.5	2	5.1	0	-	4	3.0
No-one else	6	10.0	7	31.8	3	7.7	0	-	16	12.5
Total	60–65		22		39		7		128–133	

1 This question was asked of all caregivers of Aboriginal children and culturally diverse children.
2 This question was asked of all caregivers of 5–17 year old Aboriginal children and culturally diverse children.
3 These items were asked of caregivers of Aboriginal children for whom a cultural plan was in place.
4 Column percentages do not add up to 100%, as help may have been received from more than one source.
5 Percentages are not reported for the 12–17 year age group, as n is small (<20).

Table 4.10 shows that a higher percentage of caregivers of children from culturally diverse backgrounds felt that they were 'very well' able to support the child to maintain cultural links (74%, compared with 64% of caregivers of Aboriginal children). Similar patterns were evident in relation to the child's identification with their birth family's culture, with a higher percentage of those from culturally diverse backgrounds being reported to 'very much' identify with their culture (48% compared with 35% of Aboriginal children).

Table 4.10: Caregiver reports of support for the child's cultural ties, by child's cultural background

	Aboriginal children		Culturally diverse children	
	n	%	n	%
How well caregiver can support child to maintain cultural links[1]				
Very well	280	63.9	74	74.0
Fairly well	124	28.3	21	21.0
Not very well	27	6.2	5	5.0
Not at all well	7	1.6	0	0.0
Total	**438**		**100**	
Extent to which child identifies with birth family's cultural background[2]				
Very much	63	34.8	25	48.1
A fair amount	43	23.8	13	25.0
Not very much	31	17.1	10	19.2
Not at all	44	24.3	4	7.7
Total	**181**		**52**	

1 This question was asked of all caregivers of Aboriginal children and culturally diverse children.
2 This question was asked of all caregivers of 5–17 year old Aboriginal and culturally diverse children.

As shown in Table 4.11, a high proportion of relative/kinship carers and foster carers felt they were able to support the child in maintaining cultural links 'very well' (75% and 64% respectively). There appeared to be differences between foster and relative/kinship caregivers' reports in regard to how much children identified with their birth family's cultural background, with 50% of foster carers reporting that children identified 'not very much' or 'not at all' compared with 24% of children in relative/kinship care.

Turning to differences on how much support caregivers received from others in maintaining the child's identity and carrying out the Aboriginal cultural plan, foster and relative/kinship carers received similar amounts of support from the two most common sources – the caregiver's family members and an Aboriginal or multicultural worker or organisation. However, 33% of relative/kinship carers reportedly had support from the child's community, compared with 21% of foster caregivers; and birth family members were also more frequently involved when children were in relative/kinship care (28% compared with 16% of those in foster care). On the other hand, relative/kinship carers also more often reported not receiving help (18% compared with 8% of foster caregivers).

Table 4.11: Caregiver reports of support for the child's cultural ties, by placement type

	Foster care[1]		Relative/ Kinship care[1]	
	n	%	n	%
How well caregiver can support child to maintain cultural links[1]				
Very well	228	64.2	255	74.6
Fairly well	97	27.3	77	22.5
Not very well	26	7.3	6	1.8
Not at all well	4	1.1	4	1.2
Total	**355**		**342**	
Extent to which child identifies with birth family's cultural background[2]				
Very much	48	33.8	64	41.0
A fair amount	23	16.2	54	34.6
Not very much	27	19.0	20	12.8
Not at all	44	31.0	18	11.5
Total	**142**		**156**	
Others helping child to link to culture and carry out cultural plan[3, 4]				
Caregiver's family members helping	40	59.7	35	57.4
Aboriginal or multicultural worker or organisation	19	28.4	14	28.4
Child's birth family members helping	11	16.4	17	27.9
Child's community helping	14	20.9	20	32.8
Someone else	4	5.8	0	0.0
No-one else	5	7.5	11	18.0
Total	**67–69**		**61–64**	

1 This question was asked of all caregivers of Aboriginal children and culturally diverse children.
2 This question was asked of all caregivers of 5–17 year old Aboriginal children and culturally diverse children.
3 These items were asked of caregivers of Aboriginal children for whom a cultural plan was in place.
4 Column percentages do not add up to 100%, as help may have been received from more than one source.

4.4 How well the child settled into the current placement

How well children settle into the placement can be a critical influence on their long-term outcomes and personal wellbeing (Chamberlain et al, 2006). Table 4.12 shows that the majority of caregivers thought that the child had settled in less than a week; either taking a day or two (44%) or 3–6 days (10%). Some children took about one week (9%), and around a third (37%) took longer than this to settle. While most children tended to settle quickly, settling time increased as children's age increased (i.e., more children aged 6 to 17 years took one or more months to settle compared with younger children, who typically settled within one to two weeks). A very small percentage of children were still not settled at the time of the Wave 1 interview (3%), and this was a little more common among older than among younger children (6–8% of 6–11 and 12–17 year olds compared to 1–2% of 9–35 month and 3–5 year olds).

Overall, when caregivers were asked to reflect on how well the child was currently settled, a very positive picture emerged, with 84% of caregivers reporting 'very well' and a further 14% of caregivers reporting 'fairly well'. A very small proportion of caregivers (<1%) reported the child was 'not at all well' settled. Slightly fewer caregivers of older children reported that the child was settled 'very well' or 'fairly well' than caregivers of younger children. For example, 62% of 12–17 year olds were 'very well' settled compared with 96% of 9–35 month olds.

Table 4.12: Caregiver reports of the child settling into the current household, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Time to settle into household										
0–2 days	311	55.0	100	37.9	110	33.5	37	30.3	558	43.6
3–6 days	57	10.1	30	11.4	32	9.8	12	9.8	131	10.2
1 week	49	8.7	26	9.8	35	10.7	9	7.4	119	9.3
2 weeks	53	9.4	21	8.0	25	7.6	9	7.4	108	8.4
3–4 weeks	42	7.4	31	11.7	36	11.0	13	10.7	122	9.5
5–8 weeks	25	4.4	13	4.9	20	6.1	13	10.7	71	5.6
9–12 weeks	14	2.5	13	4.9	10	3.0	8	6.6	45	3.5
13–26 weeks	7	1.2	13	4.9	23	7.0	8	6.6	51	4.0
27–52 weeks	2	0.4	11	4.2	17	5.2	3	2.5	33	2.6
Still not settled	5	0.9	6	2.3	20	6.1	10	8.2	41	3.2
Total	565		264		328		122		1,279	
How settled the child is now										
Very well	544	95.9	219	82.6	239	72.6	77	62.1	1,079	84.0
Fairly well	18	3.2	40	15.1	79	24.0	38	30.7	175	13.6
Not very well	4	0.7	4	1.5	8	2.4	7	5.7	23	1.8
Not at all well	1	0.2	2	0.8	3	0.9	2	1.6	8	0.6
Total	567		265		329		124		1,285	

4.5 Summary of key findings

Setting up the child's current placement

- It appears that most children had been placed with the expectation that the placement would be until the child turned 18 years (67%).
- Contact with the caregiving family prior to placement was common. Two thirds of children had some form of contact, most commonly more than one overnight stay, or more than a one-day visit.
- Very young children aged 9–35 months had less frequently experienced overnight visits before the placement commenced than older children.
- Slightly more than half of the POCLS children had been placed with a family with whom they were not related. When placed with relatives, the most common arrangement was grandparent care.
- Older children aged 6–17 years tended to more often be placed with caregivers with whom they were related than younger children aged 9 months to 5 years.
- Most caregivers reported making some changes to their household in preparation for the child's arrival. The most common types of changes were a modification to the caregiver's routine, the purchase of equipment or furniture and rearrangement of bedrooms.
- The types and frequency of changes reported to be needed were similar for caregivers of children aged 9 months to 11 years, but fewer caregivers of 12–17 year olds had needed to make changes to accommodate the child.

Information and support at the start of the placement

- Almost nine tenths of carers had received Confirmation of the Placement, and almost two thirds had received the child's Court Order.
- Among caregivers who reported receiving information since the start of the placement, between 34% and 61% had received an explanation of the various types of information from their caseworkers or other professionals.
- Among children aged 12–17 years who responded to questions on this issue, just over half reported that they had been involved in developing their case plan and just over a quarter had been given a copy.
- The most common issues learnt by caregivers about the child that they had not been made aware of at the start of the placement were the child's emotional and behavioural issues, physical health issues and learning needs.
- The majority of caregivers were satisfied with the information received.

Promoting the child’s identity and connection with their culture

- More than four fifths of children maintained connections to their birth family through their possession of photos, while nine tenths had retained their birth name.
- Older children more often had photographs of their birth family than younger children.
- Common actions undertaken by caregivers to help Aboriginal children and those from culturally diverse backgrounds maintain their cultural connections were: use of the child’s birth language, the child’s cultural identity and heritage being discussed, and consumption of food appropriate to the child’s culture and religion.
- Most caregivers had positive views about their ability to support the child to maintain his/her cultural ties.
- Over half (59%) of caregivers of Aboriginal children reported that children identified with their birth family’s culture ‘very much’ or ‘a fair amount’.
- Caregivers generally reported receiving high levels of support from others in helping children to maintain cultural links, with support most often coming from the caregiver’s family members, the child’s community, and from an Aboriginal or multicultural worker or organisation.

How the child settled into their current placement

- Approximately half of caregivers reported that the child had settled into the placement in less than a week, with a further tenth reportedly taking a week.
- Settling time tended to be longer among older than among younger age groups.

4.6 Conclusion

The majority of the POCLS children had been living with the current caregiver household for more than a year at the time the Wave 1 interview was conducted. Approximately two thirds of the children were placed with the expectation that the placement would be a long-term arrangement until the child turned 18 years. Contact with the caregiving family prior to placement was quite common. Most caregivers had needed to make some changes to their household in preparation for the child’s placement. At the time of the Wave 1 interview, just over half of the POCLS children were living with caregivers with whom they were not related. Many children identified with their cultural background, and most caregivers reported receiving support from others in helping children maintain these links. Most children had settled quickly when placed with the caregiver household and were very well settled at the time the Wave 1 interview was conducted.

5

Wellbeing of children and young people

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This chapter examines children's wellbeing as measured at the first wave of data collection for the Pathways of Care Longitudinal Study (POCLS), which took place, on average, 17 months after the first entry into out-of-home care (OOHC). The developmental domains of interest are the children's physical health, social-emotional wellbeing and cognitive/learning ability. The chapter provides information relevant to the study's second Key Research Question: '*What is the physical health, socio-emotional wellbeing and cognitive/learning ability of the children entering OOHC compared with other children in the community?*'[1] Appendix 5 includes details of the measures used to describe child wellbeing in this chapter.

5.1 Children's physical health

Children's physical health is connected to a variety of outcomes in adulthood (Currie, Stabile, Manivong & Roos, 2010), and also affects their current functioning in other major life domains; for example, socio-emotional wellbeing and learning progress (e.g., Behrman, 1996).

Being overweight or obese in childhood is recognised as a major health concern worldwide, with the prevalence of childhood obesity in Australia having doubled since 1985 (Booth et al, 2001). It is a risk for numerous health problems including Type II diabetes and cardiovascular disease (Decklebaum & Williams, 2001). It can also adversely affect social-emotional wellbeing (Loth, Mond, Wall & Neumark-Sztainer, 2011).

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[1] Please see Chapter 2 for a description of the data analysis undertaken in this report.

The type and amount of children's nutritional intake influences multiple aspects of health, including growth, obesity, glucose metabolism, iron and other stores, and bone and heart health (Wake, Hardy, Canterford, Sawyer & Carlin, 2007). Poor sleep impacts on daytime functioning, and can impede children's academic progress and social adjustment (Quach, Hiscock, Canterford & Wake, 2009; Scharf, Demmer, Silver & Stein, 2013). Poor sleep can also be a symptom of depression (American Psychiatric Association, 2013). The presence of diagnosed health conditions in children may place additional demands on caregivers and their families (Murphy, Christian, Caplan & Young, 2006), which may make the long-term placement of children with such conditions more difficult. Children with diagnosed health conditions need timely and appropriate services which may improve their outcomes and reduce the burden on caregivers.

These aspects of children's physical development and health are measured by caregiver reports in the POCLS. Information on the services provided to address children's health needs, and the degree to which these needs are being adequately addressed, is presented in Chapter 8.

Information about children's health

Table 5.1 shows that almost all caregivers had received the Medicare card or number (96%) for the child placed in their care, and four fifths had received the child's immunisation records. Immunisation records were more commonly received by caregivers of younger than older age groups (94% of 9–35 month olds and 86% of 3–5 year olds compared with 63% of 6–11 year olds and 50% of 12–17 year olds). 'Blue Books' (the child's personal health record) were received by caregivers of 60% of children overall, and 90% of children aged 9–35 months. Caregivers had received details of health assessments for close to two thirds of children. Around 30% of caregivers had received some details of the birth family's medical history, while a small number (8%) had received other kinds of health information.

Table 5.1: Caregiver reports of receiving child health information, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Medicare card or number	540	95.2	258	97.4	319	97.0	119	96.0	1,236	96.2
Immunisation record	529	93.5	228	86.0	204	62.6	61	50.4	1,022	80.0
Blue Book	508	89.8	147	55.5	99	30.2	17	14.2	771	60.3
Health assessment	366	66.8	169	64.3	187	57.7	70	57.9	792	63.1
Family medical history	174	31.3	70	26.6	86	26.5	30	24	360	28.7
Other	52	9.2	26	9.8	9	2.7	9	7.3	96	7.5
Total	**548–567**		**263–265**		**324–329**		**120–124**		**1,255–1,285**	

1 Column percentages do not add up to 100%, as multiple types of information may have been received.

Children’s general physical health

Caregiver perceptions of children’s general physical health during the past four weeks are shown in Table 5.2. Although not as accurate as a professional medical assessment, many research studies have used respondent ratings to assess health status and these have been shown to be predictive of mortality and functional ability (Saloman, Nordhagen, Oza & Murray, 2009).

Close to 90% of children aged 0 to 11 years were reported to be in ‘excellent’ or ‘very good’ health. However, health levels tended to be lower among 12–17 year olds in the POCLS, with 70% reported by caregivers as being in ‘excellent’ or ‘very good’ health, 22% in ‘good’ health, and 8% in ‘fair’, ‘poor’ or ‘very poor’ health.

Table 5.2: Caregiver ratings of child’s general physical health, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Excellent	337	59.4	147	55.5	170	51.7	43	34.7	697	54.2
Very good	171	30.2	95	35.9	123	37.4	44	35.5	433	33.7
Good	45	7.9	22	8.3	33	10.0	27	21.8	127	9.9
Fair	10	1.8	1	0.4	2	0.6	4	3.2	17	1.3
Poor	3	0.5	0	0	1	0.3	5	4.0	9	0.7
Very poor	1	0.2	0	0	0	0	1	0.8	2	0.2
Total	567		265		329		124		1,285	

Ratings by children aged 12–17 years about their health in the past four weeks are shown in Table 5.3 and reveal that around 60% felt they were in ‘excellent’ or ‘very good’ health, but 13% thought their health was only ‘fair’ or ‘poor’. This compares with 70% and 8% of caregiver ratings respectively. (However, the groups are not identical, with 94 children and 124 caregivers providing ratings of the young person’s health.)

The two older groups of children were also asked whether they had engaged in physical activity on a daily basis during the previous six months. The great majority had done so – 96% of 7–11 year olds[2] and 88% of 12–17 year olds.

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[2] As interviews were offered to children aged 7 years and older, the age range for this item is 7–11 years rather than the 6–11 years age band used elsewhere.

Table 5.3: Children aged 12–17 years ratings of their physical health compared with caregiver ratings

	Child report		Caregiver report	
	n	%	n	%
Excellent	38	40.4	43	34.7
Very good	20	21.3	44	35.5
Good	24	25.6	27	21.8
Fair	11	11.7	4	3.2
Poor/ Very poor	1	1.1	6	4.8
Total	94		124	

Health conditions

Caregivers were asked a series of questions about whether the child or young person had particular health conditions or a developmental delay (shown in Table 5.4). Asthma was the most common condition reported (11% overall), followed by problems with eyesight (10%). Other types of conditions with a prevalence of more than 5% were teeth problems/problems with oral hygiene, hearing problems, and emotional/psychological/nervous problems. Overall, 20 differing types of health conditions were reported. Some conditions were more common at older ages (eyesight problems, teeth problems/problems with oral hygiene, emotional/psychological/nervous difficulties) while others were more common at younger ages (hearing problems, food or digestive allergies, bronchitis).

Comparing these data to the 2007/08 Australian Bureau of Statistics National Health Survey (NHS; ABS, 2009) shows that the POCLS findings are reasonably similar to population trends in terms of the types and prevalence of the most common long-term conditions[3].

Cognitive/language developmental delays were reported among 12% of the POCLS children, most frequently at 3–5 years of age (18%). Emotional/social/behavioural developmental delays were present in 10% of children, with higher rates in the two older age brackets (15% at 6–11 years and 17% at 12–17 years). Physical developmental delays were reported for 5% of children, most commonly at 9–35 months. Comparative data from the 2007/08 NHS[4] show that, while the data items are not identical, rates of psycho-social disabilities were considerably higher among the POCLS children than in the general population.

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[3] The 2007/08 Australian Bureau of Statistics National Health Survey (ABS, 2009) found that asthma was the most frequent long-term condition among children aged 1 to 14 years, with a prevalence of 10%. The next most common conditions were eyesight problems (8%), hay fever and allergic rhinitis (7%) and undefined allergies (5%). It should be noted that the ABS data is based on a smaller age range than the POCLS data.

[4] The 2007/08 Australian Bureau of Statistics National Health Survey (ABS, 2009) found that just over 2% of 1 to 14 year old Australian children had behavioural and emotional problems, while fewer than 2% had psychological development problems. It should be noted that the ABS data is based on a smaller age range than the POCLS data.

Table 5.4: Caregiver reports of children's health conditions and developmental delays, by child age[1]

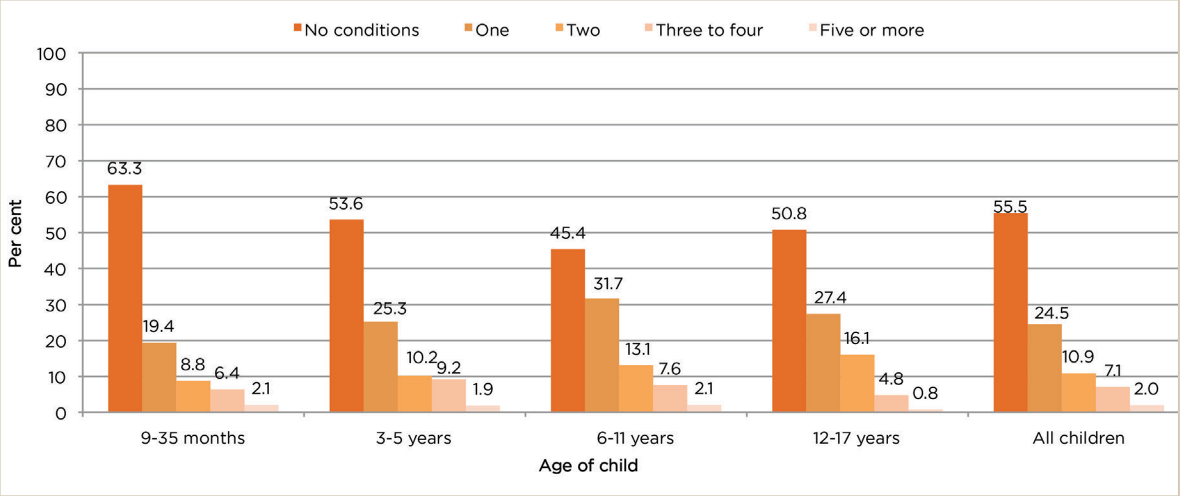
	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Asthma	71	12.5	27	10.2	32	9.7	16	12.9	146	11.4
Problems with eyesight	24	4.2	26	9.8	60	18.2	21	16.9	131	10.2
Problems with teeth/oral hygiene	10	1.8	32	12.1	50	15.2	19	15.3	111	8.6
Problems with hearing	41	7.2	13	4.9	18	5.5	0	0	72	5.6
Emotional, psychological, nervous difficulties	7	1.2	19	7.2	22	6.7	21	16.9	69	5.4
Food or digestive allergies	34	6.0	8	3.0	4	1.2	1	0.8	47	3.7
Other allergies	20	3.5	12	4.5	10	3.0	1	0.8	43	3.3
Heart condition or disease	19	3.4	9	3.4	7	2.1	0	0	35	2.7
Bronchitis	28	4.9	1	0.4	2	0.6	1	0.8	32	2.5
Respiratory allergies e.g., hay fever	14	2.5	4	1.5	6	1.8	2	1.6	26	2.0
Foetal alcohol spectrum disorder	10	1.8	3	1.1	6	1.8	0	0	19	1.5
Cerebral palsy	6	1.1	1	0.4	2	0.6	0	0	9	0.7
Epilepsy	1	0.2	2	0.8	5	1.5	1	0.8	9	0.7
Blood disorder	2	0.4	1	0.4	3	0.9	2	1.6	8	0.6
Kidney condition or disease	4	0.7	1	0.4	3	0.9	0	0	8	0.6
Diabetes	0	0	2	0.8	0	0	0	0	2	0.2
Any other long-term condition	59	10.4	31	11.7	52	15.8	13	10.5	155	12.1
Developmental delay – cognitive/language	49	8.6	48	18.1	40	12.2	14	11.3	151	11.8
Developmental delay – emotional/social/behavioural	22	3.9	32	12.1	50	15.2	21	16.9	125	9.7
Developmental delay – physical	44	7.8	9	3.4	14	4.3	0	0	67	5.2
None of the above	359	63.3	142	53.6	149	45.4	63	50.8	713	55.5
Total	**567**		**265**		**328–329**		**124**		**1,284**	

[1] Column percentages do not add up to 100%, as children may have had multiple health conditions and/or developmental delays.

Approximately 44% of the POCLS children had at least one long-term medical condition or a developmental delay of some type: 25% had one diagnosed health problem, 11% had two health problems, 7% had three or four such problems while 2% had five or more differing health problems (Figure 5.1). This is higher than the Australian child population[5].

There appeared to be age differences, with greater proportions of the youngest POCLS children being free of health problems (63% of 9–35 month olds and 54% of 3–5 year olds) by comparison with older children (45% of 6–11 year olds and 51% of 12–17 year olds).

Figure 5.1: Caregiver reports of the number of health conditions, by child age



Injuries requiring medical attention

Caregivers were asked whether the child had sustained an injury requiring medical attention since coming to live with them (Table 5.5). This had occurred for 15% of children overall, with rates relatively constant from 0 to 11 years (range of 12–16%), but more than doubling among 12–17 year olds (31%). The most common type of injury was cuts, scrapes or bruises (7%), with other types of injuries occurring among less than 3% of the sample overall. Among 12–17 year olds, the most common injuries were cuts, scrapes or bruises (11%), broken or fractured bones (11%) and sprains or strains (8%).

It appeared that children in foster and relative/kinship care had very similar types and rates of injuries; however, those in residential care had higher overall rates of injuries requiring medical attention: cuts, scrapes, bruises, and broken/fractured bones.

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[5] The 2007/08 Australian Bureau of Statistics National Health Survey (ABS, 2009) found that 37% of the general population of children had a long-term condition. It should be noted that the ABS data is based on a smaller age range than the POCLS data.

Table 5.5: Caregiver reports of child injuries requiring medical attention, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Cut, scrape or bruise	33	5.8	26	9.8	17	5.2	13	10.5	89	6.9
Broken or fractured bones	4	0.7	8	3.0	6	1.8	13	10.5	31	2.4
Dental injury	4	0.7	3	1.1	7	2.1	3	2.4	17	1.3
Sprain or strain	2	0.4	1	0.4	4	1.2	10	8.1	17	1.3
Burn or scald	3	0.5	1	0.4	4	1.2	4	3.2	12	0.9
Dislocation	2	0.4	0	0.0	0	0.0	2	1.6	4	0.3
Poisoning by substance or liquid	0	0.0	1	0.4	0	0.0	1	0.8	2	0.2
Internal injury	0	0.0	1	0.4	0	0.0	0	0.0	1	0.1
Multiple injuries	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Other	19	3.4	5	1.9	9	2.7	1	0.8	34	2.7
No injuries requiring medical attention	501	88.4	222	83.8	283	86.0	85	68.6	1,091	84.9
Total	**567**		**265**		**329**		**124**		**1,285**	

1 Column percentages do not add up to 100%, as children may have had multiple types of injuries.

Children's weight

Caregiver ratings of children's weight[6] were used to obtain an approximate picture of children's weight status. It is recognised that these ratings will not provide a precise measure of weight, but in the absence of actual measurements, they may be used to identify children with weight issues. However, some research suggests that subjective ratings of weight may correlate only moderately with actual BMI status (Campbell, Williams, Hampton & Wake, 2006) and as such this data should be treated with caution.

Most children (85%) were rated as being neither overweight nor underweight, 6% were rated as overweight, and 9% as underweight (Figure 5.2). It appeared that children aged 0 to 5 years were more frequently rated as neither overweight nor underweight (88%), than older children. The percentage seen as neither overweight nor underweight dropped for 6–11 and 12–17 year olds (81% and 72% respectively). If not in this mid-category, those aged less than 5 years tended to be seen as underweight rather than overweight. Among 12–17 year olds in particular, if children were not in the mid-category, they were more often rated as overweight than underweight (20% compared with 7%).

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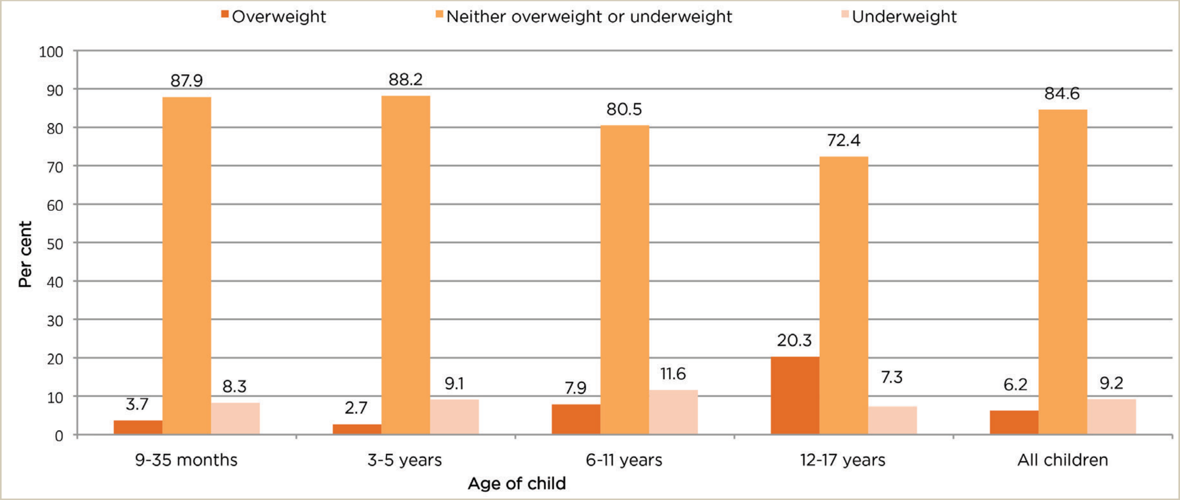
[6] Direct measures of height and weight were not sought from the POCLS children due to possible negative reactions from them as well as from their caregivers. Measurement of weight in particular can be a sensitive issue for some children and may jeopardise retention in subsequent waves.

Figure 5.2: Caregiver perceptions of children's weight, by child age



Children's dietary patterns

Caregivers were asked how many serves of vegetables, fruit, soft drinks/cordial/sports drinks and takeaway foods children consumed daily, weekly or less frequently. This information has been aggregated for this report by using the *Australian Guide to Healthy Eating* (AGHE) recommendations that were current at the time of the Wave 1 data collection[7].

Figure 5.3 shows that almost 60% of 3–5 year olds and 65% of 6–11 year olds consumed the recommended number of daily vegetable serves, according to caregiver reports, but rates were much lower among 12–17 year olds (11%). Only a minority of children did not have any vegetables each day (11–19% across the three age bands).

Figure 5.4 shows that, according to caregivers, more than 90% of 3–5 and 6–11 year olds consumed the recommended number of daily serves of fruit, but the rate fell to approximately one fifth among 12–17 year olds. This may in part be due to the larger number of serves (three) needed to meet the recommended guidelines for 12–17 year olds (a further 56% of the POCLS 12–17 year olds consumed one to two serves of fruit daily).

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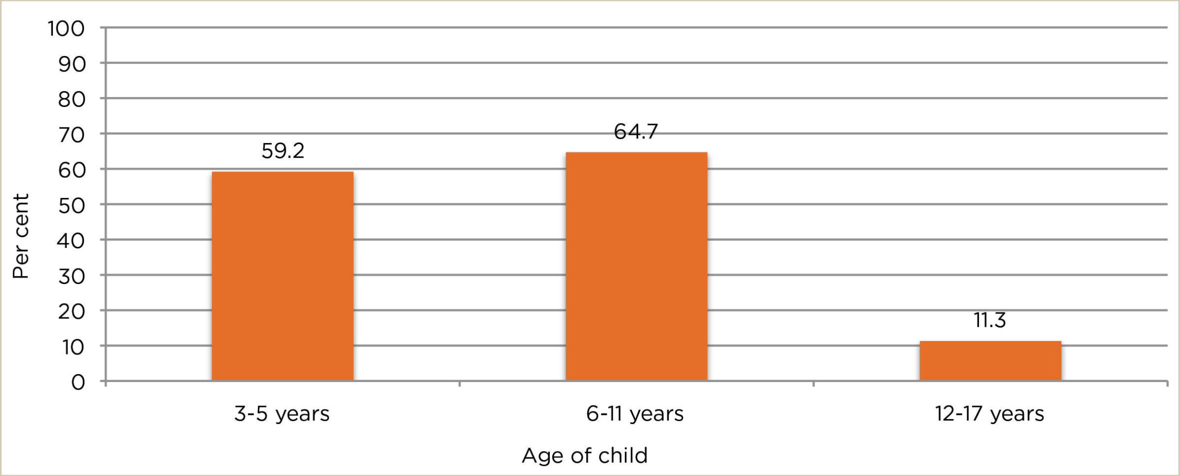
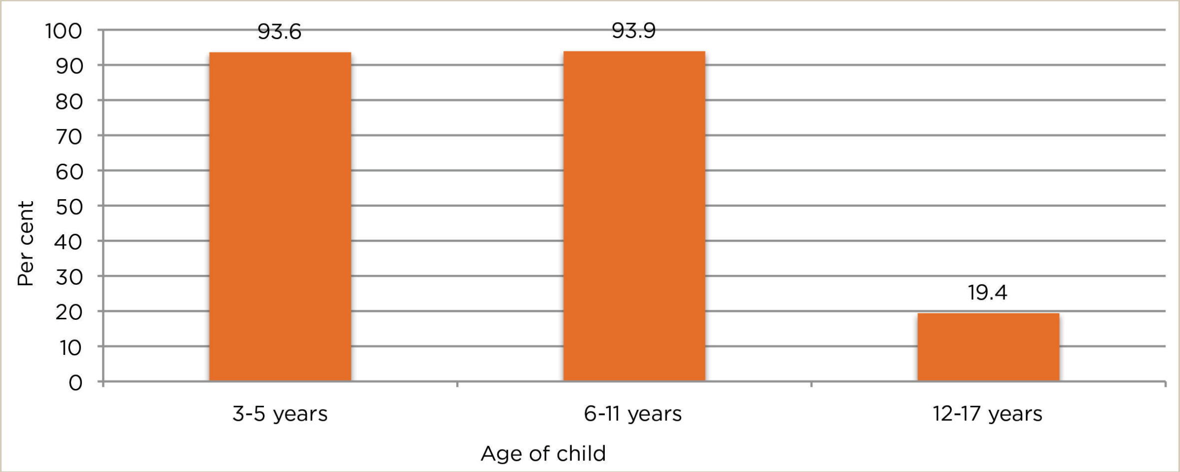
[7] The AGHE recommendations for children of different age groups were as follows: for 3–7 years of age, one serve of fruit and two serves of vegetables daily; at 8–11 years, one serve of fruit and three serves of vegetables daily; and at 12–17 years, three serves of fruit and four serves of vegetables daily. To accommodate the age band of 6–11 years used in this report, the AGHE guidelines were adjusted as they have differing criteria for 6–7 year olds and 8–11 year olds (as described above). Thus, children in this age band were considered to be meeting the AGHE guidelines if they consumed one serve of fruit and two serves of vegetables. The AGHE does not outline recommended intakes for children aged 9–35 months so results are not shown for this age group.

Figure 5.3: Caregiver reports of the percentage of children who consumed the recommended daily number of vegetable serves, by child age[1]



1 n=894, excludes children aged 9–35 months.

Figure 5.4: Caregiver reports of the percentage of children who consumed the recommended daily number of fruit serves, by child age[1]



1 n=894, excludes children aged 9–35 months.

Comparison with the Longitudinal Study of Australian Children (LSAC) shows that, while the age ranges and criteria used are not identical across the studies, the findings are generally very consistent, and indicate that the POCLS children were meeting the healthy eating guidelines at similar rates to other Australian children (although the age groups compared differ somewhat)[8].

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[8] The LSAC is a large representative longitudinal study of Australian children residing in urban and rural areas of all Australian states and territories. The LSAC data on diet are available for children aged 2 to 11 years. As reported by Daraganova and Thornton (2014), almost 50% of the LSAC children were consuming the recommended number of daily serves of vegetables, but rates dropped to 18% of 8–9 year olds and 32% of 10–11 year olds (using the recommended guideline of three daily serves). With regard to the consumption of fruit, nine tenths of 2–7 year old LSAC children met the daily recommendations as did 65% of 8–9 year olds and 55% of 10–11 year olds.

Turning now to consumption of less healthy foods, 24% of the POCLS sample aged 2–17[9] years old was reported by caregivers to drink at least one soft drink or equivalent type of beverage daily (Table 5.6). Rates were much higher among 12–17 year olds (46%), while 2 year olds had the lowest rates of all (13%). The proportion who never drank soft drinks decreased steadily with age, from 75% of 2 year olds to 21% of 12–17 year olds. Having a take-away meal such as a burger, pizza or chips was reported by caregivers to occur at least weekly for 41% of the sample. Again, this was much more common among 12–17 year olds (58%) than younger children (31% of 2 year olds, 35% of 3–5 year olds and 45% of 6–11 year olds). A higher proportion of younger children aged 2 years and 3–5 years had never consumed these types of take-away foods (33% and 23% respectively) than older children aged 6 to 17 years (15–18%).

Table 5.6: Caregiver reports of the types of foods and drinks children consumed, by child age[1]

	2 years		3-5 years		6-11 years		12-17 years		All children[1]	
	n	%	n	%	n	%	n	%	n	%
Cups of soft drink, cordial or sports drink										
1+ per day	22	12.6	50	18.9	86	26.2	55	46.2	213	24.0
3–6 a week	2	1.1	10	3.8	27	8.2	17	14.3	56	6.3
1–2 a week	20	11.4	43	16.2	64	19.5	21	17.6	148	16.7
Doesn't drink soft drink, cordial or sports drink	131	74.9	162	61.1	151	45.9	26	21.0	470	53.0
Total	175		265		328		119		887	
Takeaway food such as burgers, pizza, chips										
3 or more times a week	1	0.6	1	0.4	3	0.9	10	8.3	15	1.7
1–2 times a week	53	30.3	93	34.7	145	44.2	60	49.6	350	39.4
3–4 times a month	3	1.7	2	0.8	3	0.9	1	0.8	9	1.0
1–2 times a month	61	34.9	109	41.1	127	38.7	28	23.1	325	36.6
Rarely or never	57	32.6	61	23.0	50	15.2	22	18.2	190	21.4
Total	175		265		328		121		889	

1 This question was asked for children 2–17 years.

Children's sleep patterns

Information was collected from caregivers on the sleeping patterns and problems in children aged 9–35 months. Sleeping issues in infancy and toddlerhood can have a large impact on children's wellbeing and adjustment and may be an indicator of ongoing trauma or distress (Scharf, Demmer, Silver & Stein, 2013). They may also adversely impact on caregivers and family life. Sleep can also emerge as a significant problem in adolescence and can be a sign of depression. Reports of the sleeping patterns of children aged 12–17 years were collected.

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[9] These questions were asked of caregivers of children aged 2 years and older, not of caregivers of children aged 9 months to 23 months.

According to caregiver reports, almost all 9–35 month old children 'always' or 'usually' went to bed about the same time each night (95%), with fewer than 2% reported as 'rarely' or 'never' doing so (Table 5.7). Almost three quarters of caregivers did not find the child's sleeping pattern a problem for them and a further 20% felt that this was only a small issue. Approximately 10% of caregivers saw the child's sleeping habits as being a 'moderate' or 'large' problem for them.

These rates can be compared to rates found for children participating in the LSAC and show that, while the age ranges differ somewhat, it does not appear that 9–35 month old POCLS children experienced higher rates of sleep problems than children in the general community[10].

Nonetheless, it was quite common for some children to very regularly experience sleeping issues such as waking in the night, sleeping restlessly, or being unhappy about sleeping alone. Approximately one third experienced one or more of these types of sleeping issues on four or more nights a week. Caregivers may feel that sleep issues are to be expected, since as noted previously, very few (10%) perceived the child's sleep pattern to be a moderate or large problem for them.

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[10] A total of 17% of the LSAC Wave 1 infant cohort aged 0–1 years were reported to be experiencing 'Moderate' or 'Severe' sleeping problems (Martin, Hiscock, Hardy, Davey & Wake, 2007). Combining LSAC data over the first two waves, 25% of children aged 0–3 years were reported to have 'Moderate' or 'Severe' sleeping problems in at least one of the two data collection waves (Quach, Gold, Hiscock, Mensah, Lucas, Nicholson & Wake, 2013).

Table 5.7: Caregiver reports of sleep patterns among children aged 9–35 months

	All 9–35 month olds	
	n	%
Goes to bed at the same time each night		
Always	377	66.5
Usually	163	28.7
Sometimes	17	3.0
Rarely	9	1.6
Never	1	0.2
Whether sleeping pattern/habits are a problem for the caregiver		
No problem at all	401	70.7
A small problem	112	19.8
A moderate problem	42	7.4
A large problem	12	2.1
Issues child has on four or more nights per week[1]		
Waking during the night	134	23.6
Restless sleep	70	12.3
Not happy to sleep alone	38	6.7
Difficulty getting off to sleep at night	37	6.5
Seeming tired in the morning	22	3.9
Nightmares, night terrors	18	3.2
None of the above	387	68.3
Total	567	

1 Column percentages do not add up to 100%, as children may have multiple issues.

Slightly more than half of children aged 12–17 years (54%) reported that they felt they got ‘plenty’ of sleep, but almost one quarter (23%) felt they did not get enough sleep (Table 5.8). As poor sleep may impede school progress and psychosocial wellbeing and can be a sign of depression, this trend may be of concern.

Table 5.8: Children aged 12–17 years self report on sleep quantity

	12–17 years old	
	n	%
Plenty	51	54.3
Just enough	21	22.3
Not quite enough	13	13.8
Not nearly enough	9	9.6
Total	94	

5.2 Children's socio-emotional wellbeing

Social and emotional adjustment is often assessed by the presence or absence of behaviour problems. Child and adolescent behaviour problems can have wide-ranging negative effects on individuals, their families and caregivers in both the short and longer term. They tend to persist over time and be difficult to remediate (Lahey et al, 2004; Lavigne, Cicchetti, Gibbons, Binns, Larsen & DeVito, 2001). They can have adverse effects on children's social skill development (Segrin, 2000; Smart & Sanson, 2001), family and peer relationships (Bagwell, Molina, Pelham & Hoza, 2001), and school progress (DuPaul, McGoey, Echert & VanBrakle, 2001). Two major types of behaviour problems have been identified (Campbell, 2002): externalising problems such as hyperactivity, aggression and antisocial behaviour; and internalising problems such as anxiety and depression.

As well as behaviour problems, positive aspects of children's socio-emotional wellbeing are often assessed; for example, social competence/social skills. Socially competent behaviour is learned through interactions between the child and their family as well as in other relevant contexts such as childcare, school and peer groups (Semrud-Clikeman, 2007). Social skills enable a child to interact effectively with others and have been linked to positive outcomes such as academic achievement (Elias and Haynes, 2008), peer relationships (Ladd, 2005) and the development of socially responsible attitudes and civic mindedness (Smart, Sanson, Da Silva & Toumbourou, 2000).

Socio-emotional problems and competencies among children aged 12–35 months

The Brief Infant Toddler Social Emotional Assessment Scale (BITSEA, Briggs-Gowan & Carter, 2006), completed by caregivers, was used to assess children's socio-emotional wellbeing. It is designed for use with 12–35 month old children and yields a total problem behaviour score and a total competency score based on 42 items that are rated on a scale from 0 to 2 (0 – not true/rarely; 1 – somewhat true/sometimes; 2 – very true/often).

The POCLS sample means were 8.2 for the total behaviour score and 15.8 for the total competency score (Table 5.9). Comparisons to the minimum and maximum possible scores (0–46 for problem total and 0–22 for competence total) indicate that the POCLS children typically showed some but not a large number of behaviour problems, and relatively high levels of competencies. Data from the LSAC were used to assess the comparative wellbeing of the POCLS children and showed that, as a group, the POCLS 12–35 month old children tended to show slightly lower levels of behaviour problems and lower levels of competencies than children in the general Australian community[11].

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[11] The LSAC contained fewer BITSEA problem items than the POCLS; therefore the POCLS problem total score was recalculated to remove the items not used in the LSAC so that a valid comparison could be made. The POCLS means were 6.9 for the recalculated problem total score and 15.8 for competence total, while the corresponding LSAC means were 7.5 on problem total and 17.2 on competence total (Smart, 2011).

The BITSEA provides normative cut-offs to enable identification of children showing very high levels of behaviour problems, or very low levels of competencies. Thus a total behaviour problem score that is in the highest 25% of the US normative sample may be used to identify a child as being in the possible problem range and a total competency score in the lowest 15% of the US normative sample indicates the child is in the possible deficit/delay range.

Table 5.9: Mean levels of caregiver-reported socio-emotional problems and competencies on the BITSEA among children aged 12–35 months, by child's cultural background

	Aboriginal children	Culturally diverse children	Other Australian children	All 12–35 month olds
	Mean (95% CIs)	Mean (95% CIs)	Mean (95% CIs)	Mean (95% CIs)
Socio-emotional problems	7.7 (6.9, 8.6)	8.4 (6.7, 10.2)	8.6 (7.6, 9.5)	8.2 (7.6, 8.8)
Competence	16.2 (15.7, 16.6)	15.2 (14.1, 16.2)	15.8 (15.3, 16.3)	15.8 (15.5, 16.1)
Total for problems	186	38	227	476
Total for competencies	173	37	225	458

Table 5.10 shows that 17% of the POCLS children aged 12–35 months had high levels of problems (scores in the possible problem range) and low levels of competencies (scores in the possible deficit/delay range) according to the BITSEA norms. The norms also provide information about the severity of problems; for example, whether the child's score was in the highest 4% on behaviour problems (i.e., the child had more problems than 95% of the normative sample), the top 5–9%, 10–14% or 15–24%. More children were at the most severe end of the problem and competency distributions than at the less extreme positions, pointing to the seriousness of the socio-emotional difficulties experienced by some children. (This trend was unexpected, as it is more usual to find a smaller proportion of children at the very tail of a distribution than at less acute points of the tail.)

Table 5.10: Children aged 12–35 months showing high levels of socio-emotional problems or low levels of competencies according to caregiver report on the BITSEA, by child's cultural background

	Aboriginal children		Culturally diverse children		Other Australian children		All 12–35 month olds	
	n	%	n	%	n	%	n	%
Total with high levels of socio-emotional problems	28	15.1	8	21.1	43	18.9	83	17.4
Highest 4%	9	4.8	-	-	16	7.0	27	5.7
5% – 9%	5	2.7	2	5.3	13	5.7	20	4.2
10% – 14%	4	2.2	2	5.3	4	1.8	11	2.3
15% – 24%	4	2.2	4	10.5	3	1.3	10	2.1
25%	6	3.2	0	0.0	7	3.1	15	3.2
Total	186		38		227		476	
Total with low levels of competencies	25	14.5	7	18.9	49	21.8	78	17.0
Lowest 4%	7	4.0	3	8.1	19	8.4	34	7.4
5% – 9%	5	2.9	3	8.1	12	5.3	22	4.8
10% – 15%	13	7.5	1	2.7	8	3.6	22	4.8
Total	173		37		225		458	

Comparison of Aboriginal children, children from culturally diverse backgrounds and other Australian children revealed that group means were similar (Table 5.9), and the overlap in confidence intervals indicated that the groups did not significantly differ. Table 5.10 shows that slightly fewer Aboriginal children showed high levels of problems than other sub-groups of children (15% compared with 21% of children from culturally diverse backgrounds and 19% of other Australian children), with similar trends evident for low levels of competencies.

Children in foster care and relative/kinship care showed similar mean levels of total behaviour problems and total competencies (Table 5.11). However, as shown in Table 5.12, slightly fewer children in relative/kinship care than those in foster care showed high levels of problems (13% compared with 20%) or low levels of competencies (14% compared with 19%). As seen previously, when children showed such problems, they were more frequently at the most extreme point of the distribution rather than at less extreme positions.

Table 5.11: Mean levels of caregiver-reported socio-emotional problems and competencies on the BITSEA among children aged 12–35 months, by placement type

	Foster care	Relative/Kinship care
	Mean (95% CIs)	Mean (95% CIs)
Socio-emotional problems	8.6 (7.7, 9.4)	7.6 (6.7, 8.5)
Competence	15.7 (15.3, 16.2)	16.0 (15.5, 16.4)
Totals for problems Total for competencies	267 255	209 203

Table 5.12: Children aged 12–35 months showing high levels of problems or low levels of competencies according to caregiver report on the BITSEA, by placement type

	Foster care		Relative/Kinship care	
	n	%	n	%
Total with high levels of socio-emotional problems	54	20.2	28	13.4
Highest 4%	18	6.7	8	3.8
5% – 9%	11	4.1	9	4.3
10% – 14%	8	3.0	3	1.4
15% – 24%	8	3.0	4	1.9
25%	9	3.4	4	1.9
Total	267		209	
Total with low levels of competencies	49	19.2	28	13.8
Lowest 4%	20	7.8	13	6.4
5% – 9%	13	5.1	9	4.4
10% – 15%	16	6.3	6	3.0
Total	255		203	

Behaviour problems and competencies among 3–17 year old children

The Child Behaviour Checklist (CBCL, Achenbach & Rescorla, 2000, 2001) measures a range of child and adolescent behaviour problems and interpersonal competencies. It provides empirically derived scales that have been extensively used in prior research, and new scales that aim to parallel disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders – DSM V. The CBCL also provides cut-offs to identify children showing differing levels of problems: a 'clinical range' score indicates that the child has high levels of problems of similar severity to children who are receiving clinical treatment for a diagnosed behavioural or mental disorder; a 'borderline range' score indicates that the child has elevated, but less severe, levels of problems; and a 'normal range' score indicates that the child is in the normal range of the general child population.

There are two versions containing 99 items for 1½–5 year olds and a 138 items for 6–18 year olds. Both versions have composite internalising, externalising and total problems scales. The version for 6–18 years also includes a Competence scale. There are also eight syndrome scales for both versions and five DSM-Oriented Scales for the 1½–5 year old version and six for the 6–18 year old version. All items are rated on a scale from 0 to 2 (0 not true; 1 somewhat or sometimes true; 2 very true or often true).

In the first wave of the POCLS the CBCL was used for children aged 3–17 years. In future waves, the CBCL will also be used for children 1½–2 years old instead of the BITSEA.

According to caregivers, approximately one fifth of the POCLS children aged 3–5 years showed clinical levels of internalising, externalising or total behaviour problems (Table 5.13). A further 6–8% were classified as 'borderline' on these three outcomes, while over 70% were in the 'normal' range. Fewer children showed problems on the empirically derived sub-scales, with the percentage showing clinical-level problems ranging from a low of 4% on sleep problems and somatic complaints to a high of 14% on attention problems and withdrawal. Similarly, the proportion showing clinical levels on the DSM-oriented scales ranged from 8% for attention deficit/hyperactivity problems to 17% for pervasive developmental problems (this scale assesses autistic-type symptoms).

One third of 6–11 year olds showed clinical levels of externalising problems, while 31% were in the clinical range on total behaviour problems (Table 5.14). Fewer showed clinical levels of internalising problems (18%). Notably, only 56% and 59% of 6–11 year olds were in the 'normal' range on externalising and total behaviour problems respectively. Rates of clinical-level problems tended to be lower on the specific sub-scales, ranging from 4% for somatic complaints to 21% for rule breaking on the empirically derived sub-scales, and from 3% for somatic problems to 27% for conduct problems on the DSM-oriented sub-scales.

Close to half the children aged 12–17 years were in the clinical range on externalising problems and total behaviour problems (45% and 47% respectively), and less than half were in the 'normal' range, according to caregiver reports (Table 5.15). Approximately one quarter showed clinical levels of internalising problems. Rates of clinical-level problems were lower for the specific sub-scales, ranging from 10% for somatic complaints and anxiety-depression to 21% for social problems and aggressive behaviour on the empirically derived scales; and from 9% for somatic problems to 23% for conduct problems on the DSM-oriented scales.

Comparisons with the child and adolescent component of the first National Survey of Mental Health and Wellbeing in Australia (SMHWB; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky et al, 2000) show considerably higher rates of problems among the POCLS children, particularly in the two older age groups where rates of externalising and total behaviour problems were more than double among the POCLS 6–11 year olds and triple among 12–17 year olds[12].

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[12] The National Survey of Mental Health and Wellbeing (SMHWB) recruited a nationally representative sample of 4,500 children aged 4–17 years in 1998, with parent reports on the CBCL used to ascertain child and adolescent mental health. Although the data are not identical (as the SMHWB reports gender-specific trends and uses two age bands of 4–12 years and 13–17 years), comparisons are still feasible.

The SMHWB (Sawyer, Arney, Baghurst, Clark, Graetz, Kosky et al, 2000) found that among boys aged 4–12 years, 13.6% had clinical levels of externalising problems while 15.0% had clinical levels of internalising and total behaviour problems. For girls aged 4–12 years, rates were 12.2% for externalising, 11.3% for internalising, and 14.4% for total behaviour problems. Trends were similar for 13–17 year olds (among boys: 11.7% had clinical levels of externalising, 13.6% of internalising and 13.4% of total behaviour problems; among girls: 14.1% had clinical levels of externalising, 10.7% of internalising and 12.8% of total behaviour problems).

Table 5.13: Means and 95% confidence intervals for caregiver-reported CBCL empirical and DSM-oriented scales for children aged 3–5 years; proportions in normal, borderline and clinical range

	Mean (95% CIs)	% normal range	% borderline range	% clinical range
Empirically based scales				
Internalising	10.4 (9.3, 11.6)	74.0	7.6	18.5
Externalising	15.3 (14.0, 16.6)	70.9	8.3	20.8
Total problems	40.3 (36.7, 43.9)	72.8	6.0	21.1
Emotionally reactive	3.3 (2.8, 3.7)	81.5	8.7	9.8
Anxious-depressed	3.1 (2.8, 3.5)	88.7	6.0	5.3
Somatic complaints	1.6 (1.3, 1.8)	90.9	4.9	4.2
Withdrawn	2.5 (2.1, 2.8)	81.5	4.2	14.3
Sleep problems	2.7 (2.3, 3.0)	93.2	2.6	4.2
Attention problems	3.2 (2.9, 3.5)	77.7	7.9	14.3
Aggressive behaviour	12.1 (11.0, 13.2)	80.0	8.3	11.7
Other problems[1]	11.9 (10.7, 13.0)	-	-	-
DSM-oriented scales				
Affective problems	2.8 (2.4, 3.2)	87.2	2.3	10.6
Anxiety problems	3.7 (3.3, 4.2)	87.2	3.4	9.4
Pervasive developmental problems	4.6 (4.0, 5.1)	76.2	7.2	16.6
Attention deficit/hyperactivity problems	5.0 (4.6, 5.4)	85.3	7.2	7.6
Oppositional defiant problems	4.2 (3.8, 4.6)	83.4	3.4	13.2
Total	**265**			

1 Scale did not have normative cut-offs.

Table 5.14: Means and 95% confidence intervals for caregiver-reported CBCL empirical and DSM-oriented scales for children aged 6–11 years; proportions in normal, borderline and clinical range

	Mean (95% CIs)	**% normal range**	**% borderline range**	**% clinical range**
Empirically based scales				
Internalising	7.0 (6.1, 7.8)	76.9	4.9	18.2
Externalising	12.6 (11.3, 13.9)	55.7	10.5	33.9
Total problems	38.2 (34.8, 41.6)	58.5	10.8	30.8
Anxious-depressed	3.5 (3.1, 4.0)	83.1	10.2	6.8
Withdrawn-depressed	1.8 (1.5, 2.1)	86.2	5.5	8.3
Somatic complaints	1.6 (1.4, 1.9)	91.1	4.9	4.0
Social problems	4.1 (3.7,4.5)	77.2	9.9	12.9
Thought problems	3.4 (3.0, 3.9)	74.8	6.5	18.8
Attention problems	6.2 (5.6, 6.7)	70.2	12.6	17.2
Rule breaking behaviour	4.0 (3.5, 4.4)	72.0	7.4	20.6
Aggressive behaviour	8.6 (7.8, 9.5)	71.3	10.8	16.9
Other problems[1]	5.0 (4.6, 5.4)	-	-	-
DSM-oriented scales				
Affective problems	2.2 (1.9, 2.6)	82.8	8.0	9.2
Anxiety problems	2.1 (1.9, 2.4)	84.3	5.9	9.9
Somatic problems	0.9 (0.7, 1.0)	93.2	3.7	3.1
Attention deficit/hyperactivity problems	5.2 (4.8, 5.6)	72.3	12.3	15.4
Oppositional defiant problems	3.2 (2.9, 3.5)	80.3	6.5	13.2
Conduct problems	5.1 (4.5, 5.7)	64.3	9.2	26.5
Total	327–329			

[1] Scale did not have normative cut-offs.

Table 5.15: Means and 95% confidence intervals for caregiver-reported CBCL empirical and DSM-oriented scales for children aged 12–17 years; proportions in normal, borderline and clinical range

	Mean (95% CIs)	% normal range	% borderline range	% clinical range
Empirically based scales				
Internalising	10.2 (8.7, 11.7)	58.1	14.5	27.4
Externalising	16.6 (14.3, 18.8)	44.4	10.5	45.2
Total problems	47.6 (41.8, 53.3)	43.6	9.7	46.8
Anxious-depressed	4.5 (3.7, 5.3)	74.2	16.1	9.7
Withdrawn-depressed	3.5 (2.9, 4.1)	71.8	15.3	12.9
Somatic complaints	2.2 (1.6, 2.7)	84.7	5.7	9.7
Social problems	4.9 (4.1, 5.6)	61.3	17.7	21.0
Thought problems	3.7 (3.0, 4.4)	65.3	14.5	20.2
Attention problems	6.8 (6.0, 7.7)	64.5	19.4	16.1
Rule breaking behaviour	6.8 (5.7, 7.8)	62.9	17.7	19.4
Aggressive behaviour	9.8 (8.4, 11.2)	66.1	12.9	21.0
Other problems[1]	5.4 (4.7, 6.1)	-	-	-
DSM-oriented scales				
Affective problems	3.9 (3.2, 4.6)	67.7	17.7	14.5
Anxiety problems	2.3 (1.9, 2.7)	79.0	7.3	13.7
Somatic problems	1.3 (0.9, 1.7)	87.9	3.2	8.9
Attention deficit/hyperactivity problems	5.4 (4.7, 6.1)	66.1	16.1	17.7
Oppositional defiant problems	3.6 (3.1, 4.1)	75.0	12.9	12.1
Conduct problems	7.1 (6.0, 8.3)	50.8	26.6	22.6
Total	124			

1 Scale did not have normative cut-offs.

The CBCL also measures children's academic and social competencies. Table 5.16 shows that among 12–17 year olds, approximately one fifth showed very low levels of competencies overall, while 60% were in the normal range. The areas in which children aged 12–17 years showed the highest rates of difficulties were the Social and School sub-scales (17% and 15% showed very low levels in these areas, respectively).

Table 5.16: Means and 95% confidence intervals on caregiver-reported CBCL competency scales for children aged 12–17 years; proportions in normal, borderline and clinical range

	Mean (95% CIs)	**% normal range**	**% borderline range**	**% clinical range**
Total competency	19.0 (18.2, 19.9)	60.4	17.8	21.8
Activities	9.0 (8.5, 9.5)	79.8	11.3	8.9
Social	6.2 (5.7, 6.6)	59.7	23.4	16.9
School	3.8 (3.6, 4.0)	80.2	5.0	14.9
Total	101–124			

Table 5.17 shows that Aboriginal children generally showed lower rates of clinical range behaviour problems than other Australian children (excluding children from culturally diverse backgrounds), according to caregiver reports. Similarly on competencies, Aboriginal children aged 12–17 years were less likely to show very low levels than other Australian children. Findings for children from culturally diverse backgrounds were not included due to the small numbers available at some ages (for example, at 3–5 years n=15, and at 12–17 years n=13).

Table 5.17: Percentage of children in borderline and clinical range on caregiver-reported CBCL internalising, externalising, total problems and total competency scales, by child age and cultural background[1]

	Aboriginal children		Other Australian children (excluding culturally diverse)	
	% borderline range	% clinical range	% borderline range	% clinical range
3–5 year olds				
Internalising	6.9	15.8	8.3	22.6
Externalising	6.9	20.8	10.5	23.3
Total problems	5.9	17.8	6.8	26.3
Total	101		133	
6–11 year olds				
Internalising	6.7	15.0	3.8	18.8
Externalising	10.0	32.5	10.0	38.1
Total problems	8.3	29.2	12.5	35.0
Total	120		160	
12–17 year olds				
Internalising	18.2	18.2	14.1	28.2
Externalising	9.1	39.4	9.9	46.5
Total problems	9.1	42.4	8.5	49.3
Total competency	10.0	13.3	24.1	20.4
Total	30–33		54–71	

[1] Findings for children from culturally diverse backgrounds were not included due to the small numbers available at some ages.

Table 5.18 shows that, among 3–5 year olds, children in foster care appeared to show higher rates of clinical range externalising and internalising problems than those in relative/kinship care, but were similar on total behaviour problems. Among 12–17 year olds, children in foster care again had higher rates of all types of behaviour problems than those in relative/kinship care and also more frequently showed very low competencies. Rates of clinical-level behaviour problems were highest among 12–17 year olds in residential care. However, since the number of children in residential care is small, these results should be interpreted with caution.

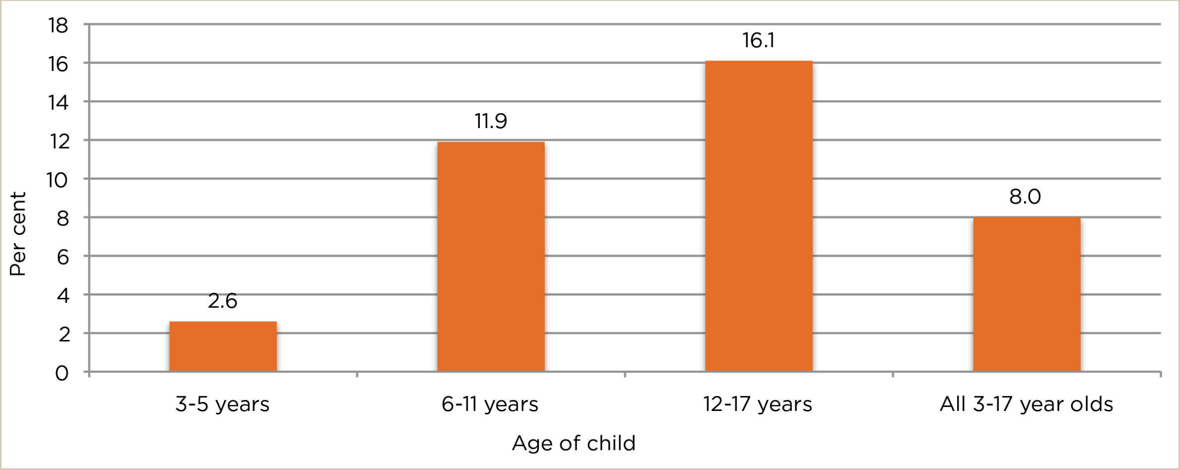
Table 5.18: Percentage of children in borderline and clinical range on caregiver-reported CBCL internalising, externalising, total problems and total competency scales, by child age and placement type

	Foster care		Relative/Kinship care		Residential care	
	% borderline range	% clinical range	% borderline range	% clinical range	% borderline range	% clinical range
3–5 year olds						
Internalising	6.5	21.6	8.7	15.1	-	-
Externalising	10.8	23.0	5.6	18.3	-	-
Total problems	6.5	21.6	5.6	20.6	-	-
Total	139		126		-	-
6–11 year olds						
Internalising	5.2	20.8	4.7	15.8	-	-
Externalising	6.5	44.2	14.0	24.6	-	-
Total problems	14.3	37.7	7.6	24.6	-	-
Total	154		171		-	-
12–17 year olds						
Internalising	10.9	26.1	9.6	23.1	30.8	38.5
Externalising	13.0	41.3	7.7	36.5	11.5	69.2
Total problems	10.9	43.5	9.6	36.5	7.7	73.1
Total competency	22.0	17.1	10.9	28.3		
Total	41–46		46–52		14–26	

Use of prescription medication to control children's behaviour

Caregivers reported that 8% of children were taking prescribed medication to control their behaviour with the rate rising steadily with age from 3% at 3–5 years to 16% at 12–17 years (Figure 5.5). Table 5.19 shows that a slightly lower proportion of children from culturally diverse backgrounds were taking prescribed medications to control their behaviour (4%) than Aboriginal children and other Australian children (8% and 9% respectively). Similar proportions of children in foster and relative/kinship care were taking prescribed medications for behaviour management; however, rates were higher among children in residential care (39% compared with 8% of children in foster care and 6% of children in relative/kinship care).

Figure 5.5: Percentage of children taking prescribed medication to control their behaviour as reported by caregivers, by child age[1]



1 This question was asked of caregivers of children aged 3 years and older.

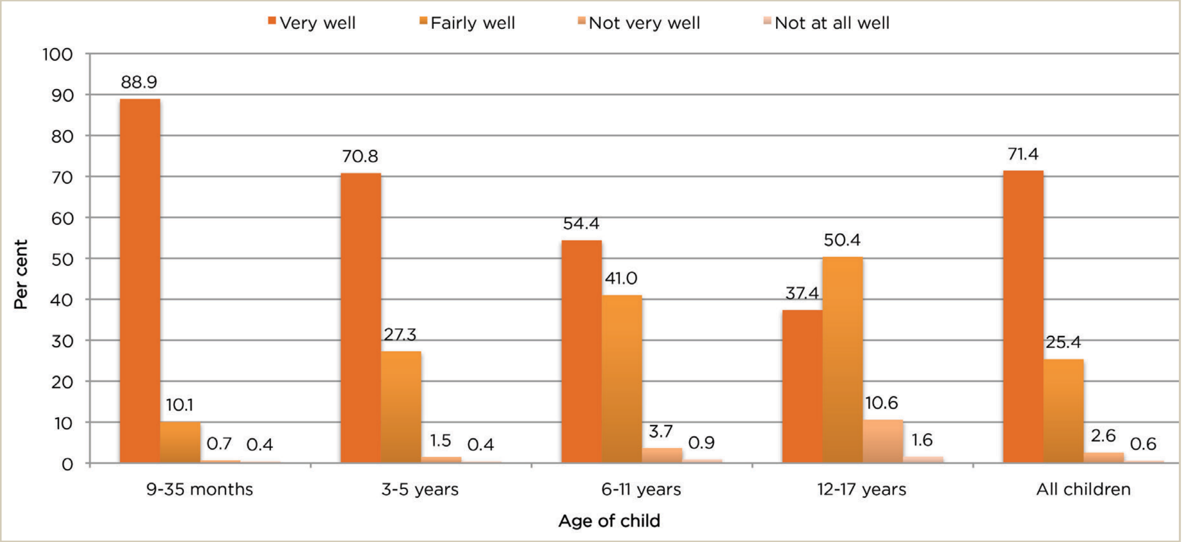
Table 5.19: Number and proportion of children taking prescribed medication to control their behaviour as reported by caregivers, by child's cultural background and placement type

	Aboriginal children		Culturally diverse children		Other Australian children	
	n	%	n	%	n	%
Yes	23	7.8	3	4.1	36	8.7
Total	296		73		413	
	Foster		**Relative/Kinship**		**Residential**	
	n	%	n	%	n	%
Yes	32	8.0	24	6.1	10	38.5
Total	401		393		26	

Caregivers' perceptions of how the child is going

Caregivers were asked to give their general perception of how the child or young person was going, which may be used as an indicator of socio-emotional wellbeing (Figure 5.6). Overall, almost three quarters were perceived to be going 'very well'. There appeared to be age differences, with more caregivers of young children believing the child was going 'very well' (89% of caregivers of 9–35 month olds and 71% of caregivers of 3–5 year olds) than caregivers of older children (54% of 6–11 year olds and 37% of 12–17 year olds). On the other hand, very few caregivers believed the child was progressing 'not very well' or 'not at all well' (ranging from 1% of 9–35 month olds to 12% of 12–17 year olds).

Figure 5.6: Caregivers' perceptions of how the child is going, by child age



Another indicator used to infer wellbeing was the child's receipt of an award, prize or trophy for things done well in the past six months. Child and young person self reports revealed that more than nine tenths of 7–11 year olds[13] had received formal recognition for an achievement (92%) as had 60% of 12–17 year olds.

Children's perceptions of their socio-emotional wellbeing

Children were asked a series of questions about their socio-emotional wellbeing. These differed across the two age bands[14] (7–11 and 12–17 years) to ensure that the questions used were developmentally appropriate.

Children aged 7–11 years were asked how often they had experienced a range of emotional states (happiness, worry, sadness, anger), and how often they had been in trouble (Table 5.20). They were then asked if they had talked to various people (e.g., carer family members, birth family members, and friends) when they were experiencing these emotional states and how helpful this support had been in general (Tables 5.21 and 5.22).

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[13] These data were taken from the child interview which was offered to children seven years and older, hence the age band is 7–11 years rather than the 6–11 years age band used elsewhere.

[14] Interviews were offered to children aged 7 years and older. Thus for this section, the age bands used are 7–11 years and 12–17 years.

Almost half (46%) of 7–11 year old children had ‘always’ been happy and a further 26% had ‘often’ been happy (Table 5.20). Only 6% felt they had ‘rarely’ or ‘never’ been happy. Between 15% and 25% had ‘always’ or ‘often’ felt scared/worried, sad, or angry/mad. The proportion who ‘rarely’ or ‘never’ experienced these emotions ranged from 33% to 43%. Trends were similar for the frequency of getting into trouble, with this happening ‘always’ or ‘often’ for 22% of children compared with ‘rarely’ or ‘never’ for 31% of children.

Table 5.20: Children aged 7–11 years reports of happiness, distress, anger, or being in trouble

	Always		Often		Sometimes		Rarely		Never	
	n	%	n	%	n	%	n	%	n	%
Feel happy	104	46.4	58	25.9	48	21.4	10	4.5	4	1.8
Get scared or worried	15	6.9	40	18.3	88	40.4	29	13.3	46	21.1
Feel sad	9	4.0	24	10.8	93	41.7	53	23.8	44	19.7
Get angry or mad	25	11.3	23	10.4	100	45.0	36	16.2	38	17.1
Get in trouble	21	9.5	28	12.6	105	47.3	40	18.0	28	12.6
Total	218–224									

Figure 5.7: Children aged 7–11 years reports of happiness, distress, anger, or being in trouble

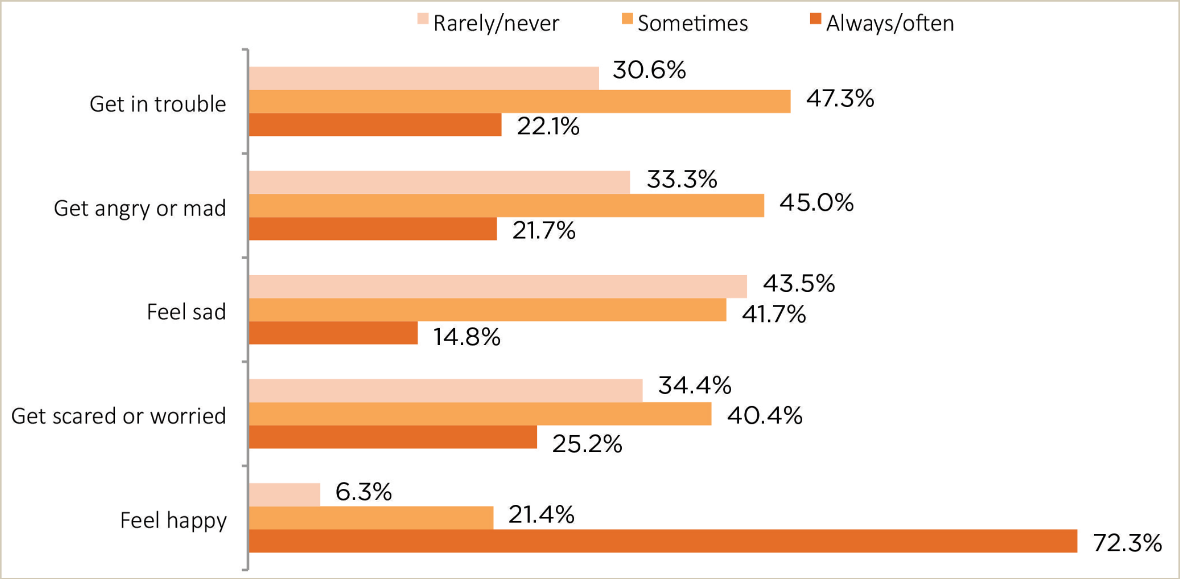

Table 5.21: Children aged 7–11 years reports of people spoken to when feeling worried, sad or angry[1]

	Yes		No	
	n	%	n	%
People living with now	192	88.9	24	11.1
Own family	149	68.7	68	31.3
Teachers or school counsellors	144	66.1	74	33.9
Friends	124	57.4	92	42.6
Caseworkers	77	36.5	134	63.5
Other	31	14.7	180	85.3
Totals	211–218			

1 Column percentages do not add up to 100%, as children could choose more than one type of confidant.

Table 5.22: Children aged 7–11 years reports of how helpful the support had been

	7–11 years	
	n	%
Very helpful	134	65.0
Quite helpful	56	27.2
Somewhat helpful	10	4.9
Not at all helpful	6	2.9
Total	**206**	

Table 5.21 shows that according to children, they most often talked with members of the caregiver family when experiencing these emotions (89%). Approximately two thirds had talked with members of their birth family or a teacher/school counsellor, while 57% had talked with friends. Slightly over one third had talked with their caseworker.

Almost all 7–11 year old children had found the support they received to be ‘very’ (65%) or ‘quite’ helpful (27%, Table 5.22). Few felt it had been only ‘somewhat’ or ‘not at all’ helpful (8%). As children were asked in general how helpful the support had been, it is not possible to determine how helpful each separate source of support had been. Nevertheless, it seemed that most 7–11 year old children had a support network available to them that they found helpful.

The older age group of 12–17 year olds were asked a series of questions[15] about:

- whether they had felt unhappy/sad/depressed; nervous/stressed/under pressure or been in trouble for their behaviour in the past six months
- how bad these feelings had been
- whether they had talked to anyone about these feelings
- how helpful others had been.

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[15] These questions were taken from the 2008 NSW version of the Australian School Students’ Alcohol and Drug (ASSAD) survey, which enables comparison to the general population of NSW adolescents.

Overall, 62% of children aged 12–17 years had experienced feelings of unhappiness, sadness or depression on one or more days in the past six months; 54% had felt nervous, stressed or under pressure on one or more days in this time period; and 74% had been in trouble because of their behaviour on one or more of these days (Table 5.23). Comparisons suggest that it is normal for young people to experience at least occasional psychosocial distress, with findings for the POCLS sample no worse than the NSW 2008 general population of young people except on getting into trouble because of one's behaviour[16].

While it is not possible to determine how frequently children aged 12–17 years experienced psychosocial distress from these questions, an indication of the severity of these feelings was obtained. This showed that when these children experienced unhappiness, sadness or depression, almost one quarter perceived these feelings to be 'almost more than they could take' and a further one third thought they had been 'quite bad' (Table 5.23). Fewer of the POCLS children aged 12–17 years who experienced nervousness/stress under pressure reported these feelings to be 'almost more than they could take' (13%) or 'quite bad' (19%). When POCLS children had been in trouble for their behaviour, 5% felt it had been 'almost more than they could take' and 29% that it had been 'quite bad'.

Comparison with the general population shows that when the POCLS 12–17 year olds experienced distress or had been in trouble for their behaviour, they seemed to react more intensely than other children of the same age[17]. However, it should be noted that in the absence of information about the frequency of such feelings (i.e., on how many days in the past six months they had been experienced), the pervasiveness and seriousness of psychosocial distress cannot be determined.

The POCLS 12–17 year olds were also asked who they had spoken to about these feelings, and how helpful the support had been in general. For those experiencing psychosocial distress (i.e., unhappiness, sadness or depression; or nervousness, stress or being under pressure), friends were the most common source of support (63% and 65% respectively), followed by the caregiving family (52% and 47%), the birth family (46% and 37%) and teachers/school counsellors (39% and 35%). Around one quarter had discussed their distress with caseworkers (30% and 24% respectively). Only 31–42% felt their discussions with others had been 'very' helpful, while 34–36% felt they had been 'quite' helpful (Table 5.24). Nevertheless, only 10% of those experiencing unhappiness, sadness or depression and 5% of those experiencing nervousness, stress or being under pressure felt the discussions had been 'not at all' helpful.

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[16] Data taken from the NSW ASSAD findings reported by the Centre for Epidemiology and Research (2009) show that 70% of the general population of 12–17 year olds in NSW in 2008 had experienced unhappiness, sadness or depression on one or more days in the previous six months; 67% had been nervous, stressed or under pressure, and 64% had been in trouble because of their behaviour in this time span.

[17] Among the 2008 NSW general population of 12–17 year olds, 7% reported that their feelings of unhappiness/sadness/depression were 'almost more than they could take' and 11% that they had been 'quite bad'; 5% that their feelings of nervousness/stress/being under pressure were 'almost more than they could take' and 12% that these had been 'quite bad'; while for only 3% was the trouble they had been in for their behaviour 'almost more than they could take' and for 10% it was 'quite bad' (Centre for Epidemiology and Research, 2009).

Looking next at being in trouble because of one's behaviour, the most common people adolescents had talked to were caregiving family members (60%), perhaps because the family were aware of the behaviour. Other types of people often talked to were the young person's birth family and friends. As for ratings of how helpful the support received was, slightly under one third felt the discussion had been 'very' helpful, a further 47% felt it had been 'quite' helpful, while 13% felt it had been 'not at all' helpful.

Thus 12–17 year olds appeared to have similar types of support figures to 7–11 year olds, but they tended to talk less often to these support figures about their feelings. Additionally, they seemed to have less positive perceptions of how helpful the support had been.

Table 5.23: Children aged 12–17 years reports of distress or being in trouble in the last six months, and people consulted

	Felt unhappy, sad or depressed		Felt nervous, stressed or under pressure		Been in trouble because of behaviour	
	n	%	n	%	n	%
Distress or being in trouble						
No	33	37.9	41	46.1	23	25.8
Yes, at home and school	35	40.2	22	24.7	33	37.1
Yes, only at home	12	13.8	7	7.9	15	16.9
Yes, only at school	7	8.0	19	21.3	18	20.2
Total	**87**		**89**		**89**	
If yes, how bad was it						
Almost more than I could take	12	23.1	6	12.5	3	4.8
Quite bad	17	32.7	9	18.8	18	28.6
Worse than usual	8	15.4	7	14.6	11	17.5
About usual	15	28.8	26	54.2	31	49.2
Total	**52**		**48**		**63**	
Who spoken to[1]						
People living with now	29	51.5	22	46.8	38	60.3
Own (birth) family	26	45.6	17	37.0	26	41.3
Friends	36	63.2	30	65.2	30	48.4
Teachers or school counsellors	22	38.6	16	34.8	18	29.0
Caseworkers	17	29.8	11	24.4	15	23.8
Other	13	23.2	10	22.7	11	18.3
Total	56–57		44–47		60–63	

[1] Column percentages do not add up to 100%, as children could choose more than one confidant.

Table 5.24: Children aged 12–17 years reports of how helpful the support had been

	Felt unhappy, sad or depressed		Felt nervous, stressed or under pressure		Been in trouble because of behaviour	
	n	%	n	%	n	%
Very helpful	21	42.0	12	30.8	15	31.9
Quite helpful	17	34.0	14	35.9	22	46.8
Somewhat helpful	7	14.0	11	28.2	4	8.5
Not at all helpful	5	10.0	2	5.1	6	12.8
Total	50		39		47	

Children aged 12–17 years reports of substance use

Several questions about substance use were asked of 12–17 year olds, with findings shown in Table 5.25. These were derived from the ASSAD survey and were selected because they have known acceptability to an adolescent population and are relatively brief.

By comparison with national trends from the 2011 ASSAD (White & Bariola, 2012), the POCLS adolescents reported considerably higher rates of cigarette use in their lifetime (44% of the POCLS sample compared with 23% of the ASSAD cohort), in the past four weeks (55% compared with 9%), and past seven days (48% compared with 7%). They had less often consumed alcohol, however, with fewer ever having consumed alcohol in their lifetime (49% compared with 74%), the last four weeks (21% compared with 29%) or the last seven days (9% compared with 17%). However, they were somewhat more likely to have used illicit drugs in their lifetime (22% compared with 16%), and in the last four weeks (15% compared with 8%). Thus, it appears that the POCLS children aged 12–17 years reported higher levels of cigarette and illicit drug use, but lower levels of alcohol consumption than the general adolescent population.

Table 5.25: Children aged 12–17 years who reported use of cigarettes, alcohol or drugs[1]

	Never		Ever in lifetime		In last four weeks[2]		In last seven days	
	n	%	n	%	n	%	n	%
Smoked cigarettes	51	56.0	40	44.0	22	55.0	19	47.5
Consumed alcohol	45	50.5	44	49.4	9	20.5	4	9.1
Used illicit drugs	71	78.0	20	22.0	3	15.0	2	10.0

1 N=91 children answered the ‘ever’ smoked cigarette question, 89 answered the ‘ever’ consumed alcohol question, and 91 answered the ‘ever’ used drugs question. The n decreased with each subsequent question depending on how many had answered the previous question affirmatively.

2 Includes those who had used the substance in the last seven days. Use in the last four weeks or seven days was calculated as the proportion who had ‘ever’ used in their lifetime.

5.3 Children’s cognitive and language development

Children’s cognitive and language capacities are key influences on their developmental pathways. Research indicates that high-level cognitive abilities are predictive of better school achievement (Deary, Strand, Smith & Fernandes, 2007), higher occupational status in adulthood (Sigelman & Rider, 2008), psychological wellbeing (Robinson, 1998), and decreased risk of mortality (Jokela, Batty, Deary, Gale & Kivimaki, 2009). Conversely, lower cognitive abilities are a risk factor for adolescent delinquency (Ge, Donnellan & Wenk, 2001; McGloin & Pratt, 2003), learning difficulties (Hoard, Geary & Hamson, 1999), and externalising behaviour problems (Eliott & Mirsky, 2002; Schoenmaker, Mulder, Dekovic & Matthys, 2013). Cognitive ability has been identified as a key contributor to resiliency among children growing up in high-risk environments (e.g., the seminal work of Werner & Smith, 1989). Language development is a crucial developmental task and underpins many later competencies. Language impairment in the early years is a strong predictor of academic, social and behavioural problems and can have long-term, negative social and economic impacts (Bornstein, Hahn & Suwalsky, 2013; Law, Rush, Schoon & Parsons, 2009; Schoon, Parsons, Rush & Law, 2010).

To measure children’s timely attainment of developmental milestones, the POCLS used the caregiver-completed Ages and Stages Questionnaire (ASQ-3; Squires & Bricker, 2009). The ASQ-3 assessed children’s developmental status from 9 to 66 months of age over a range of domains (e.g. motor skills, problem solving, and language development). Language skills were assessed by three measures, as differing instruments were required to assess this rapidly developing capacity. To assess the early emergence of cognitive and language skills, the caregiver-completed Communication and Symbolic Behaviour Scales Infant and Toddler Checklist (CSBS-ITC; Wetherby & Prizant, 2003) for children aged 9–23 months was used. For children aged 24–35 months, the caregiver-completed toddler and early-childhood versions of the Macarthur-Bates Communicative Developmental Inventories III (MCDI-III; Fenson, Marchman, Thal, Dale, Bates & Reznick, 2007; Fenson, Pethick, Renda, Cox, Dale & Reznick, 2000) were used. Finally, for children aged 3–17 years, the interviewer-administered Peabody Picture Vocabulary Test IV (PPVT-IV; Dunn & Dunn, 2007) assessed children’s receptive language skills. To assess general non-verbal intelligence, the interviewer-administered Matrix Reasoning Test from the Wechsler Intelligence Test for Children (WISC-IV; Wechsler, 2003) was used with children aged 6–16 years.

Children’s attainment of developmental milestones

The caregiver-completed Ages and Stages Questionnaire (ASQ-3) measures child development across five domains: Communication; Gross Motor skills; Fine Motor skills; Problem Solving and Personal-Social capacities. The measure has 19 different versions to assess development at differing ages and normative cut-offs are provided which enable differentiation of children developing typically from those who are not. There are 30 items rated on a scale as 10 (yes), 5 (sometimes) and 0 (not yet). In the POCLS, the ASQ was used in relation to children aged 9–66 months. The wording of the questionnaires were amended (with permission) to be appropriate for the Australian context and to enable administration by interviewer (without the need for any carer testing of child skills, which is part of the carer-completed measure).

Table 5.26 shows that for children aged 9–35 months and 36–66 months more than 80% of children were developing typically. Table 5.27 shows that 9–35 month old Aboriginal children and children from culturally diverse backgrounds were generally similar, although those from culturally diverse backgrounds appeared to be faring worse on gross motor development than the other two sub-groups (28% compared with 18% and 16% respectively); however, the small sample of culturally diverse children should be noted and findings interpreted with caution. However, 36–66 month old Aboriginal children tended to show higher rates of atypical development on almost all scales than other Australian children. Due to the very small sample size available for children from culturally diverse backgrounds in the age bracket of 36–66 months, their results are not discussed.

Table 5.26: Caregiver reports of children's development on the ASQ-3, mean scores, 95% confidence intervals, typical and atypical development, by child age

	Mean (95% CIs)		Developing typically		A typical development	
			n	%	n	%
9–35 months						
Communication	42.1	(40.7, 43.5)	458	87.2	67	12.8
Gross Motor	46.8	(45.4, 48.3)	431	81.9	95	18.1
Fine Motor	43.5	(42.1, 44.8)	448	85.2	78	14.8
Problem Solving	42.2	(40.9, 43.5)	433	82.3	93	17.7
Personal-Social	44.7	(43.5, 45.9)	459	87.4	66	12.6
Total	525–526					
36–66 months						
Communication	46.0	(43.9, 48.1)	181	82.6	38	17.4
Gross Motor	50.4	(48.5, 52.2)	190	86.0	31	14.0
Fine Motor	39.8	(37.4, 42.2)	188	85.1	33	14.9
Problem Solving	45.7	(43.6, 47.7)	187	84.6	34	15.4
Personal-Social	49.2	(47.5, 50.9)	199	90.5	21	9.6
Total	219–222					

Table 5.27: Caregiver reports of children's atypical development on the ASQ-3, by child age and cultural background

	Aboriginal children		Culturally diverse children		Other Australian children	
	n	%	n	%	n	%
9–35 months						
Communication	23	11.6	5	11.9	32	12.4
Gross Motor	36	18.1	12	27.9	42	16.3
Fine Motor	36	18.1	7	16.3	30	11.6
Problem Solving	31	15.6	7	16.3	48	18.6
Personal-Social	23	11.6	6	14.0	31	12.0
Total	199		42–43		258	
36–66 months						
Communication	16	20.5	4	-	16	14.2
Gross Motor	13	16.5	3	-	13	11.4
Fine Motor	15	19.0	3	-	12	10.5
Problem Solving	18	22.8	1	-	13	11.4
Personal-Social	9	11.5	2	-	9	7.9
Total	69–79		13[1]		103–114	

1 Due to the small sample size (less than 20), percentages are not shown and results are not discussed further.

Comparison of children in foster and relative/kinship care revealed that slightly more children in foster care appeared to show atypical development across each area than those in relative/kinship care (Table 5.28), with differences most evident on gross motor development at 9–35 months (21% compared with 15%), and on problem solving and fine motor development (20% compared with 11%; 18% compared with 12%; respectively) at 36–66 months.

Table 5.28: Caregiver reports of atypical development on the ASQ-3, by child age and placement type

	Foster care		Relative/Kinship care	
	n	%	n	%
9–35 months				
Communication	42	14.0	25	11.2
Gross Motor	62	20.6	33	14.7
Fine Motor	48	16.0	30	13.3
Problem Solving	55	18.3	38	16.9
Personal-Social	38	12.6	28	12.5
Total	301		224	
36–66 months				
Communication	21	19.1	17	15.6
Gross Motor	17	15.2	14	12.8
Fine Motor	20	17.9	13	11.9
Problem Solving	22	19.6	12	11.0
Personal-Social	12	10.8	9	8.3
Total	110–112		109	

Language development

To assess early emerging language capacities, the caregiver-completed Communication and Symbolic Behaviour Scales Infant and Toddler Checklist (CSBS-ITC) was used in relation to 9–23 month old children. There are 24 items in the CSBS-ITC checklist and it consists of three sub-scales – Social, Speech and Symbolic – which combine to form a Total Score. The scales yield standard scores and percentiles, with percentile scores at or below the 10th percentile considered of concern.

While the majority of children were developing normally, approximately one quarter had speech development that was ‘of concern’, and one fifth showed ‘of concern’ levels on symbolic skill levels (Table 5.29), according to caregiver reports on this scale. Furthermore, approximately one fifth was in the ‘of concern’ range on the total composite score. These rates were considerably higher than the 10% expected according to the norms.

Fewer children from culturally diverse backgrounds showed developmental levels ‘of concern’ on the social, speech and total scales by comparison with other sub-groups (e.g., 18% showed slower than average speech development compared with 31% of Aboriginal children and 25% of other Australian children) (Table 5.30). Again, the small number of children from culturally diverse backgrounds indicates that caution is needed in interpreting these findings. A higher proportion of Aboriginal children were in the ‘of concern’ range on the speech and symbolic sub-scales than other Australian children.

Children in foster care appeared to have slightly higher rates of developmental levels ‘of concern’ across all scales than those in relative/kinship care (Table 5.31), with the greatest difference occurring on the social (20% compared with 15%) and total development scales (23% compared with 18%).

Table 5.29: Caregiver-reported CSBS mean standard scores, 95% confidence intervals, and proportion at or below 10th percentile

	Mean standard scores (95% CIs)	At or below 10th percentile	
		n	%
Social	9.8 (9.4, 10.2)	54	17.6
Total	307		
Speech	8.7 (8.4, 9.1)	82	26.5
Total	309		
Symbolic	9.2 (8.8, 9.5)	55	18.8
Total	292		
Total	94.7 (93.2, 96.4)	77	21.0
Total	366		

Table 5.30: Number and proportion at or below 10th percentile on the caregiver-reported CSBS, by child's cultural background

	Aboriginal children		Culturally diverse children		Other Australian children	
	n	%	n	%	n	%
Social	18	16.4	3	10.7	28	18.2
Speech	34	30.6	5	17.9	38	24.5
Symbolic	25	23.8	7	25.9	20	13.8
Total	27	20.8	5	14.3	37	20.6
Total	105–130		27–35		145–180	

Table 5.31: Number and proportion at or below 10th percentile on the caregiver-reported CSBS, by placement type

	Foster care		Relative/ Kinship care	
	n	%	n	%
Social	35	19.7	19	14.7
Speech	50	27.9	32	24.5
Symbolic	35	20.7	20	16.3
Total	49	23.2	28	18.1
Total	169–211		123–155	

The caregiver-completed Macarthur-Bates Communicative Developmental Inventories III (MCDI-III) was used to assess language development among children aged 24–35 months. There are two versions, the MacArthur Communicative Development Inventories Short Form and the MacArthur-Bates Communicative Developmental Inventories, which were used for children aged 24–29 months and 30–35 months respectively. For both versions, caregivers were asked, using the list provided, which words they had heard the child use in daily speech. This measure consists of 100 vocabulary words for children aged 24–35 months (plus one item about word combinations for 24–29 month olds). The number of words indicated by the carer is summed to give a total out of 100 which can be converted to percentile ranks. Caregivers of the older group of children (30–35 months) were also asked whether children used sentences varying in complexity.

Percentiles are provided that can be used to identify children showing slower than average language development. The recommendation of Heilman, Weismer, Evans and Hollar (2005) has been followed in applying a cut-off of 'below the 15th percentile' to identify children as having significantly poorer language skills.

Using this cut-off, 13% of 24–29 month old and 28% of 30–35 month old children showed slower than average language acquisition in terms of the number of words used in their daily speech (Table 5.32). A higher proportion (41%) showed slower than average use of complex sentences.

Table 5.32: Caregiver-reported MCDI-III mean percentile scores, 95% confidence intervals, and number and proportion below the 15% percentile, by child age

	Mean percentile scores and 95% CIs	% below 15th percentile	
		n	%
24–29 months			
Words	45.7 (40.2, 51.1)	11	12.6
Total	**87**		
30–35 months			
Words	37.0 (31.2, 42.7)	23	27.7
Sentences	2.6 (1.9, 3.3)	35	40.7
Total	**83–86**		

Bearing in mind the relatively small sample sizes[18], Table 5.33 shows that similar percentages of children in foster and relative/kinship care displayed slower than average vocabulary development at 24–29 months (although the rate of problems in both groups was less than that expected via the norms). At 30–35 months, it appeared that more children in foster than relative/kinship care showed slower than average vocabular and sentence development, with rates higher than would be expected via the norms.

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[18] Due to very small cell sizes, the comparisons of Aboriginal, culturally diverse and other Australian children are not presented here.

Table 5.33: Number and proportion below the 15% percentile on the caregiver-reported MCDI-III, by placement type

	Foster care		Relative/ Kinship care	
	n	%	n	%
24–29 months				
Words	6	12.8	5	13.2
N	47		38	
30–35 months				
Words	14	31.1	9	23.7
Sentences	24	52.2	11	27.5
Total	45–47		38–40	

The interviewer-administered Peabody Picture Vocabulary Test Version 4 (PPVT-IV) was used to assess language capacities in children aged 3 to 17 years. The PPVT-IV measures children's understanding of spoken words (i.e., their receptive language skills) and can be used to assess growth in vocabulary acquisition over time. There are 228 items in the test, but covering a wide age range, so children complete a smaller number of items. The mean standard score for the US normative sample is 100 and the standard deviation is 15. Thus, scores below 85 may be interpreted as indicating language skills below the normal range and scores above 115 as language skills above the normal range. These would place children in the lowest and highest 15% of the normative US sample distribution.

Table 5.34 shows the POCLS mean standard scores for differing age groups and reveals that across all ages, the mean score was lower than the normative mean of 100. Additionally, the mean standard score decreased as age increased, with the mean standard score for 12–17 year olds close to the cut-off for 'below normal' range language skills.

The proportion of children within each age group whose language skills were 'below normal range'; 'within normal range'; or 'above normal range' are also shown in Table 5.34. The proportion in the 'below normal range' level rose from 17% at 3–5 years (which was close to normative expectations), to 27% at 6–11 years and 42% at 12–17 years. Conversely, few children were 'above normal range': 5% at 3–5 years, and 3% at the two older ages. The high percentage of 12–17 year olds showing below normal range language skills was particularly noteworthy.

Table 5.34: PPVT-IV mean standard scores, 95% confidence intervals, and the number and proportion below, within, or above normal range, by child age

	Mean and 95% CIs	Standard score below 85		Standard score 85 – 115		Standard score above 115	
		n	%	n	%	n	%
3–5 years							
Standardised score	93.9 (92.3, 95.4)	41	17.3	184	77.6	12	5.1
Total	237						
6–11 years							
Standardised score	90.6 (89.1, 92.2)	83	27.4	212	70.0	8	2.6
Total	303						
12–17 years							
Standardised score	86.3 (83.4, 89.1)	44	42.3	57	54.8	3	2.9
Total	104						

Proportionately more Aboriginal children and children from culturally diverse backgrounds showed ‘below normal range’ language skills, while fewer were ‘within the normal range’ or ‘above the normal range’ than other Australian children (Table 5.35). These trends were particularly marked for children from culturally diverse backgrounds, but likely reflect these children’s lesser exposure to the English language. (It is to be expected that those from culturally diverse backgrounds will score more poorly than other children as English is likely to be their second language.)

Table 5.35: Number and proportion below, within, or above normal range on the PPVT-IV, by child's cultural background

	Standard score below 85		Standard score 85 – 115		Standard score above 115	
	n	%	n	%	n	%
Aboriginal children	69	29.5	160	68.4	5	2.1
Total	**234**					
Culturally diverse children	19	33.9	37	66.1	-	-
Total	**56**					
Other Australian children	77	23.8	231	71.3	16	4.9
Total	**324**					

Comparison of children in differing placement types (Table 5.36) revealed that proportionately more children in foster care showed 'below normal range' language skills than those in relative/kinship care (28% and 23% respectively). The rate of 'below normal range' language skills among children in residential care was 48%, which was considerably higher than found for children in other placement types, although the very small sample of children in residential care should be noted. Very few children in all three placement types showed 'above normal range' language skills (fewer than 5%).

Table 5.36: Number and proportion below, within, or above normal range on the PPVT-IV, by placement type

	Standard score below 85		Standard score 85 – 115		Standard score above 115	
	n	%	n	%	n	%
Foster care	85	28.0	206	67.8	13	4.3
Total	**304**					
Relative/Kinship care	73	22.9	236	74.0	10	3.1
Total	**319**					
Residential care	10	47.6	11	52.4	0	0
Total	**21**					

Cognitive development

The interviewer-administered Matrix Reasoning Test (MR) from the Wechsler Intelligence Test for Children Version 4 (WISC-IV; Wechsler 2004) was used to assess general non-verbal intelligence among children aged 6 to 16 years. The 35 items in the MR sub-scale yields a standard score with a possible range of one to 19. The normative mean is 10 with a standard deviation of three. Thus scores below seven are indicative of 'below normal range' cognitive abilities (i.e., in the lowest 15% of the normative population of children) and scores above 13 are indicative of 'above normal range' cognitive abilities (i.e., in the highest 15% of the normative population of children).

Table 5.37 shows mean standard scores for children aged 6–11 years and 12–16 years. As for the PPVT-IV, these are below the normative mean of 10, and are lower among 12–16 year olds than 6–11 year olds. Further, a higher proportion of children were in the ‘below normal range’ category than expected according to the norms (28% of 6–11 year olds and 30% of 12–16 year olds compared with 15% expected). As seen for the PPVT-IV, a much smaller proportion was in the ‘above normal range’ category (4% of 6–11 year olds and 3% of 12–16 year olds compared with 15% expected).

Table 5.37: Mean standard scores on the MR test, 95% confidence intervals, and the number and proportion below, within, or above normal range, by child age

	Mean and 95% CIs	Standard score below 7		Standard score between 7 and 13		Standard score above 13	
		n	%	n	%	n	%
6–11 years							
Standardised score	8.2 (7.9, 8.5)	84	28.0	204	68.0	12	4.0
Total	300						
12–16 years							
Standardised score	7.8 (7.2, 8.3)	29	29.9	65	67.0	3	3.1
Total	97						

Children from culturally diverse backgrounds were less likely to show ‘below normal range’ cognitive capacities and a higher proportion was in the ‘normal’ and ‘above normal’ ranges than the Aboriginal children and other Australian children (Table 5.38). In fact, the proportion in the ‘below normal range’ for children from culturally diverse backgrounds was close to that expected according to the norms. Aboriginal children and other children tended to be faring less well, with greater proportions in the ‘below normal range’ and fewer in the ‘normal’ and ‘above normal’ range categories.

Table 5.38: Number and proportion below, within, or above normal range on the MR test, by child’s cultural background

	Standard score below 7		Standard score between 7 and 13		Standard score above 13	
	n	%	n	%	n	%
Aboriginal children	46	33.6	90	65.7	1	0.7
Total	137					
Culturally diverse children	7	16.3	32	74.4	4	9.3
Total	43					
Other Australian children	59	29.2	133	65.8	10	5.0
Total	202					

The rate of 'below normal range' cognitive capacities among children in foster care was double that of children in relative/kinship care (39% compared with 18% respectively, Table 5.39). As seen earlier, comparatively few children in these two placement types showed 'above normal range' capacities (4%). While children in residential care were likely faring more poorly than those in other placement types, the small sample size precludes further interpretation.

Table 5.39: Number and proportion below, within, or above normal range on the MR test, by placement type

	Standard score below 7		Standard score between 7 and 13		Standard score above 13	
	n	%	n	%	n	%
Foster care	69	38.6	103	57.5	7	3.9
Total	179					
Relative/Kinship care	36	17.9	158	78.6	7	3.5
Total	201					
Residential care	8	-	9	-	1	-
Total	18					

5.4 How the children are faring overall

The baseline data described in this chapter shows the children's wellbeing across different domains of functioning including the child's physical health, socio-emotional wellbeing and cognitive/learning ability. Figure 5.8 below shows the proportions of children showing problems in 0 to 3 domains of wellbeing calculated according to the age ranges and key study measures[19]. Approximately half (48%) of the study children were not showing problems across any developmental domains measured, 30% showed problems in one developmental domain, 16% showed problems in two developmental domains, while 5% showed problems across all three developmental domains measured. Children aged 12–17 years showed more problems in all areas of wellbeing measured than younger children.

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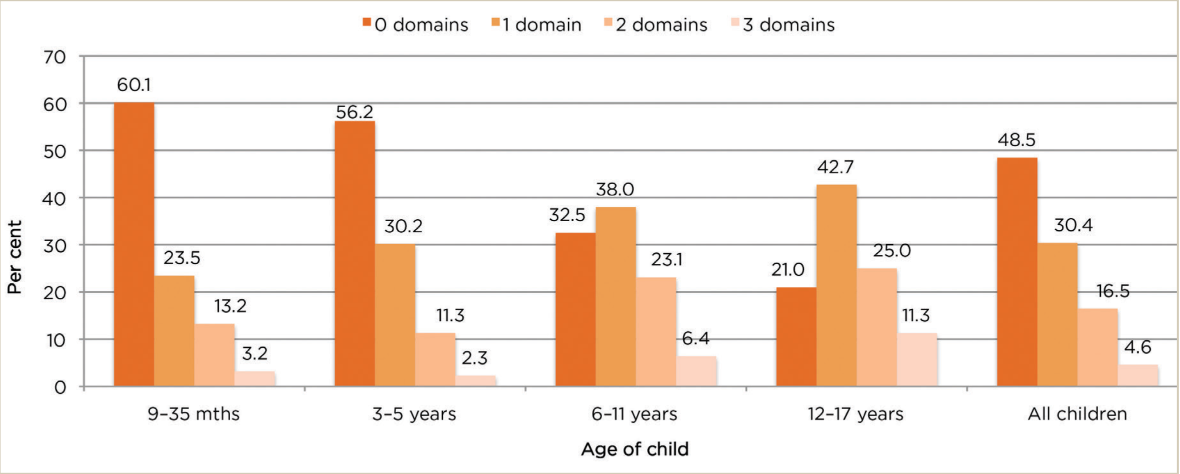
[19] The following variables were used to classify whether or not a child showed problems across each of the three domains of wellbeing (physical health, socio-emotional wellbeing and cognitive/learning ability), according to the age of the child. Health: ASQ-3 (atypical development on gross motor or fine motor 9 months–5 years) and at least two long-term diagnosed physical health conditions (6–17 years). Socio-emotional: BITSEA (problem scale cut-off 9–35 months), CBCL (total problem cut-off 3–17 years). Cognitive/learning: ASQ-3 (atypical development on communication or problem solving 9–35 months), PPVT-IV (below normal range 3–17 years), MR (below normal range 6–16 years). See Table 2.6 for a description of the measures used in the POCLS interview to examine children's wellbeing.

Figure 5.8: Proportions of children showing developmental problems across 0 to 3 domains of functioning, by child age



5.5 Summary of key findings

Physical health

- Overall, most children seemed to be progressing well in terms of their general physical health and lifestyle, although a sizable proportion also had a long-term health condition.
- Approximately half were perceived by caregivers to be in 'Excellent' general physical health and a further one third was seen as being in 'Very good' health.
- The great majority of children were judged by caregivers to be neither underweight nor overweight and appeared to be following a healthy diet, with fruit and vegetables consumed at least daily.
- Few (15%) had sustained an injury needing medical attention, most commonly a cut, scrape or bruise.
- On the other hand, half the sample had a health condition or developmental delay, with one fifth having two or more health conditions. 12–17 year olds tended to be faring more poorly, with fewer seen as being in excellent or good health, and a higher proportion having long-term health conditions. They tended to be more injury-prone, and were also more often consuming a less healthy diet.

Socio-emotional wellbeing

- Children were not faring as well on socio-emotional adjustment with the proportions showing high levels of behaviour problems increasing with age from 17% among 12-35 month old children, to 47% among 12-17 year olds.
- Externalising problems (e.g., aggression, hyperactivity) were more common than internalising problems (e.g., anxiety, depression) for those aged over 6 years.
- Among 12-17 year olds, approximately one-fifth showed very low levels of competencies overall.

- Additionally, most caregivers felt that children were progressing very well, and many 6-17 year olds had received an award, prize or trophy for things done well in the past six months.

Cognitive/Language ability

- More than four fifths of children aged 9–66 months were meeting developmental milestones on aspects such as communication, gross and fine motor skills, problem solving and personal-social skills, as reported by caregivers.
- However, approximately one quarter of children aged 9–23 months showed slower than average speech development.
- A sizable minority of the POCLS children aged 6 years and above showed below normal range language skills (27% of 6–11 year olds and 42% of 12–17 year olds).
- On non-verbal intelligence, almost twice as many 6–16 year old children were in the ‘below normal range’ category than would be expected according to norms, although overall, approximately 70% of children were in the normal range on this measure.

5.6 Conclusion

This chapter presented baseline data on the physical health, socio-emotional wellbeing and language/cognitive development of the POCLS children who entered OOHC for the first time. Overall, approximately half (48%) of the study children were not vulnerable across any developmental domains measured, 46% were vulnerable in one or two developmental domains and 5% were vulnerable across all three developmental domains. In terms of their physical health, most children seemed to be progressing well when compared with children in the general population. In the area of socio-emotional wellbeing, the POCLS children showed higher levels of behaviour problems from 3 years of age than usually found in the general population, particularly of the externalising type. This was especially evident among 12–17 year olds. Finally, children aged 9 months to 5 years were generally developing normally in terms of developmental milestones, but there were some signs of slower than average language development. While the majority of children were in the normal range on cognitive abilities and language development, rates of difficulties in these areas were higher among children aged 6 years or older than would be expected by normative comparisons. Children in residential care appeared to be experiencing poorer wellbeing than children in other placement types.

6

Children's childcare and educational experiences

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This chapter explores the childcare and educational experiences of children in OOHC, two important factors that influence wellbeing outcomes. Childcare can vary in quality, amount and type. High quality childcare (reflected in adult-to-child ratios, size of groups, and childcare workers' training and experience) has been associated with more highly developed cognitive and language capacities, as well as more cooperative and less oppositional or aggressive behaviour (National Institute of Child Health and Human Development, 1998, 2000, 2003a). While long hours of childcare have been linked to poorer outcomes among children (National Institute of Child Health and Human Development 1998, 2006), this finding is mainly observed when childcare quality is lower. Indeed, longer hours were found to be associated with better outcomes when quality was high, pointing to the interconnections between quality and quantity (Love et al, 2003). Research on differing types of childcare (e.g., formal, informal, centre based, family day care) shows that formal centre-based care is associated with higher levels of cognitive and language development than informal, home-based care (Harrison & Ungerer, 2002; National Institute of Child Health and Human Development, 2002), although inconsistent findings have been found in relation to child behaviour problems (Harrison & Ungerer, 2002; National Institute of Child Health and Human Development, 2003b). Overall, research confirms that childcare type, quality and quantity can be significant influences on children's development.

School is an important environment for children (Gutman & Feinstein, 2008; Marin & Brown, 2008). School is a place where children learn academic and social skills that will influence many aspects of their wellbeing, development, and later lives (Gilliam &

Gulløv, 2014; Hattie, 2008; Seefeldt, 2005). The poor educational performance of children in OOHC has been a concern, internationally, for a number of decades. In Australia, the limited research to date has found the following issues to be more common for children in OOHC: spending significant time away from school, falling behind academically, behavioural issues, social issues, suspension, expulsion, bullying, early school leaving and leaving without qualifications (CREATE Foundation, 2001, 2004; de Lemos, 1997; NSW Office of the Children's Guardian, 2003 in Townsend 2012). A recent study by Townsend (2012) in NSW found that some children in OOHC were doing well academically; however, the educational outcomes for children in OOHC were significantly poorer than those of students in the general population. This was evident in their literacy and numeracy results during their primary and early high school periods. A key conclusion from this research is that the educational underperformance of children in OOHC cannot be solely attributed to the individual child; a significant proportion of the reasons lie in the ways in which the home, school, and particularly the care and education systems prioritise and support children's education (Townsend, 2012).

The Pathways of Care Longitudinal Study (POCLS) gathered information on children aged 9 months to 5 years on the provision of learning and social activities; and childcare type and quantity. For children aged 6 to 17 years[1], information was collected about their primary and secondary school experiences; caregivers' support for learning; and caregivers' perceptions of the child's school progress and work experience. Children's own perceptions of school life were also obtained. This chapter provides information relevant to the POCLS Key Research Question "*In what ways do the characteristics of the child, carer, home/family and community affect the children's and young people's developmental pathways, and how do these differ from similarly situated children in the general population?*" [2].

6.1 Children's childcare experiences

Types of childcare attended[3]

Figure 6.1 shows that, among 9–35 month olds, 52% attended one or more of the types of childcare about which information was sought, with considerably more children attending a childcare centre (39%) than family day care (10%). More than 90% of 3 year old children attended childcare, most commonly at a childcare centre (60%) or preschool (32%). Among 4–5 year olds, 96% were in some form of childcare, with 53% attending preschool and 47% a childcare centre. Only a small proportion of 4–5 year olds attended family day care. It is not possible to determine the total proportion of POCLS children who were receiving an early childhood education (preschool) program from these data, as we do not know how many children attending a childcare centre that offered this type of program were receiving preschool education.

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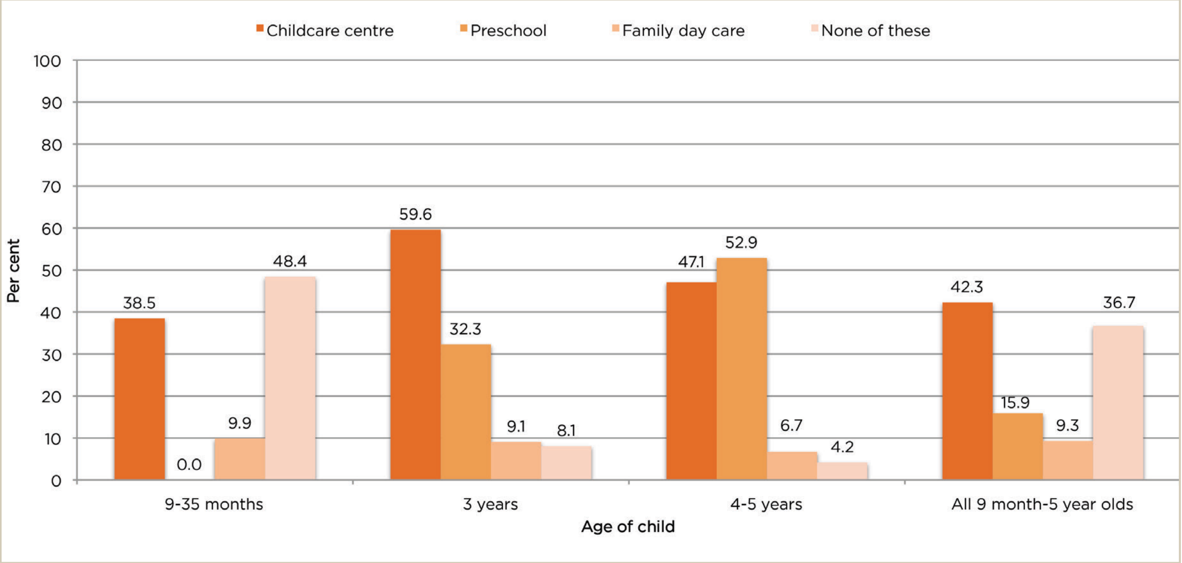
[1] Includes 44 children aged 5 years who were attending school.

[2] Please see Chapter 2 for a description of the data analysis undertaken in this report.

[3] While numbers and percentages are shown for each separate type of childcare, children could have attended more than one type (e.g., at a childcare centre and at family day care); hence there may be some overlap.

Figure 6.1: Caregiver reports of types of child care currently attended by children, by child age[1]



1 n=566 9–35 month olds; n=99 3 year olds; n=119 4–5 year olds; n=787 all 0–5 year olds. Percentages do not add up to 100% because children could have been attending more than one type of childcare.

Comparing these findings to Australian national data collected in 2008 (Australian Bureau of Statistics, 2008), shows that a higher percentage of POCLS children were attending some form of childcare than Australian children in general.[4]

Childcare arrangements appear to be very similar for Aboriginal children and other Australian children (Table 6.1); however, fewer children from culturally diverse backgrounds were attending a childcare centre or preschool. A higher percentage of children from culturally diverse backgrounds (57%) did not attend childcare as compared with all other children (34% of Aboriginal children and 37% of other Australian children).

Table 6.1: Caregiver reports of types of childcare attended for children aged 9 months–5 years, by child's cultural background[1]

Childcare type	Aboriginal		Culturally diverse		Other children	
	n	%	n	%	n	%
Childcare centre	133	44.5	17	28.3	162	42.3
Family day care	28	9.4	5	8.3	35	9.1
Preschool	48	16.1	5	8.3	64	16.7
Did not attend any of these types of childcare	103	34.4	34	56.7	140	36.6
Total	299		60		383	

1 Percentages do not add up to 100% because children could have been attending more than one type of childcare.

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[4] Australian national data collected in 2008 (ABS, 2008) shows that 24% of 0–2 year olds experienced 'long day care' (most likely a childcare centre) and 7% experienced other types of informal care (e.g., family day care, occasional care). Rates for 3–5 year olds in the Australian general population were 26% and 6% respectively.

Attendance at a childcare centre was less common among children in foster care (37%) compared with those in relative/kinship care (48%). Just under a third (30%) of children in relative/kinship care were not attending any of the types of childcare listed compared with just under half (42%) of children in foster care (Table 6.2).

Table 6.2: Caregiver reports of types of childcare attended for children aged 9 month–5 years, by placement type[1]

Childcare type	Foster care		Relative/Kinship care	
	n	%	n	%
Childcare centre	164	37.4	169	48.4
Family day care	40	9.1	33	9.5
Preschool	66	15.1	59	16.9
Did not attend any of these types of childcare	185	42.2	104	29.8
Total	**438**		**349**	

1 Percentages do not add up to 100% because children could have been attending more than one type of childcare.

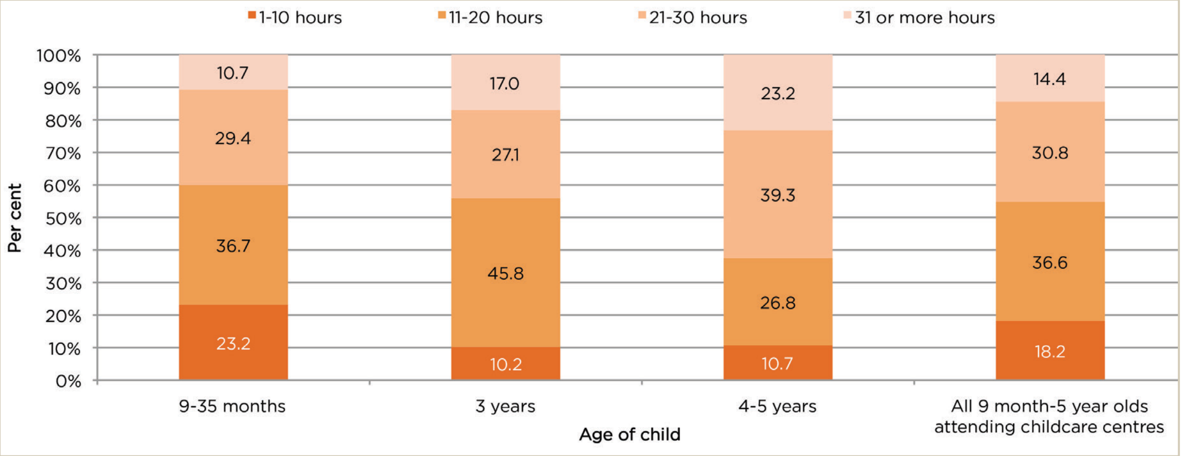
Number of childcare hours per week

Figure 6.2 shows that among the 9–35 month olds and 3 year olds, the most common amount of time spent at a childcare centre was 11–20 hours per week. Among 4–5 year olds, the most common length of time spent in this type of childcare per week was 21–30 hours. The percentage experiencing few hours (i.e., 1–10 hours) was highest among 9–35 month olds (23%) compared with older children (10–11%). Conversely, the percentage experiencing 31 or more hours was progressively higher at each age band.

Figure 6.3 shows the range of hours spent by children of differing ages in family day care. It should be noted that the actual numbers are quite small and therefore trends should be interpreted with caution. Most children in each age group spent between one and 20 hours per week in family day care, with 11–20 hours the most usual.

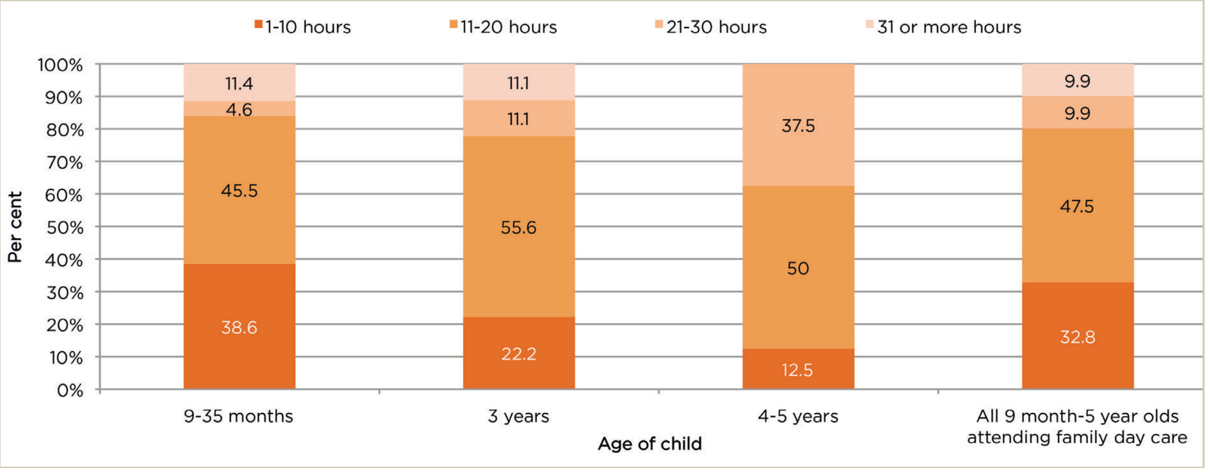
Lastly, with regard to time spent in preschool (not shown), 28% of 3 year olds spent 1–10 hours, 56% spent 11–20 hours, and a further 16% of 3 year olds spent 21–30 hours in preschool. Among 4–5 year olds, 15% spent 1–10 hours in preschool, 48% spent 11–20 hours, 32% spent 21–30 hours, and 5% spent 31 or more hours. Thus, as might be expected, as age increased, so did hours spent in preschool.

Figure 6.2: Caregiver reports of the typical number of hours per week spent at a childcare centre, by child age[1]



1 n=177 9–35 month olds; n=59 3 year olds; n=56 4–5 year olds; n=292 all 9 month–5 year olds.

Figure 6.3: Caregiver reports of the typical number of hours per week spent attending family day care, by child age[1]



1 n=44 9–35 month olds; n=9 3 year olds; n=8 4–5 year olds; n=61 all 9 month–5 year olds.

Table 6.3 suggests that children in foster care tended to spend a smaller number of hours in childcare than children in relative/kinship care. For instance, 63% of children in foster care spent between one and 20 hours per week in a childcare centre compared with 47% of those in relative/kinship care, while 11% of those in foster care spent 31 or more hours per week in this type of care compared with 18% of children in relative/kinship care. Results were similar for family day care and preschool.

Findings on hours spent in childcare for children in differing care arrangements are likely to be slightly biased for the youngest age groups, as there was a higher proportion of 9–35 month old children in foster care (49%) than in relative/kinship care (41%).

Table 6.3: Caregiver reports of the typical number of hours per week spent in differing types of childcare currently attended, by placement type

	Foster care		Relative/Kinship care	
	n	%	n	%
Childcare centre				
1–10 hours	29	19.7	24	16.6
11–20 hours	63	42.9	44	30.3
21–30 hours	39	26.5	51	35.2
31 or more hours	16	10.9	26	17.9
Total	147		145	
Family day care				
1–10 hours	14	40.0	6	23.1
11–20 hours	18	51.4	10	38.5
21–30 hours	2	5.7	4	15.4
31 or more hours	0	0.0	6	23.1
Total	35		26	
Preschool				
1–10 hours	12	19.4	12	21.1
11–20 hours	36	58.1	23	40.4
21–30 hours	12	19.4	19	33.3
31 or more hours	2	3.2	3	5.3
Total	62		57	

6.2 Children aged 9 months to 5 years participation in social and learning activities

Considerable research shows that the home learning environment is an important influence on children’s cognitive and language development (Linver, Brooks-Gunn & Kohen, 2002; National Institute of Child Health and Human Development, 2003b; Yeung, Linver & Brooks-Gunn, 2002). Data from the Longitudinal Study of Australian Children (LSAC) showed that parents’ engagement in activities such as reading to the child, telling the child stories, and doing musical activities together were associated with greater school readiness, as well as social and emotional wellbeing (Smart, Sanson, Baxter, Edwards & Hayes, 2008).

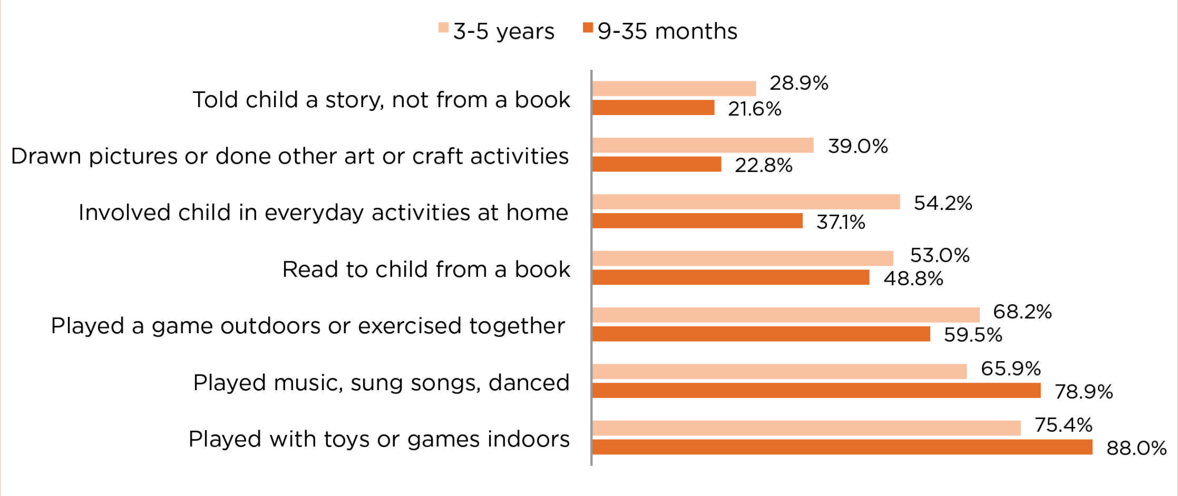
Caregivers reported how many days in the past week they (or someone else in the family) had engaged with the child in a range of activities in the home (Table 6.4). This information was collected in relation to 9–35 month old and 3–5 year old children. The most frequently cited activity was playing with toys or games indoors, with 88% of caregivers of children aged 9–35 months and 75% of caregivers of children aged 3–5 years indicating that this had occurred on six or seven days in the previous week. Playing music, singing songs, or dancing with the child were also common activities, with 79% of 9–35 month olds and 66% of children aged 3–5 years participating in these activities on six or seven days in the past week. Eighty-nine per cent of caregivers of children aged 9–35 months had read to the child from a book on one or more days in the past week, compared with 94% of children aged 3–5 years.

Table 6.4: Caregiver reports of the frequency of activities undertaken at home with child in the past week, by child age[1]

	Not in past week		1–2 days		3–5 days		6–7 days	
	n	%	n	%	n	%	n	%
9–35 months								
Played with toys or games indoors, for example with dolls or toy cars, with the child (n=567)	5	0.9	9	1.6	54	9.5	499	88.0
Played music, sang songs, danced or did other musical activities with the child (n=565)	8	1.4	28	5.0	83	14.7	446	78.9
Played a game outdoors or did exercise together, like walking, swimming, cycling (n=565)	33	5.8	62	11.0	134	23.7	336	59.5
Read to the child from a book (n=565)	61	10.8	89	15.8	139	24.6	276	48.8
Involved the child in everyday activities at home, such as cooking or caring for pets (n=566)	220	38.9	45	8.0	91	16.1	210	37.1
Drew pictures or did other art or craft activities with the child (n=566)	200	35.3	116	20.5	121	21.4	129	22.8
Told the child a story, not from a book (n=566)	247	43.6	96	17.0	101	17.8	122	21.6
3–5 years								
Played with toys or games indoors, for example with dolls or toy cars, with the child (n=264)	16	6.1	9	3.4	40	15.2	199	75.4
Played a game outdoors or did exercise together, like walking, swimming, cycling (n=264)	6	2.3	27	10.2	51	19.3	180	68.2
Played music, sang songs, danced or did other musical activities with the child (n=264)	14	5.3	27	10.2	49	18.6	174	65.9
Involved the child in everyday activities at home, such as cooking or caring for pets (n=264)	42	15.9	25	9.5	54	20.5	143	54.2
Read to the child from a book (n=264)	17	6.4	34	12.9	73	27.7	140	53.0
Drew pictures or did other art or craft activities with the child (N=264)	28	10.6	50	18.9	83	31.4	103	39.0
Told the child a story, not from a book (n=263)	87	33.1	46	17.5	54	20.5	76	28.9

1 Percentages do not add up to 100%, as children could have been involved in multiple activities.

Figure 6.4: Caregiver reports of activities undertaken at home with the child in the past week, by child age[1]



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1 Percentages do not add up to 100%, as children could have been involved in multiple activities.

Comparison of foster and relative/kinship carer reports of the activities undertaken with the child (Table 6.5) showed that foster carers appear to have slightly higher rates of very regularly participating in most activities with the child (i.e., on 6–7 days in the past week). The largest differences appear to be in reading a book to the child on 6–7 days in the past week (56% of foster carers and 43% of relative/kinship carers) and playing with toys or games indoors with the child (89% and 78% respectively).

Table 6.5: Caregiver reports of the frequency of activities undertaken at home with child in the past week, by placement type[1]

	Not in past week		1–2 days		3–5 days		6–7 days	
	n	%	n	%	n	%	n	%
Foster care								
Played with toys or games indoors, for example with dolls or toy cars, with the child (n=459)	7	1.5	3	0.7	41	8.9	408	88.9
Played music, sang songs, danced or did other musical activities with the child (n=458)	11	2.4	31	6.8	66	14.4	350	76.4
Played a game outdoors or did exercise together, like walking, swimming, cycling (n=457)	21	4.6	32	7.0	104	22.8	300	65.6
Read to the child from a book (n=458)	36	7.9	54	11.8	110	24.0	258	56.3
Involved the child in everyday activities at home, such as cooking or caring for pets (n=458)	144	31.4	36	7.9	72	15.7	206	45.0
Drew pictures or did other art or craft activities with the child (n=458)	133	29.9	86	18.8	118	25.8	121	26.4
Told the child a story, not from a book (n=459)	183	39.9	81	17.6	87	19.0	108	23.5
Relative/Kinship care								
Played with toys or games indoors, for example with dolls or toy cars, with the child (n=372)	14	3.8	15	4.0	53	14.2	290	78.0
Played music, sang songs, danced or did other musical activities with the child (n=371)	11	3.0	24	6.5	66	17.8	270	72.8
Played a game outdoors or did exercise together, like walking, swimming, cycling (n=372)	18	4.8	57	15.3	81	21.8	216	58.1
Read to the child from a book (n=371)	42	11.3	69	18.6	102	27.5	158	42.6
Involved the child in everyday activities at home, such as cooking or caring for pets (n=372)	118	31.7	34	9.1	73	19.6	147	39.6
Drew pictures or did other art or craft activities with the child (n=372)	95	25.5	80	21.5	86	23.1	111	29.8
Told the child a story, not from a book (n=370)	151	40.8	61	16.5	68	18.4	90	24.3

[1] Percentages do not add up to 100%, as children could have been involved in multiple activities.

A range of benefits can be gained from children's participation in learning, social or cultural activities external to the caregiving home. These activities can foster children's intellectual, emotional and creative development, and build persistence and self esteem (Crnéc et al, 2006). The experiences gained may be broadening and enhance children's understanding of their world. Increased opportunities to interact with peers and other adults can also enrich children's communication and social skills (Ladd, 2005).

Information on the activities children took part in outside the home was collected from caregivers of children aged 9 months to 5 years old (Table 6.6). The most common activity was attending playgroup, with 26% of all caregivers of children aged 9 months to 5 years indicating that the children had participated in this activity. A higher percentage of children aged 9–35 months (31%) attended playgroup than older children (17% of 3 year olds and 18% of children aged 4–5 years). This is likely to be attributable to the age of the child and the fact that older children tended to be attending preschool. One quarter of caregivers reported that children attended a different type of organised play or other activity type to those specified in the survey (e.g., going to church or Sunday school, and physical activities such as dancing, swimming or gymnastics). Fewer than 10% of children had attended the other types of activities listed in Table 6.6 and, overall, approximately half (53%) had not been involved in any of the activities. There was a modest but consistent trend for children in foster care to have higher rates of participation in out-of-home and within-home activities than those in relative/ kinship care.

Table 6.6: Caregiver reports of children's current participation in activities outside of the home, by child age[1]

	9–35 months		3 years		4–5 years		All 9 month–5 year olds	
	n	%	n	%	n	%	n	%
Playgroup	136	30.6	17	17.2	21	17.6	174	26.2
Library story time or other reading program	40	9.0	7	7.1	13	10.9	60	9.0
Parent and child lessons or programs[2]	20	4.5	2	2.0	4	3.4	26	3.9
Toy library	16	3.6	4	4.0	7	5.9	27	4.1
Other organised play or group activity (specify)[2]	109	24.5	27	27.3	31	26.1	167	25.2
None of these	224	50.3	59	59.6	66	55.5	352	53.1
Total	**445**		**99**		**119**		**663**	

1 Column percentages do not add up to 100%, as children could have participated in multiple activities.
2 As the categories 'parent and child lessons or programs' and 'other organised play or group activity' are similar, there may be some overlap in the percentages reported as engaging in these activities.

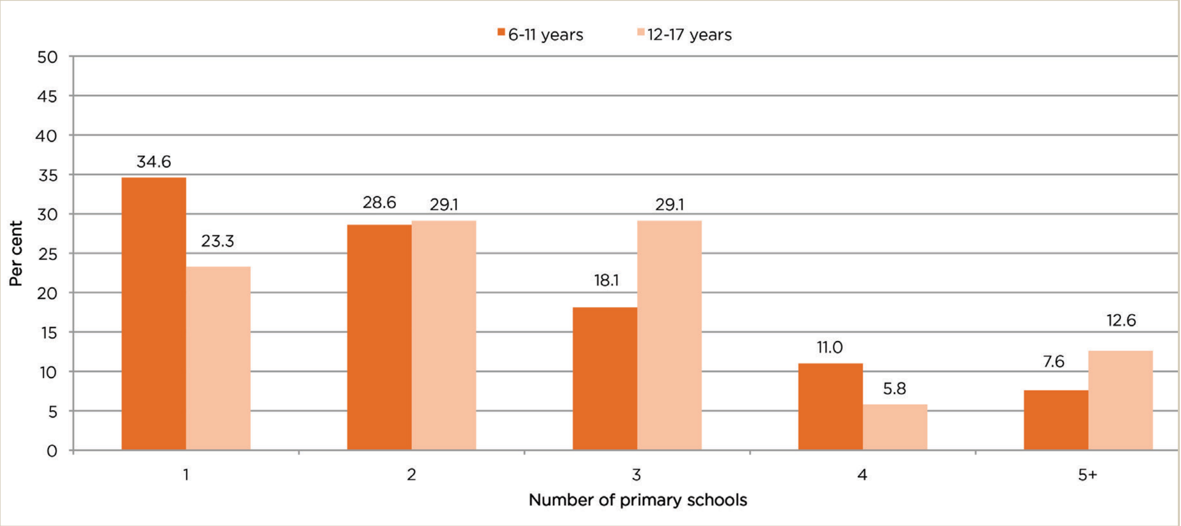
6.3 Children's primary and secondary school experiences

Number of schools attended

Figure 6.5 shows that at the time of the Wave 1 interview, approximately two thirds of 6–11 year olds[5] had experienced at least one change of primary school during their school careers, as had three quarters of 12–17 year olds. Almost one fifth of all children had attended more than three primary schools by the time of the Wave 1 interview. It should be noted that caregivers may not be aware of any school changes prior to placement with them, so these figures may underestimate the total number of schools attended throughout the child's school life.

Figure 6.6 shows the number of secondary schools attended by 12–17 year olds during their school life. The majority (52%) had experienced one or more changes of secondary school, with approximately one fifth having attended three or more secondary schools.

Figure 6.5: Caregiver reports of the number of primary schools attended, by child age[1]



[1] n=353 6–11 year olds; n=103 12–17 year olds. The 6–11 year group includes a small proportion of 5 year olds for whom data was provided (see body of report for the explanation).

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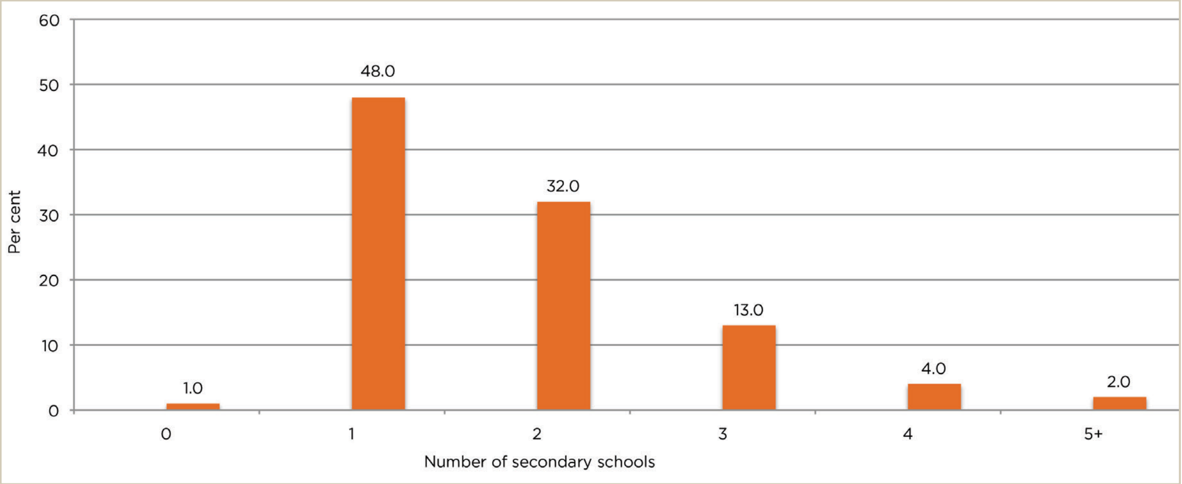
[5] A total of 313 children aged 6–11 years were attending school at the time of the Wave 1 interview. There were also 44 children aged 5 years (16% of 5 year olds in the POCLS) who were attending school. In the next section, the 6–11 year old group includes all 6–11 year olds who were attending school and the small percentage of 5 year olds who were also attending school. For reader ease, the group is still described as 6–11 years.

Figure 6.6: Caregiver reports of the number of secondary schools attended by 12–17 year olds[1,2]



1 n=100 12–17 year olds.
2 Zero means no secondary school attended.

As shown in Table 6.7, over half (56%) of 6–11 year olds and two thirds (66%) of 12–17 year olds had changed schools when first placed with the current caregiving family. Some children had changed schools since coming to live with the caregiving family (8% of 6–11 year olds and 22% of 12–17 year olds). Reasons for changing schools since being placed included: being out of the area, moving from primary to secondary school, peer issues and child behavioural issues.

Eleven per cent of 6–11 year olds and 13% of 12–17 year olds were reported to have repeated a grade during their school life (again, this may be an underestimate, since caregivers may not have knowledge about the child repeating grades prior to the child coming into their care). This is higher than the rate reported by the Organisation for Economic Co-operation and Development (OECD) (2013)[6]. However, as the OECD and the POCLS data are not equivalent (e.g., the age spans differ), this comparison should be interpreted with caution.

Type of school attended

As shown in Table 6.7, most children were currently attending a government school (90% of 6–11 year olds and 75% of 12–17 year olds). The more diverse schooling arrangements for children aged 12–17 years included home schooling (2%), distance education (2%), attendance of a different type of school (3%; e.g., a special school), as well as attendance at a non-government school (13%). Very few children were not currently attending school (less than 1% of 6–11 year olds and 9% of 12–17 year olds).

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[6] Research conducted in 2012 revealed that the proportion of Australian 15 year olds who had repeated a grade at some stage in their school life was 8.5%.

Children's education plans

As shown in Table 6.7, approximately one quarter of caregivers of 6–11 year olds and 30% of caregivers of 12–17 year olds reported that an OOHC education plan was in place for the child (8% of carers of 6–11 year olds and 11% of carers of 12–17 year olds did not know whether a plan had been developed). About one third of children were reported by caregivers to receive some type of special education or remedial services at school or attend a special school. A smaller proportion (16% of 6–11 year olds and 26% of 12–17 year olds) were receiving additional help or tutoring from someone outside the household, with this most commonly occurring once a week. The majority of children (63%) in residential care appear to have an OOHC education plan; however, the sample size was small.

Child absences from school

As shown in Table 6.7, approximately two thirds of 6–11 year olds had not missed any days from school in the previous month. However, fewer 12–17 year olds had not been absent (48%). The most common number of days missed by children was 1–2 days, although approximately one fifth of the older group had been absent on more days. The most common reasons for school absence reported by caregivers of 6–11 year olds were illness (62%) and appointments (17%), with only a small number reported to be absent because they had been suspended or expelled (6%). Similarly, the most frequent reason for school absence among 12–17 year olds was illness (41%) and appointments (29%), with 15% being absent because they had been suspended or expelled.

Table 6.7: Caregiver reports of schooling history, by child age

	6–11 years[1]		12–17 years	
	n	%	n	%
Child has repeated a grade	34	10.7	14	13.0
Total	318		108	
Current grade in school				
Kindergarten	32	9.9	0	0.0
Year 1–3	179	55.2	0	0.0
Year 4–6	112	34.6	12	10.6
Year 7–9	1	0.3	78	69.0
Year 10–12	0	0.0	23	20.4
Total	324		113	
Child changed schools when first placed with family	207	56.4	76	66.1
Total	367		115	
Child changed schools since placed with family	29	7.8	26	22.4
Total	370		116	
Reason for school change since placement				
School out of area	18	60.0	10	38.5
To change peer group	0	0.0	1	3.8
Other	12	40.0	15	57.7
Total	30		26	
Type of school currently attended				
A government school	335	90.1	90	75.0
Non-government or private school	30	8.1	15	12.5
Home schooled	0	0.0	2	1.7
Distance education	0	0.0	2	1.7
Other school[2]	5	1.3	4	3.3
Not attending school	2	0.5	11	9.2
Total	372		120	
Services received				
Child has OOHC education plan	90	26.4	31	30.1
Total	341		103	
Child receives special services at school[3]	114	34.7	43	35.3
Total	329		122	
Child has additional tutoring from outside the household	24	16.0	24	25.5
Total	150		94	
More than weekly	8	33.3	8	33.3
Once a week	14	58.3	14	58.3
Less than weekly	2	8.3	2	8.3
Total	24		24	

	6–11 years[1]		12–17 years	
	n	%	n	%
Days absent in past month				
None	94	63.9	54	47.8
1–2 days	40	27.2	36	31.9
3–5 days	11	7.5	10	8.8
6–10 days	2	1.4	4	3.5
More than 10 days	0	0.0	9	8.0
Total	**147**		**113**	
Reasons for absence[4]				
Unwell	33	62.3	24	40.7
Appointments	9	17.0	17	28.8
Suspended or expelled	3	5.7	9	15.3
Other reasons for absence	10	18.9	19	32.2
Total	**53**		**59**	

1 Includes a small number of 5 year olds who were attending school and excludes 6 year olds who were not attending school.
2 Includes behavioural school and special needs school.
3 Includes special education, remedial services, special class or special school.
4 Percentages do not add up to 100%, as children may have been absent for multiple reasons.

A number of school-related differences were evident between children in foster care and relative/kinship care (Table 6.8). Those in foster care were more likely to have repeated a grade; to have changed schools when placed with the caregiving family and after being placed; to have an education plan in place; and to be receiving special services at school or out-of-home tutoring than those in relative/kinship care.

Children in residential care differed from children in other placement types in several aspects. They had more often changed schools since being placed in residential care, and they were more likely to be receiving special education or remedial services at school or attending a special school. The majority (63%) were reported to have an OOHC education plan in place by comparison with a minority of children in other placement types. Additionally, a higher proportion of those in residential care were not attending school (27% compared with 5–6%). However, as the sample size was frequently less than 20, other results for this sub-group are not discussed.

Table 6.8: Caregiver reports of schooling history, by placement type

	Foster care		Relative/ Kinship care		Residential care[1]	
	n	%	n	%	n	%
Number of primary schools attended						
0	10	4.7	8	3.3	0	-
1	52	24.4	88	36.2	6	-
2	56	26.3	72	29.6	3	-
3	53	24.9	38	15.6	3	-
4	24	11.3	19	7.8	2	-
5 or more	18	8.5	18	7.4	4	-
Total	213		243		18	
Number of secondary schools attended						
0	5	13.2	4	7.8	1	-
1	15	39.5	27	52.9	7	-
2	12	31.6	13	25.5	7	-
3	3	7.9	4	7.8	6	-
4	2	5.3	2	3.9	0	-
5 or more	1	2.6	1	2.0	0	-
Total	38		51		21	-
Repeated a grade	26	13.5	20	9.3	2	-
Total	192		215		19	
Current grade in school						
Kindergarten	14	7.1	18	8.1	0	-
Year 1–3	86	43.4	93	42.1	0	-
Year 4–6	61	30.8	62	28.1	1	-
Year 7–9	28	14.1	41	18.6	9	-
Year 10–12	9	4.5	7	3.2	7	-
Total	198		221		17	
Child changed schools when placed with family/facility	139	62.9	131	53.7	13	65.0
Total	221		244		20	
Child changed schools since placed with family/facility	28	12.6	21	8.6	6	28.6
Total	223		245		21	
Reason for school change since placement						
School out of area	19	65.5	7	33.3	2	-
To change peer group	0	0.0	1	4.8	0	-
Other	10	34.5	13	61.9	4	-
Total	29		21		6	-
Current type of school						
Government school	196	83.4	218	83.8	14	53.9
Non-government or private school	21	8.9	23	8.8	1	3.9
Home schooled	0	0.0	2	0.8	0	0.0

	Foster care		Relative/ Kinship care		Residential care[1]	
	n	%	n	%	n	%
Distance education	1	0.4	0	0.0	1	3.9
Other school[2]	5	2.1	1	0.4	3	11.5
Not attending school	12	5.1	16	6.2	7	26.9
Total	**235**		**260**		**26**	
Services received						
Child has OOHC education plan	72	35.1	39	17.4	10	62.5
Total	**205**		**224**		**16**	
Child receives special services at school[3]	84	39.8	59	26.3	14	53.8
Total	**211**		**224**		**26**	
Child has additional tutoring from outside the household	23	21.7	22	15.9	3	15.0
Total	**106**		**138**		**20**	
More than once a week	11	47.8	4	18.2	1	-
Once a week	12	52.2	15	68.2	1	-
Less than once a week	0	0.0	3	2.2	1	-
Total	**23**		**22**		**3**	
Days absent in past month						
None	61	58.1	78	57.4	9	-
1–2 days	29	27.6	45	33.1	2	-
3–5 days	12	11.4	8	5.9	1	-
6–10 days	2	1.9	4	2.9	0	-
More than 10 days	1	1.0	1	0.7	7	-
Total	**105**		**136**		**19**	
Reasons for absence[4]						
Unwell	23	52.3	27	46.6	3	-
Appointments	11	25.0	14	24.1	1	-
Suspended or expelled	4	9.1	5	8.6	3	-
Other (specify)	8	18.2	15	25.9	6	-
Total	**44**		**58**		**10**	

1 When the n is less than 20, percentages are not provided, and these trends are not discussed further.

2 Includes behavioural school and special needs school.

3 Includes special education, remedial services, special class or special school.

4 Percentages do not add up to 100%, as children may have been absent for multiple reasons.

Caregivers' involvement in and perceptions of children's school life

Table 6.9 suggests that most of the current caregivers or other adults in the household had a high degree of involvement in the child's schooling. For example, more than 90% reported that they (or another adult in the household) had talked with the child's teacher, year coordinator or school principal about the child since the child came to live with them. Most caregivers of 6–11 year olds had attended an event in which the child had participated (85%), although fewer caregivers of 12–17 year olds had done so (55%), perhaps because of more limited opportunities. The majority of caregivers (83% for 6–11 year olds; 76% for 12–17 year olds) had attended a parent-teacher meeting; however, fewer caregivers (47% for 6–11 year olds; 44% for 12–17 year olds) had attended an education planning meeting regarding the child. Close to one half of caregivers (42% for 6–11 year olds; 50% for 12–17 year olds) had contacted a school counsellor about the child or young person.

More caregivers of 6–11 year olds reported helping children with homework on a daily basis (55%) than caregivers of 12–17 year olds (24%). Approximately one third of caregivers of 6–11 year olds were concerned about how the child was learning preschool and school skills, with 23% reporting that they were definitely concerned, while another 14% reported that they were a little concerned (this question was not asked of caregivers of 12–17 year old children). Additionally, caregivers of 36% of 6–11 year olds and 56% of 12–17 year olds felt that the child was experiencing academic or other problems at school. A higher percentage of 12–17 year olds had found it difficult to settle into their new school (43%) by comparison with 6–11 year olds (30%).

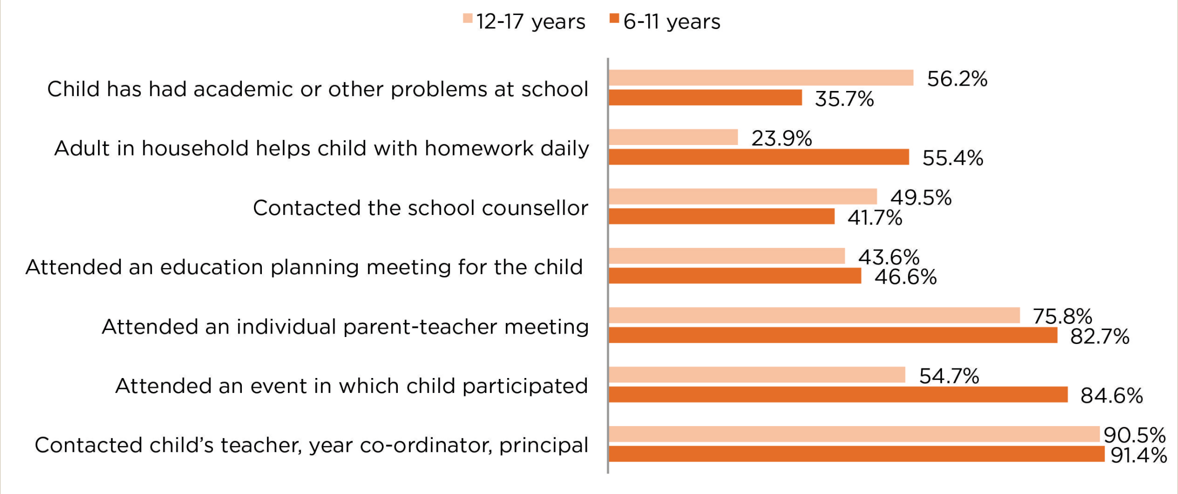
Table 6.9: Caregiver reports of their involvement in the child's learning, by child age

	6–11 years[1]		12–17 years	
	n	%	n	%
Carer school contact[2]				
Contacted the child's teacher, year coordinator, principal	338	91.4	86	90.5
Attended an event in which the child participated (e.g., sporting event, musical performance)	313	84.6	52	54.7
Attended an individual parent-teacher meeting	306	82.7	72	75.8
Attended an education planning meeting for the child	172	46.6	41	43.6
Contacted the school counsellor	154	41.7	47	49.5
Total	**369–375**		**94–95**	
Adult in household helps the child with homework				
Daily	82	55.4	22	23.9
A few times a week	34	23.0	15	16.3
Once a week	10	6.8	14	15.2
A few times a month	7	4.7	13	14.1
Less often	15	10.1	28	30.4
Total	**148**		**92**	
The child had difficulty settling into the new school	40	29.6	28	43.1
Total	**135**		**65**	
The carer has concerns about how the child is learning preschool or school skills				
Yes	85	23.0	-	-
A little	50	13.5	-	-
No	235	63.5	-	-
Total	**370**		**-**	
The child has had academic or other problems at school	117	35.7	68	56.2
Total	**328**		**121**	

1 Includes a small number of 5 year olds who were attending school and excludes 6 year olds who were not attending school.

2 Percentages do not add up to 100%, as caregivers may have had multiple types of contact.

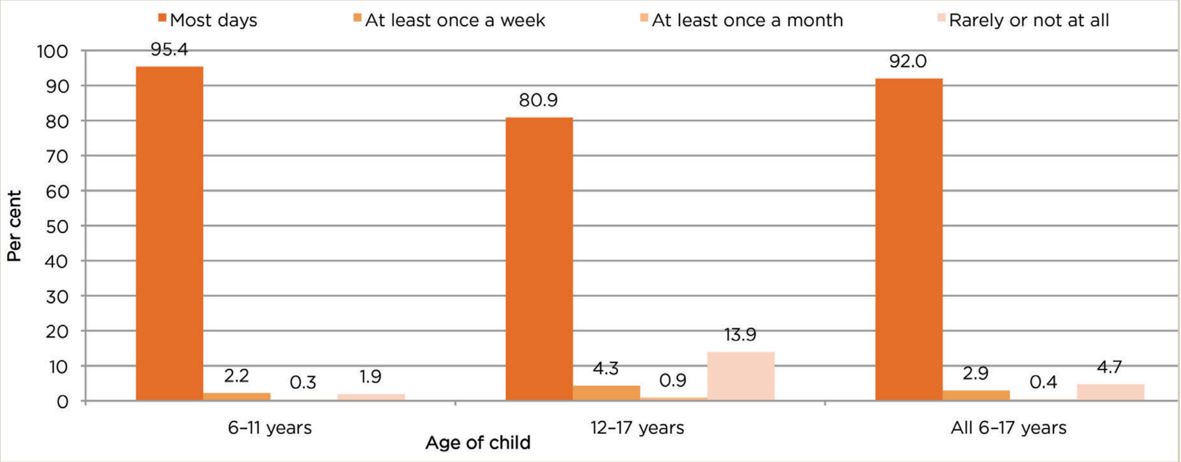
Figure 6.7: Caregiver reports of their involvement in child's learning, by child age [1,2]



1 The 6–11 year age group includes a small number of 5 year olds who were attending school and excludes 6 year olds who were not attending school.
2 Percentages do not add up to 100%, as caregivers may have had multiple types of contact.

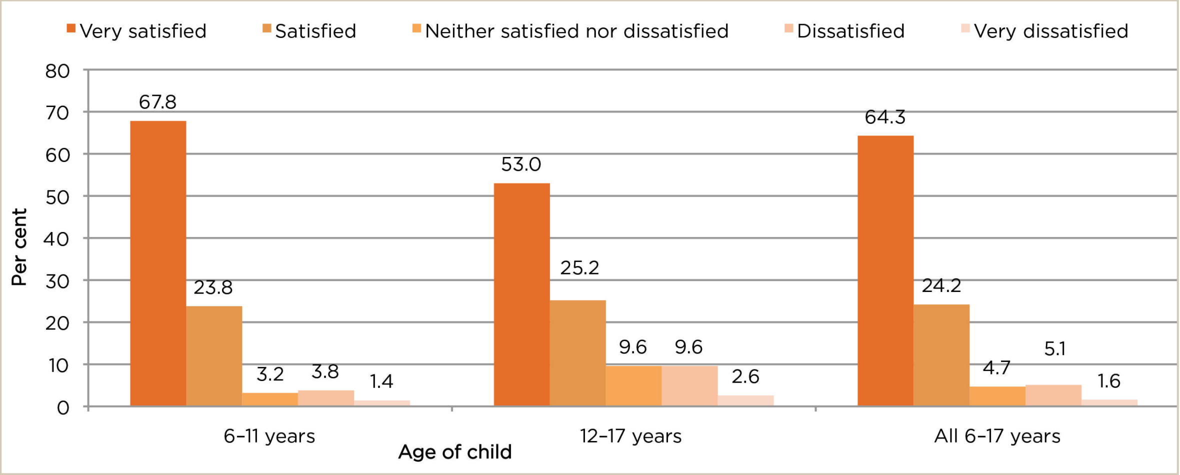
According to caregivers, almost all 6–11 year olds looked forward to going to school on most days, as did four fifths of 12–17 year olds (Figure 6.8). Only 2% of 6–11 year olds rarely or never looked forward to going to school, although 14% of 12–17 year olds did so. Approximately 90% of caregivers were 'very satisfied' or 'satisfied' that the school was meeting the child or young person's needs (Figure 6.9).

Figure 6.8: Caregiver reports of the percentage of children who look forward to going to school, by child age[1]



1 n=368 6–11 year olds; n=115 12–17 year olds; n=483 all children. The 6–11 year group includes a small proportion of 5 year olds for whom data was provided (see body of report for the explanation).

Figure 6.9: Caregiver reports of satisfaction with the current school meeting child's needs, by child age[1]



[1] n=370 6–11 year olds; n=115 12–17 year olds; n=485 all children and young people. The 6–11 year group includes a small proportion of 5 year olds for whom data was provided (see body of report for the explanation).

Differences between children in foster or relative/kinship care are shown in Table 6.10, as well as residential care where applicable. Foster carers and residential care workers appear to be more likely than relative/kinship carers to have contacted the child's teacher, year coordinator or school principal (although overall, rates of contact were high). Similarly, more foster carers and fewer relative/kinship carers had attended an education planning meeting regarding the child. Most residential care workers had attended an education planning meeting. A higher percentage of relative/kinship carers were 'very satisfied' that the school was meeting the child's needs than foster carers, and fewer had concerns about the child's learning or felt that the child or young person was experiencing academic or other problems at school. Residential care workers less often reported that children looked forward to going to school most days or believed that schools were meeting children's needs.

Table 6.10: Caregiver reports of support for child's learning, and perceptions of the child's learning progress, by placement type

	Foster care		Relative/ Kinship care		Residential care	
	n	%	n	%	n	%
Carer school contact						
Contacted the child's teacher, year coordinator or principal	209	93.7	216	88.2	19	95.0
Attended an individual parent-teacher meeting	186	83.4	193	78.8	15	75.0
Attended an event in which the child participated (e.g., sporting event, musical performance)	174	78.0	192	78.4	14	70.0
Attended an education planning meeting for the child	121	55.3	93	38.1	19	95.0
Contacted the school counsellor	89	40.1	113	46.1	9	45.0
Total	219–223		235–245		20	
Adult in household helps the child with homework						
Daily	45	42.9	59	43.7	4	-
A few times a week	19	18.1	30	22.2	8	-
Once a week	12	11.4	12	8.9	-	-
A few times a month	6	5.7	14	10.4	1	-
Less often	23	21.9	20	14.8	6	-
Total	105		135		19	
The child had difficulty settling into the new school	31	30.7	27	32.1	10	-
Total	101		84		15	
The child looks forward to school						
Most days	206	92.8	231	94.7	10	50.0
At least once a week	6	2.7	6	2.5	2	10.0
At least once a month	1	0.5	-	-	1	5.0
Rarely or not at all	9	4.1	7	2.9	7	35.0
Total	222		244		20	
School is meeting the child's needs						
Very satisfied	136	61.0	168	68.6	10	50.0
Satisfied	60	26.9	55	22.4	3	15.0
Neither satisfied nor dissatisfied	8	3.6	14	5.7	1	5.0
Dissatisfied	15	6.7	5	2.0	5	25.0
Very dissatisfied	4	1.8	3	1.2	1	5.0
Total	223		245		20	
Carer has concerns about how the child is learning preschool or school skills[1]						
Yes	69	23.9	40	13.6	-	-
A little	34	11.8	36	12.2	-	-
No	186	64.4	218	74.1	-	-

	Foster care		Relative/ Kinship care		Residential care	
	n	%	n	%	n	%
Total	289		294		-	
Child has had academic or other problems at school	94	47.0	70	31.3	21	84.0
Total	200		224		25	

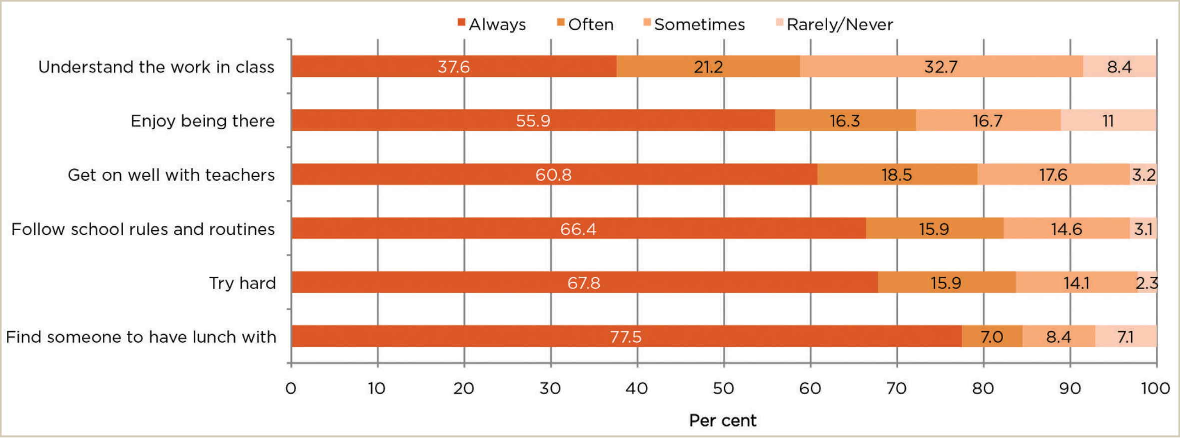
1 Question asked to caregivers of children aged 3–11 years only.

Children's perceptions of school life

Children aged 7–17 years who were currently attending school were asked their perceptions of school life, in relation to managing the work, following school rules/ routines, and their social relationships[7]. The 12–17 year old group was asked several additional questions to capture issues that are more salient in secondary than primary school.

In all aspects of school life, children aged 7–11 years did not appear to be experiencing difficulties (i.e., most answered 'always' or 'often' on the various aspects). The exception was 'understanding the work in class' where 41% said they 'rarely/never' or only 'sometimes' did so. Regarding the social aspects of school life, 85% of children were 'always' or 'often' able to find someone to have lunch with, 79% of children were 'always' or 'often' getting on well with their teachers, and 72% reported that they 'always' or 'often' enjoyed being at school (see Figure 6.10).

Figure 6.10: Child reports on aspects of school life for children aged 7–11 years[1]



1 n=226–227 over the various aspects.

Looking next at 12–17 year olds, in relation to academic aspects of school life, 36% said they 'rarely/never' or only 'sometimes' understood the work in class and 48% said they 'rarely/never' or only 'sometimes' completed assignments, projects and homework on time. However, in relation to motivational aspects, 76% reported that

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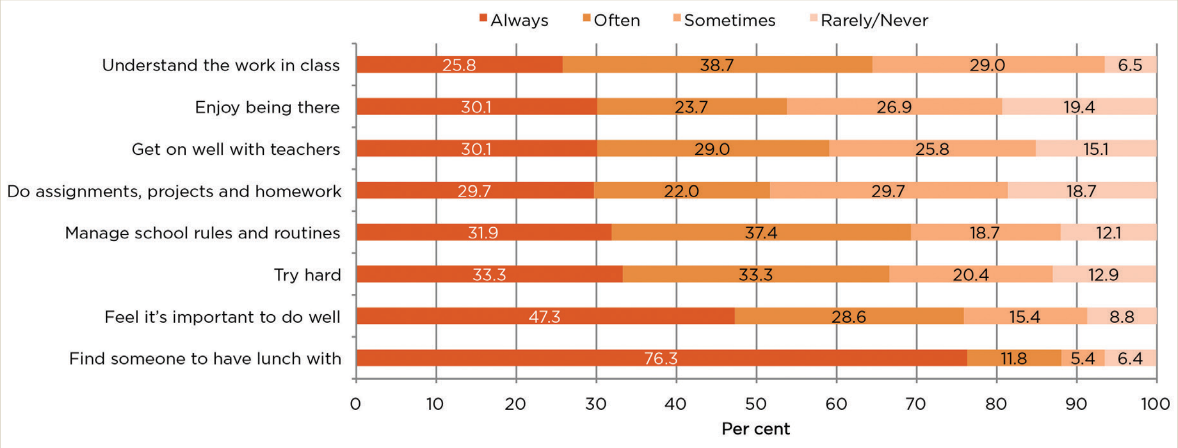
[7] Interviews were offered to children aged 7 years and older. Thus, for this section, the age bands are 7–11 years and 12–17 years.

they 'always' or 'often' believed it was important to do well and 67% reported that they 'always' or 'often' felt they tried hard. Regarding social aspects of school life, while 88% of children aged 12–17 years felt they were 'always' or 'often' able to find someone to have lunch with, only 59% reported that they 'always' or 'often' got on well with teachers, and only 54% reported that they 'always' or 'often' enjoyed being at school (Figure 6.11). Thus, a substantial minority appeared to be experiencing difficulties at school.

Figure 6.11: Child reports on aspects of school life for children aged 12–17 years[1]



[1] n=91–93 over the various aspects.

6.4 Children aged 14–17 years work experiences

As the study progresses, and children grow up, we will learn more about young people's participation in paid work. However, in Wave 1, only 10 of 67 children aged 14–17 years were in paid work (e.g., at a supermarket, restaurant, shop) and one young person was earning an income from odd jobs (e.g., baby sitting, mowing lawns, delivering flyers), as reported by caregivers. Hours of work ranged from one hour per week to 38 hours, with roughly equal numbers working fewer than 10 hours, 11–20 hours or 21–38 hours. Caregivers were asked how these children were getting on at work, with 80% perceiving that the children were 'always' or 'often' getting on well with supervisors and workmates, working hard and doing well (however, as noted, numbers are very small and therefore are indicative only).

6.5 Summary of key findings

Childcare

- Approximately half of 9–35 month old children were attending some form of childcare, as were more than 90% of 3 year olds and 96% of 4–5 year olds. This was most often at a childcare centre, except at 4–5 years, when preschool was the most frequent type.

- The most common amount of time spent across all types of childcare was 2–3 days for 0–3 year olds (i.e., 11–20 hours per week) and 3–4 days for 4–5 year olds (i.e., 21–30 hours per week).
- Children in foster care were less likely to be attending any type of childcare, and when in childcare tended to spend fewer hours there.

Out–of–home and within–home learning and social activities

- Approximately three quarters of children aged 9 months to 5 years had very frequently (i.e., on most days per week) taken part in a range of within–home activities (including playing with toys or games indoors, playing music, singing songs and dancing) with their caregivers or other adults in the household.
- Almost all caregivers had read to the child on at least one day in the past week.
- Just under half of 9 month to 5 year old children had participated in activities outside of the home. About one quarter had attended playgroup, while fewer than 10% had attended the other activities listed (e.g., library story time/other reading program).
- Foster carers were slightly more likely to engage in out–of–home and within–home activities with children than relative/kinship carers.

School

- Most POCLS children had experienced some disruptions in schooling, with two thirds of 6–11 year olds[8] and three quarters of 12–17 year olds reported by caregivers to have experienced one or more primary school changes during their school life. (As caregivers may not have full details of the child's change of schools prior to their placement, this may be an underestimate.)
- More than half (56%) of 6–11 year olds and two thirds of 12–17 year olds had changed schools upon being placed, and 8% and 22% respectively had changed schools since being placed.
- Approximately one fifth of all children had attended more than three primary schools in their lives and one fifth of 12–17 year olds had attended three or more secondary schools.
- Almost all 6–11 year olds were currently going to school, although 9% of 12–17 year olds were not.
- Just over a quarter of children were reported to have an OOHC education plan (26% of 6–11 year olds and 30% of 12–17 year olds), although around one in 10 caregivers did not know if an OOHC education plan had been developed. Children in foster care were more likely to have an education plan in place than those in relative/kinship care.
- The great majority of caregivers reported being involved in their child's schooling, including talking with school personnel about the child, attending a parent-teacher meeting or an event in which the child had participated, attending an education

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[8] The 6–11 year old group also includes a small number of 5 year olds who were attending school (they comprised 16% of the 5 year olds in the cohort).

planning meeting about the child or contacting a school counsellor. Residential care workers and foster carers had more often than relative/kinship carers been in contact with the school about the child.

- 11% of 6–11 year olds and 13% of 12–17 year olds had repeated a grade at some stage, and slightly more than one third were currently receiving special education or remedial services at school, or attended a special school.
- Approximately one third of caregivers of 6–11 year olds were concerned about the child's learning development, and caregivers of just over one third of 6–11 year olds and 56% of 12–17 year olds felt that the child was experiencing academic or other problems at school.
- Almost all caregivers of 6–11 year olds believed children looked forward to going to school, as did four fifths of caregivers of 12–17 year olds. Most caregivers were 'very satisfied' or 'satisfied' that schools were meeting children's needs.
- While a large majority of 7–11 year olds had positive views about school regarding most of the aspects covered[9], a sizeable minority of 12–17 year olds seemed to be experiencing difficulties (such as learning and motivational aspects, getting on with teachers, enjoying being at school) based on their own self reports.

Work experience

- 10 of 67 children age 14–17 years were in paid work, and one young person was earning an income from odd jobs, as reported by caregivers. Types of paid work included sales or hospitality. Caregivers reported that these children were getting on well with supervisors and workmates, working hard and doing well.

6.6 Conclusion

Many POCLS children who were not yet of school age attended some form of childcare, most commonly at a childcare centre (except at 4–5 years, when preschool was more common). School age children frequently had to change schools when they entered care. For many, this was an additional change to the school changes already experienced. Approximately one tenth had repeated a school grade at some stage, while approximately one third was receiving special services or remedial help at school. Just over one quarter of caregivers reported that the child had an OOHC education plan. School absenteeism was relatively common, most frequently due to health reasons. Most caregivers were monitoring and supporting their child's school progress. A sizable minority was concerned about the child's learning progress and felt that the child was experiencing problems at school. On the other hand, most caregivers believed that children looked forward to going to school and felt that schools were meeting children's needs. Most 7–11 year olds had positive perceptions of their school life, but a substantial minority of 12–17 year olds did not. There were several differences between children from key sub–groups (differing ethnic and cultural backgrounds, placement types). In particular, children in residential care, while a very small group overall, seemed to have multiple problems and were faring less well at school.

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[9] The age range for child reports was 7–11 years, not 6–11 years.

7

Caregiver parenting practices and children's relationships

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Children in out-of-home care (OOHC) have two sets of relationships that are likely to have a crucial influence on their adjustment and wellbeing: their relationship with caregivers and with their birth parents and extended families. The quality of these relationships, and also children's relationships with their siblings and with other children living in the caregiver's household, are also very important contributors to children's reported happiness and adjustment as well as the stability of their placement (Buist & Vermande, 2014; Pike, Coldwell & Dunn, 2005; Schofield, Beek & Ward, 2012; Stacks & Partridge, 2011; Volling, 2003). Thus aspects of parenting and children's relationships with carers, birth family, siblings and peers are assessed in the Pathways of Care Longitudinal Study (POCLS).

The data in this chapter describe the current caregiver's and child's perceptions of parenting practices as well as their views on the child's relationships with members of their caregiving family, birth family and peers. The type and frequency of the child's contact with their birth family and other relatives are also explored. This chapter examines elements of the POCLS Key Research Question 8: '*What are the placement characteristics and placement stability of the children and how do these influence their outcomes?*' and Key Research Question 11: '*How does contact between the children in OOHC and their birth parents, siblings, and/or extended family influence their outcomes?*'[1].

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[1] Please see Chapter 2 for a description of the data analysis undertaken in this report.

7.1 Caregiver parenting practices

Caregivers' perceptions

Four key aspects of parenting practices are measured in the POCLS:

- **Warmth** – includes caregivers' affection, emotional availability and involvement for children aged 9 months to 17 years.
- **Hostility** – includes caregivers' punitiveness, physical punishment and anger for children aged 9 months to 17 years.
- **Monitoring** – including caregivers' knowledge and oversight of the child's activities for children aged 10 to 17 years.
- **Self-efficacy in managing difficult behaviour** – includes caregivers' confidence when dealing with challenging behaviours for children aged 2 to 17 years.

Caregivers were asked to report on their own parenting practices across these four aspects in the Wave 1 interview[2]. The set of items comprising the *warmth, hostility, monitoring* and *difficult behaviour self-efficacy* scales were each added up, yielding four total scores (one for each measure).

Overall, caregivers tended to show high levels of warmth, with a mean score across all caregivers of 17.9 (Table 7.1). This is towards the high end of the possible range from four (low warmth) to 20 (high warmth), and suggests that caregivers 'often' to 'almost always' showed warmth in their interactions with the child (as the mean was equivalent to a score between four and five on each item).

Overall, caregivers tended to show low levels of hostility (mean=6.1). This mean score is well below the mid-point of the range from three (low hostility) to 30 (high hostility) and equates to a response of two to each item.

Overall, caregivers tended to show high levels of monitoring of children's activities, with a mean score for caregivers on the monitoring scale of 18.0. The monitoring total score could range from four, indicating low parental monitoring, to 20, indicating high monitoring. This score is consistent with young people's reports where 80% of young people reported that caregivers 'always' or 'often' knew where the young person went when going out (see next section).

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[2] Four scales were selected to measure aspects of parenting for the POCLS:

Warmth Scale captures the degree of warm and positive parenting displayed by caregivers (Paterson & Sanson, 1999). It consists of four items (e.g., how often do you enjoy listening to and doing things with the child), with responses of 1 = 'never/almost never', 2 = 'rarely', 3 = 'sometimes', 4 = 'often', and 5 = 'always/almost always' provided.

Hostility Scale (Institut de la Statistique du Quebec, 2000) captures aspects of harsh parenting/discipline. Caregivers responded to three items (e.g., thinking about the last four weeks, how often have you been angry with the child), with responses ranging from 1 ('not at all') to 10 ('all the time').

Monitoring Scale measures caregivers' level of knowledge of the activities of young people. The scale comprises four items (e.g., how often do you know who [study child] is with when he/she is away from home, i.e., his/her placement). Caregivers could respond 5 = 'always', 4 = 'mostly', 3 = 'sometimes', 2 = 'rarely' or 1 = 'never' for each item.

Difficult Behaviour Self-efficacy Scale (DBSES; Hastings & Brown, 2002), measures caregivers' degree of self-efficacy when dealing with challenging child behaviours by using three of the five items comprising this scale (e.g., how confident are you in dealing with the challenging behaviours of the child), with responses scored from 1–7, where 1 = 'not at all confident' to 7 = 'very confident'.

Overall, caregivers showed high levels of self-efficacy in managing difficult behaviour with a mean score of 17.7 across the range of three (lower levels of self-efficacy) to 21 (higher levels of self-efficacy).

Caregivers differed significantly[3] on reported warmth, according to the age of the children in their care, with caregivers of younger children showing more warmth than caregivers of older children (Table 7.1). Similarly, there were significant differences in reported hostility. Caregivers of the youngest group of children (9–35 months olds) were significantly lower on hostility than caregivers of older age groups. Caregivers of 10–11 year old children showed significantly higher levels of monitoring than caregivers of 12–17 year olds[4]. On self-efficacy in managing difficult behaviour, caregivers of 12–17 year olds showed significantly lower levels than caregivers of those aged 9–35 months and 3–5 years while caregivers of 6–11 year olds showed significantly lower levels than caregivers of those aged 9–35 months.

Table 7.1: Caregiver reports on aspects of their own parenting, by child age

	9-35 months	3-5 years	6-11 years	12-17 years	All ages
	Mean (95% CIs)	**Mean** (95% CIs)	**Mean** (95% CIs)	**Mean** (95% CIs)	**Mean** (95% CIs)
Warmth	18.9 (18.8, 19.0)	18.0 (17.8, 18.3)	16.9 (16.6, 17.2)	15.5 (14.9, 16.0)	17.9 (17.7, 18.0)
Total	567	265	329	124	1,285
Hostility	5.0 (4.7, 5.2)	6.9 (6.4, 7.4)	7.2 (6.7, 7.6)	6.5 (5.9, 7.2)	6.1 (5.9, 6.3)
Total	567	265	328	123	1,283
Monitoring[1]	-		19.0 (18.8, 19.3)	17.2 (16.7, 17.7)	18.0 (17.6, 18.3)
Total	-	-	85	124	209
Difficult Behaviour Self-efficacy Scale[2]	18.4 (18.0, 18.8)	18.0 (17.6, 18.4)	17.4 (17.0, 17.8)	16.7 (16.1, 17.4)	17.7 (17.5, 17.9)
Total	176	265	329	124	894

1 Totals were smaller for the monitoring scale as this was only used with caregivers of children aged 10–17 years.
2 Totals were smaller for the DBSES scale as this was only used with caregivers of children aged 2–17 years.

There was little difference in reported parenting practices between foster carers and relative/kinship carers (Table 7.2). However, residential care workers were significantly lower than both foster carers and relative/kinship carers on warmth, hostility and monitoring. Age differences across placement types may explain much of this difference, as children in residential care tend to be older than those in foster care or relative/kinship care. Additionally, residential care workers may have a different type of relationship with children than foster or relative/kinship carers.

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[3] A non-overlap in confidence intervals indicates that there were significant differences between groups.

[4] The monitoring items were asked only in relation to children aged 10 years and above. Hence the age band here is 10–11 years rather than 6–11 years.

Table 7.2: Caregiver reports on aspects of their own parenting, by placement type

	Foster care		Relative/ Kinship care		Residential care	
	Mean	95% CIs	Mean	95% CIs	Mean	95% CIs
Warmth	17.9	17.7, 18.1	17.9	17.7, 18.2	15.5	14.5, 16.4
Total	661		598		26	
Hostility	6.1	5.8, 6.4	6.1	5.8, 6.4	4.6	3.7, 5.6
Total	661		597		25	
Monitoring[1]	18.4	18.1, 18.8	18.3	17.6, 18.7	15.2	13.9, 16.6
Total	84		99		26	
Difficult Behaviour Self-efficacy Scale[2]	17.6	17.3, 17.9	17.8	17.4, 18.1	17.2	16.1, 18.2
Total	435		433		26	

1 Totals were smaller for the monitoring scale as this was only used with caregivers of children aged 10 to 17 years.

2 Totals were smaller for the DBSES scale as this was only used with caregivers of children aged 2 to 17 years.

Children's perceptions

Overall, children had positive views of their caregivers' parenting with most children aged 7–11 years and children aged 12–17 years reporting that the adult who looked after them 'always' helped them if they had a problem (72%); 'always' listened to them (68–73%); and 'always' praised them for doing well (65–71%). Fewer children said the adults looking after them did things with them that were just for fun (51% of 7–11 years; 46% of 12–17 years) or that caregivers 'always' spent time just talking with them (30% of 7–11 years; 40% of 12–17 years). Generally, there appeared to be little difference in the pattern of responses between children aged 7–11 years and those aged 12–17 years (Tables 7.3 and 7.4).

Approximately three quarters of children aged 12–17 years said that caregivers 'always' or 'often' knew what they did with their free time, whereas only 12% of these children reported that their caregivers 'rarely' or 'never' knew. Similarly, 80% of children aged 12–17 years said caregivers 'always' or 'often' knew where they went when going out, while 13% of caregivers were reported to 'never' or 'rarely' know (Table 7.4).

Table 7.3: Child aged 7–11 years reports on aspects of the caregivers' parenting[1]

	Always		Often		Sometimes		Rarely		Never	
Thinking about the adults who look after you, how often do they:	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Help you if you have a problem (n=226)	163	72.1	31	13.7	27	11.9	3	1.3	2	0.9
Listen to you (n=225)	153	68.0	36	16.0	29	12.9	4	1.8	3	1.3
Praise you for doing well (n=224)	146	65.2	34	15.2	36	16.1	4	1.8	4	1.8
Do things with you that are just for fun (n=226)	116	51.3	44	19.5	50	22.1	10	4.4	6	2.7
Spend time just talking with you (n= 221)	66	29.9	59	26.7	78	35.3	13	5.9	5	2.3

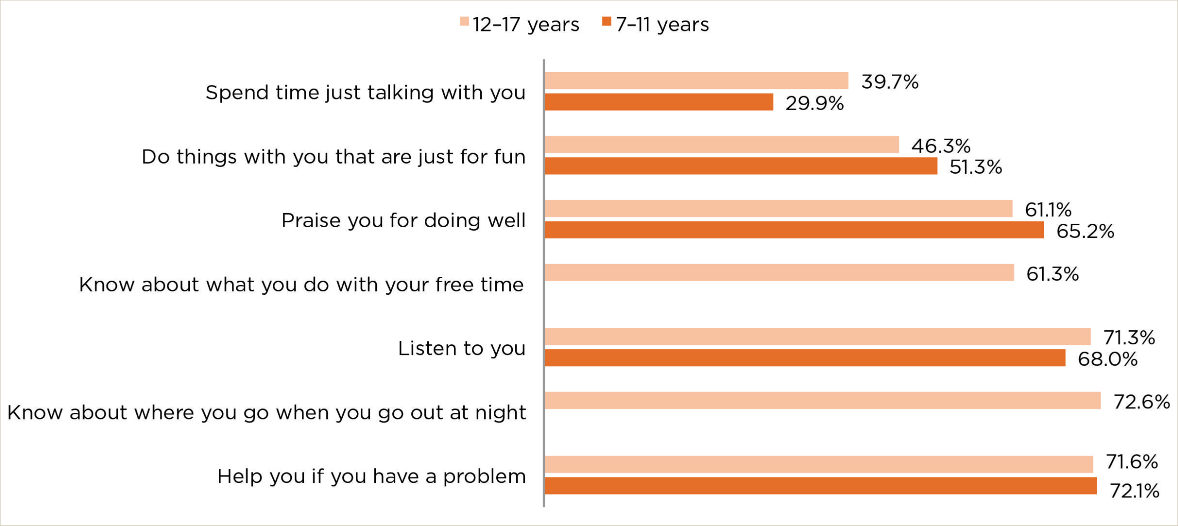
1 Column percentages do not add up to 100%, as adults may do more than one of these things. A small number of children chose not to answer the questions (missing data range: n=3–7).

Table 7.4: Children aged 12–17 years reports on aspects of the caregivers' parenting[1]

	Always		Often		Sometimes		Rarely		Never	
Thinking about the adults who look after you, how often do they:	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Help you if you have a problem (n=95)	68	71.6	17	17.9	5	5.3	5	5.3	0	0.0
Know about where you go when you go out at night (n=84)	61	72.6	6	7.1	6	7.1	3	3.6	8	9.5
Listen to you (n=94)	67	71.3	11	11.7	12	12.8	4	4.3	0	0.0
Know about what you do with your free time (n=93)	57	61.3	13	14.0	12	12.9	2	2.2	9	9.7
Praise you for doing well (n=95)	58	61.1	21	22.1	9	9.5	5	5.3	2	2.1
Do things with you that are just for fun (n=95)	44	46.3	18	18.9	23	24.2	9	9.5	1	1.1
Spend time just talking with you (n=93)	36	39.7	26	28.0	21	22.6	9	9.7	1	1.1

1 Column percentages do not add up to 100%, as adults may do more than one of these things. Some children chose not to answer the questions (missing data range: n=4–15).

Figure 7.1: Children aged 7 to 17 years reports who reported 'always' on aspects of caregivers' parenting, by child age[1]



[1] Percentages do not add up to 100%, as adults may do more than one of these things. Some children chose not to answer the questions (missing data range: n=3–15).

7.2 Children's relationships with members of the caregiving household

Most caregivers (84%) thought they knew the study child 'very well', and a further 15% answered 'fairly well' (Table 7.5)[5]. Only 1% of caregivers reported knowing the study child 'not very well' or 'not at all' well. Caregivers of younger children more often reported that they knew the child well (e.g., 96% of caregivers of children aged 9–35 months) (compared to 61% of caregivers of 12–17 year olds).

The great majority of caregivers reported having either a 'very close' (78%) or 'quite close' (20%) relationship with the study child. There were age variations, with caregivers of younger children more often reporting feeling 'very close' to the child than caregivers of older children. This difference was most evident when comparing caregivers of children aged 9–35 months (95%) with those of children aged 12–17 years (48%).

Similarly, most caregivers reported either a 'very close' (72%) or 'quite close' (23%) relationship between the study child and other children in the household. Caregivers reported that over half of children aged 9 months to 11 years (56% to 90%) had a 'very close' relationship with other children in the household. This contrasts with findings for the oldest age group where caregivers reported just over one-third of 12–17 year olds (35%) had a 'very close' relationship with other children in the household.

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[5] As described in Section 4, the most common length of time the POCLS children had been residing in their current placement at the time of the Wave 1 interview was 12–17 months. The most prevalent length of time children aged 9–35 months had been in their current placement at the Wave 1 interview was 6–11 months (38%) compared with 12–17 year olds which was 18 months or longer (42%).

Table 7.5: Caregiver reports of study child-caregiver household relationships, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
How well carers knew the child										
Very well	545	96.1	222	83.8	242	73.6	76	61.3	1085	84.4
Fairly well	22	3.9	41	15.5	81	24.6	44	35.5	188	14.6
Not very well	0	0.0	2	0.8	5	1.5	3	2.4	10	0.8
Not at all well	0	0.0	0	0.0	1	0.3	1	0.8	2	0.2
Total	567		265		329		124		1,285	
Carer's relationship with the child										
Very close	540	95.2	196	74.2	209	63.9	59	48.0	1004	78.4
Quite close	26	4.6	67	25.4	110	33.6	54	43.9	257	20.1
Not very close	1	0.2	1	0.4	8	2.4	10	8.1	20	1.6
Total	567		264		327		123		1,281	
Child's relationship with other children in household										
Very close	431	90.0	171	71.3	162	56.4	34	35.4	798	72.4
Quite close	47	9.8	61	25.4	102	35.5	42	43.8	252	22.9
Not very close	1	0.2	8	3.3	23	8.0	20	20.8	52	4.7
Total	479		240		287		96		1,102	

[1] Most caregivers interviewed were female (n=790; 91%).

There appear to be some differences across placement type in caregiver-child relationships (Table 7.6). A much higher proportion of relative/kinship carers (82%) and foster carers (76%) reported 'very close' relationships with the study child compared with residential care workers (39%). The same trend was apparent for the study child's relationship with other children in the household or residential facility (76% for relative/kinship care, 71% for foster care and 14% for residential care). This is not surprising given the different placement models. Again, the majority of relative/kinship carers (88%) and foster carers (82%) were more likely to feel that they knew the child 'very well' while fewer residential care workers felt they knew the child 'very well' (62%).

Table 7.6: Caregiver reports of study child-caregiver household relationships, by placement type[1]

	Foster care		Relative/ Kinship care		Residential care	
	n	%	n	%	n	%
How well carers knew the child						
Very well	544	82.3	525	87.8	16	61.5
Fairly well	113	17.1	67	11.2	8	30.8
Not very well	3	0.5	5	0.8	2	7.7
Not at all well	1	0.2	1	0.2	0	0
Total	**661**		**598**		**26**	
Carer's relationship with child						
Very close	502	76.4	492	82.3	10	38.5
Quite close	145	22.1	97	16.2	15	57.7
Not very close	10	1.5	9	1.5	1	3.9
Total	**657**		**598**		**26**	
Child's relationship with other children in household						
Very close	419	71.4	376	76.3	3	13.6
Quite close	139	23.7	103	20.9	10	45.5
Not very close	29	4.9	14	2.8	9	40.9
Total	**587**		**493**		**22**	

1 Most carers interviewed were female (n=790; 91%).

7.3 Children's relationships with their peers

Peer relationships can be strong influences on children and can affect their wellbeing (e.g., Rubin, Coplan, Chen, Bowker & McDonald, 2011; Sturaro, van Lier, Cuijpers & Koot, 2011); development of prosocial skills (Rubin et al, 2011); and school adjustment (Boulton, Don & Boulton, 2011; Ryan, 2012). Research on children's peer relationships generally focuses on two elements. Firstly, in relation to children's friendships, researchers generally look at the existence of a close friendship, the number of close friends a child has, the quality of these relationships, as well as the support provided by friends (Schneider, 2000). The second area of research examines how children are getting on with others in their broader peer group, focusing on aspects such as peer acceptance, rejection, and sociometric status, which is the degree to which children are liked or disliked by their peers (Schneider, 2000).

For the POCLS at Wave 1, the focus is on children's friendships, although there are also some measures of how the child interacts with their peers relative to other children. Caregivers of children aged 6 to 17 years were asked a series of questions about the study child's friendships and to rate how well the child got along with siblings, caregivers, and other children. Table 7.7 shows that almost three quarters (73%) of children aged 6 to 17 years had two or more close friends (excluding siblings). However, 12% of children aged 6–11 years, and 15% of children aged 12–17 years were reported by caregivers to have no close friends, and hence at risk of social isolation. Fewer 12–17 year old children (32%) had four or more friends than 6–11 year old children (39%).

As might be expected, children aged 12–17 years tended to take part in more activities outside of school hours with friends than younger children. Just over one third of 12–17 year olds undertook three or more activities per week compared with about one in five 6–11 year olds.

Generally, most caregivers reported that compared with others of the same age, the child got along with their birth or foster siblings either ‘better’ (29%) or ‘average’ (56%). Few caregivers felt that the study child was ‘worse’ than average in getting along with birth or foster siblings than other children of the same age (11%). Good relationships with siblings were more common for children aged 6–11 years (32% got on ‘better’) than 12–17 year olds (21% got on ‘better’).

A similar trend emerged when the child’s relationships with other children was examined: 19% of caregivers across both age groups reported that the study child was ‘worse’ in this regard compared with children of a comparable age and 27% were getting on ‘better’. There were some age differences; for example, 29% of 6–11 year olds were getting along ‘better’ with other children of their age compared with 20% of 12–17 year olds.

Table 7.7: Caregiver reports on the study child's friendships, by child age

	6–11 years		12–17 years		Total (6–17 years)	
	n	%	n	%	n	%
Number of close friends excluding siblings						
None	40	12.2	18	14.5	58	12.9
1	41	12.5	23	18.6	64	14.2
2 or 3	118	36.1	43	34.7	161	35.7
4 or more	128	39.1	40	32.3	168	37.3
Total	327		124		451	
Number of times a week child does things with friends outside of school hours						
Less than 1	168	51.9	45	36.3	213	47.5
1 or 2	89	27.5	34	27.4	123	27.5
3 or more	67	20.7	45	36.3	112	25.0
Total	324		124		448	
Compared to others of same age, how well does the child:						
Get along with birth/foster siblings						
Worse	32	10.0	17	13.9	49	11.1
Average	174	54.2	73	59.8	247	55.8
Better	103	32.1	25	20.5	128	28.9
No siblings	12	3.7	7	5.7	19	4.3
Total	321		122		443	
Get along with other kids						
Worse	61	18.6	26	21.0	87	19.2
Average	171	52.1	73	58.9	244	54.0
Better	96	29.3	25	20.2	121	26.8
Total	328		124		452	
Behave with carers						
Worse	33	10.1	19	15.3	52	11.6
Average	166	50.9	51	40.1	217	48.2
Better	127	39.0	54	43.5	181	40.2
Total	326		124		453	
Play and work alone						
Worse	55	16.8	17	13.7	72	16.0
Average	117	35.8	53	42.7	170	37.7
Better	155	47.4	54	43.6	209	46.3
Total	327		124		451	

When caregivers were asked to compare the child to others of the same age on how they behaved towards them, nearly half (48%) felt children's behaviour towards them was 'average' and 40% was 'better'. Only 12% felt the child's behaviour was 'worse' relative to children of the same age. Caregivers were also very positive about children's capacity to play and work alone, with 46% of children in their care having 'better' behaviour than children of a similar age. Few age differences were discernible.

Table 7.8 shows proportionately more children in residential care were reported to have no close friends and fewer to have four or more friends than children in relative/kinship or foster care. It appears that children in relative/kinship care tended to have a slightly larger circle of friends than those in foster care, with fewer having no friends.

Caregivers of children in relative/kinship care tended to be more positive about the child's ability to get on with peers and with birth/foster siblings than foster carers and especially residential carers. For example, 25–31% of children in relative/kinship care and foster care were 'better' at getting on with others of the same age compared with 4% of children in residential care. However, there were only minor differences between children in the three care types on how they behaved towards caregivers.

Table 7.8: Caregiver reports on the friendships of children aged 6–17 years, by placement type

	Foster care		Relative/ Kinship care		Residential care	
	n	%	n	%	n	%
Number of close friends excluding siblings						
None	33	16.6	17	7.5	8	30.8
1	31	15.6	28	12.4	5	19.2
2 or 3	68	34.2	82	36.3	11	42.3
4 or more	67	33.7	99	43.8	2	7.7
Total	**199**		**226**		**26**	
Number of times a week child does things with friends outside of school hours						
Less than 1	98	49.5	107	47.8	8	30.8
1 or 2	61	30.8	57	25.4	5	19.2
3 or more	39	19.7	60	26.8	13	50.0
Total	**198**		**224**		**26**	
Compared to others of same age, how well does the child:						
Get along with birth/foster siblings						
Worse	31	15.8	12	5.4	6	23.1
Average	103	52.6	129	58.4	15	57.7
Better	54	27.6	72	32.6	2	7.7
No siblings	8	4.1	8	3.6	3	11.5
Total	**196**		**221**		**26**	
Get along with other kids						
Worse	49	24.4	30	13.3	8	30.8
Average	101	50.2	126	56.0	17	65.4
Better	51	25.4	69	30.7	1	3.9
Total	**201**		**225**		**26**	
Behave with carers						
Worse	27	13.5	22	9.8	3	11.5
Average	88	44.0	117	52.2	12	46.2
Better	85	42.5	85	37.9	11	42.3
Total	**200**		**224**		**26**	
Play and work alone						
Worse	42	21.0	25	11.1	5	19.2
Average	67	33.5	91	40.4	12	46.2
Better	91	45.5	109	48.4	9	34.6
Total	**200**		**225**		**26**	

7.4 Children's relationship with their birth family

Table 7.9 describes the birth family members with whom study children reportedly had good relationships according to caregivers and shows a higher percentage of older children (50% of 12–17 year olds) had good relationships with birth mothers than younger children (25% of 9–35 months). Although not as pronounced, a similar pattern was evident for the child's relationship with siblings (61% for children aged 12–17 years; 44% for children aged 9–35 months). When the relationship between the child and their birth father was considered, between 20% to 30% of children were reported to have a good relationship with the father across all age groups. Very few children were reported as not having a good relationship with any member of their birth or extended family (4% to 18%), although this was more common among 9–35 month olds.

Also examined was the degree to which the child's needs in maintaining family relationships were being met (see second panel of Table 7.9). According to carers, between 74% and 82% of children's needs were met 'very well' or 'fairly well'. Children aged 12–17 years were the most likely to have their needs 'not at all well' met (11%).

Table 7.9: Caregiver reports of who the child has a good relationship with their birth family, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Relationship with family member[1]										
Mother	132	24.6	115	44.9	155	48.9	57	50.0	459	37.5
Father	106	19.8	74	28.9	96	30.3	22	19.3	298	24.4
Siblings (brother or sister)	236	44.0	137	53.5	184	58.0	70	61.4	627	51.3
Maternal grandparents	143	26.7	83	32.4	116	36.6	38	33.3	380	31.1
Paternal grandparents	91	17.0	50	19.5	68	21.5	8	7.0	217	17.7
Maternal great grandparents	33	6.2	22	8.6	22	6.9	6	5.3	83	6.8
Paternal great grandparents	18	3.4	8	3.1	14	4.4	2	1.8	42	3.4
Maternal aunts/uncles	139	25.9	74	28.9	96	30.3	34	29.8	343	28.0
Paternal aunts/uncles	73	13.6	43	16.8	65	20.5	20	17.5	201	16.4
Cousins	161	30.0	80	31.3	115	36.3	38	33.3	393	32.1
None of these	96	17.9	19	7.4	11	3.5	6	5.3	132	10.8
Total	536		256		317		114		1,223	
How well study child's needs met in maintaining family relationships										
Very well	261	47.1	95	37.3	123	37.7	42	33.9		41.4
Fairly well	177	31.9	113	44.3	140	42.9	50	40.3		38.1
Not very well	68	12.3	34	13.3	44	13.5	19	15.3		13.1
Not at all well	48	8.7	13	5.1	19	5.8	13	10.5		7.4
Total	554		255		326		124		1,259	

[1] Column percentages do not add up to 100%, as children may have relationships with multiple family members.

A greater percentage of children in relative/kinship care than in foster care had good relationships with all types of birth family members and their extended family (Table 7.10). This was particularly evident for their relationships with cousins (58% compared with 9%), maternal aunts/uncles (49% compared with 10%), paternal aunts/uncles (29% compared with 5%), and maternal grandparents (48% compared with 16%). Children in foster care tended to have the lowest rates of good relationships with birth family and extended family members and were also more likely to not have a good relationship with any of these relatives (19% compared with 8% of children in residential care and 4% of those in relative/kinship care). Many children in residential care had good relationships with mothers (60%), siblings (56%), and maternal grandparents (40%).

According to caregivers, the needs of most children in relative/kinship care (84%) were being ‘very’ or ‘fairly’ well met in maintaining family relationships compared with 76% of children in foster care and 73% of children in residential care. Overall, these results suggest that at Wave 1 of the POCLS, children in relative/kinship care had stronger connections to birth family and extended family members than children in other placement types. This is not a surprising finding given that in most instances children in relative/kinship care are placed with members of their extended family.

Table 7.10: Caregiver reports of who the child has a good relationship with their birth family, by placement type

	Foster care		Relative/ Kinship care		Residential care	
	n	%	n	%	n	%
Relationship with family member[1]						
Mother	183	32.2	261	44.8	15	60.0
Father	110	19.4	184	31.6	3	12.0
Siblings (brother or sister)	299	52.6	314	53.9	14	56.0
Maternal grandparents	93	16.4	277	47.5	10	40.0
Paternal grandparents	53	9.3	164	28.1	0	0.0
Maternal great grandparents	15	2.6	67	11.5	1	4.0
Paternal great grandparents	5	0.9	37	6.3	0	0.0
Maternal aunts/uncles	58	10.2	283	48.5	2	8.0
Paternal aunts/uncles	28	4.9	170	29.2	3	12.0
Cousins	52	9.2	337	57.8	5	20.0
None of these	109	19.2	21	3.6	2	8.0
Total	**568**		**583**		**25**	
How well study child’s needs met in maintaining family relationships						
Very well	244	37.8	270	45.9	7	26.9
Fairly well	246	38.1	222	37.8	12	46.2
Not very well	94	14.6	68	11.6	3	11.5
Not at all well	61	9.5	28	4.8	4	15.4
Total	**645**		**588**		**26**	

1 Column percentages do not add up to 100%, as children may have relationships with multiple family members.

7.5 Children’s contact with their birth family

Contact between children in OOHC and their birth family and other relatives is a complex policy and practice issue (e.g., Quinton, Rushton, Dance & Mayes, 1997; Quinton, Selwyn, Rushton & Dance, 1999; Ryburn, 1999). Scott, O’Neill and Minge’s (2005) literature review described several positive outcomes of contact, including the increased likelihood of restoration (e.g., Delfabbro, Barber & Cooper, 2002); the fostering of the child’s sense of connectedness and identity; the rebuilding and strengthening of relationships with birth parents; and the continuance of relationships with other birth relatives such as siblings and the child’s extended family. Scott and colleagues also outlined possible negative emotional effects, such as distress, grief, anxiety, resentment or anger (Rickford, 1996); and the potential for the child to experience an emotional ‘tug of war’ between the caregiving and birth families (Leathers, 2003).

Frequency of birth family contact

Table 7.11 shows that a large majority of children were in contact with their birth mothers (83%) and about half were in contact with birth fathers (52%) and birth siblings (49%). Grandparents were the most common extended family relative that children had contact with (57% of study children had contact with at least one grandparent). Aunts and uncles were the second most common extended family relative children had contact with (53%) followed by cousins (44%). Only 1% of children had no contact with their birth family or other relatives. Some age differences were evident. For example, fewer 12–17 year olds than younger children had contact with their birth fathers and paternal grandparents but more 12–17 year olds were in contact with their siblings.

Table 7.11: Caregiver reports of which birth family members the child has contact with (not including those they live with), by child age

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Mother	460	81.1	231	87.2	280	85.1	97	78.2	1,068	83.1
Father	299	52.7	146	55.1	183	55.6	42	33.9	670	52.1
Siblings (brothers or sisters)	253	44.6	115	43.4	178	54.1	82	66.1	628	48.9
Grandparents	324	57.1	159	60.0	192	58.4	53	42.7	728	56.7
Maternal grandparents[1]	206	36.3	86	32.5	116	35.3	41	33.1	449	34.9
Paternal grandparents[1]	147	25.9	75	28.3	86	26.1	14	11.3	322	25.1
Maternal great grandparents[1]	54	9.5	24	9.1	24	7.3	1	0.8	103	8.0
Paternal great grandparents[1]	30	5.3	11	4.2	10	3.0	3	2.4	54	4.2
Aunts/uncles	265	46.7	140	52.8	203	61.7	69	55.6	677	52.7
Maternal aunts/uncles[1]	198	34.9	98	37.0	150	45.6	56	45.2	502	39.1
Paternal aunts/uncles[1]	115	20.3	63	23.8	88	26.8	25	20.2	291	22.7
Cousins	211	37.2	110	41.5	178	54.1	64	51.6	563	43.8
None of these	5	0.9	1	0.4	6	1.8	2	1.6	14	1.1
Total	567		265		329		124		1,285	

1 Note that these categories are not mutually exclusive; for example, some children may see several grandparents and some children may only see one.

Table 7.12 looks at how often children were in contact with various birth family members and shows that between 2% and 14% of children had contact with various family members on ‘most days’; between 12% and 27% had contact ‘at least weekly’; 25% to 45% had contact ‘less than weekly but at least monthly’; and 27% to 57% had ‘less than monthly’ contact with various family members. Looking at contact with grandparents, 15% to 18% of children had at least weekly or more frequent contact with their paternal and maternal grandparents, while just over half had less than monthly contact with grandparents.

Table 7.12 Caregiver reports on how often birth family contact occurs[1]

	Less than monthly		Less than weekly		At least weekly		Most days	
	n	%	n	%	n	%	n	%
Mother (n=1,067)	535	50.1	353	33.1	151	14.2	28	2.6
Father (n=666)	363	54.5	190	28.5	91	13.7	22	3.3
Siblings (n=628)	255	40.6	252	40.1	86	13.7	33	5.6
Maternal grandparents (n=446)	248	55.6	115	25.8	59	13.2	24	5.4
Paternal grandparents (n=317)	181	57.1	90	28.4	39	12.3	7	2.2
Maternal great grandparents (n=95)	37	38.9	29	30.5	23	24.2	6	6.3
Paternal great grandparents (n=53)	27	50.9	13	24.5	8	15.1	5	9.4
Maternal aunts/uncles (n=498)	207	41.6	125	25.1	117	23.5	49	9.8
Paternal aunts/uncles (n=289)	122	42.2	73	25.3	65	22.5	29	10.0
Cousins (n=561)	190	33.9	149	26.6	144	25.7	78	13.9
Other relatives (n=49)	13	26.5	22	44.9	13	26.5	1	2.0

1 Column percentages do not add up to 100%, as children may have contact with multiple family members.

Table 7.13 looks at differences across age groups on the frequency of contact and shows that a slightly higher percentage of the oldest age group (22% to 25% of 12–17 year olds) had regular contact with their birth parents (i.e., at least weekly or more often) than younger age groups (12% to 15% of 9 month to 11 year olds). There was also some variation across age groups for contact with siblings, with those under 12 years more likely to have less than monthly contact (39% to 44%) than children aged 12–17 years (34%).

Table 7.13 Caregiver reports of the child's frequency of contact with birth family, by child age[1]

	Less than monthly		Less than weekly		At least weekly		Most days	
	n	%	n	%	n	%	n	%
Mother								
9–35 months (n=460)	235	51.1	152	33.0	62	13.5	11	2.4
3–5 years (n=231)	118	51.1	77	33.3	32	13.9	4	1.7
6–11 years (n=280)	143	51.1	95	33.9	33	11.8	9	3.2
12–17 years (n=96)	39	40.6	29	30.2	24	25.0	4	4.2
Father								
9–35 months (n=297)	169	56.9	80	26.9	36	12.1	12	4.0
3–5 years (n=145)	84	57.9	40	27.6	18	12.4	3	2.1
6–11 years (n=183)	90	49.2	60	32.8	28	15.3	5	2.7
12–17 years (n=41)	20	48.8	10	24.4	9	22.0	2	4.9
Siblings								
9–35 months (n=253)	110	43.5	92	36.4	41	16.2	10	4.0
3–5 years (n=115)	45	39.1	51	44.3	13	11.3	6	5.2
6–11 years (n=178)	72	40.4	76	42.7	20	11.2	10	5.6
12–17 years (n=82)	28	34.1	33	40.2	12	14.6	9	11.0

1 Column percentages do not add up to 100%, as children may have contact with multiple family members.

Less than monthly contact with birth parents and siblings was more common among children in foster care than relative/kinship care (Table 7.14). Further, children in foster care were less likely to have weekly or more frequent contact with these birth family members than those in relative/kinship care.

Table 7.14 Caregiver reports of the child's frequency of contact with birth family, by placement type[1]

	Less than monthly		Less than weekly		At least weekly		Most days	
	n	%	n	%	n	%	n	%
Mother								
Foster care (n=540)	324	60.0	167	30.9	42	7.8	7	1.3
Relative/Kinship care (n=507)	204	40.2	179	35.3	104	20.5	20	3.9
Residential care (n=20)	7	35.0	7	35.0	5	25.0	1	5.0
Father								
Foster care (n=330)	207	62.7	96	29.1	22	6.7	5	1.5
Relative/Kinship care (n=331)	154	46.5	91	27.5	69	20.8	17	5.1
Residential care (n=5) 1	2	-	3	-	0	-	0	-
Siblings								
Foster care (n=366)	160	43.7	151	41.3	42	11.5	13	3.6
Relative/Kinship care (n=245)	87	35.5	93	38.0	44	18.0	21	8.6
Residential care (n=17) 1	8	-	8	-	0	-	1	-

1 Percentages are not shown for contact with fathers or siblings for children in residential care because of the low n available (< 20).

Type of birth family contact

The type of contact children had with birth family and extended family members is shown for the total sample and children of differing ages in Table 7.15. Looking first at unsupervised contact, across all age groups, 7% of children had face-to-face unsupervised contact with their birth mother, while 6% had unsupervised contact with their birth father. Older children were more likely to have unsupervised face-to-face contact with their birth parents than younger children. Children of all ages tended to have more unsupervised contact with siblings than with birth parents, with higher rates at 12–17 years than at younger ages. Rates of unsupervised contact were much higher for extended family members (grandparents, aunts/uncles, and cousins).

Overall, across all age groups, 76% of children had supervised contact with their birth mother compared with 45% of children who had supervised contact with their birth father. Fewer children aged 12–17 years had supervised contact with mothers than younger children (69% compared with 89% to 96%) and this trend was also evident for their supervised contact with fathers and siblings. However, 12–17 year olds had higher rates than other age groups of non face-to-face contact with birth family members and other relatives (e.g., by telephone, mail, email or social networking). To illustrate, 62% of 12–17 year olds had these types of contact with their birth mothers compared with 25% of children aged 6–11 years. This likely reflects older children's ability to use these types of communication, in particular online-based methods. Few children over all age groups had an overnight stay with their birth parents.

Table 7.15 Caregiver reports of the type of birth family contact, by child age[1]

	Face-to-face unsupervised		Face-to-face supervised		Overnight		Non face-to-face contact[2]	
	n	%	n	%	n	%	n	%
9–35 months								
Mother (n=460)	22	4.8	442	96.1	6	1.3	29	6.3
Father (n=299)	22	7.4	277	92.6	2	0.7	17	5.7
Siblings (n=253)	55	21.7	200	79.1	12	4.7	13	5.1
Grandparents (n=320)	131	40.9	206	64.4	19	5.9	17	5.3
Aunts/Uncles (n=264)	156	59.1	127	48.1	19	7.2	12	4.6
Cousins (n=210)	108	51.4	105	50.0	7	3.3	7	3.3
3–5 years								
Mother (n=231)	16	6.9	216	93.5	4	1.7	49	21.2
Father (n=145)	13	9.0	128	88.3	4	2.8	26	17.9
Siblings (n=115)	27	23.5	89	77.4	6	5.2	14	12.2
Grandparents (n=157)	63	40.1	99	63.1	17	10.8	23	14.7
Aunts/Uncles (n=140)	76	54.3	65	46.4	15	10.7	10	7.1
Cousins (n=110)	57	51.8	54	49.1	9	8.2	5	4.6
6–11 years								
Mother (n=280)	28	10.0	249	88.9	5	1.8	71	25.4
Father (n=183)	33	18.0	151	82.5	7	3.8	43	23.5
Siblings (n=178)	39	21.9	141	79.2	16	9.0	23	12.9
Grandparents (n=192)	97	50.5	98	51.0	34	17.7	38	19.8
Aunts/Uncles (n=203)	140	69.0	69	34.0	21	10.3	27	13.3
Cousins (n=178)	114	64.0	63	35.4	15	8.4	25	14.0
12–17 years								
Mother (n=96)	26	27.1	66	68.8	8	8.3	59	61.5
Father (n=41)	14	34.2	25	61.0	6	14.6	20	48.8
Siblings (n=82)	35	42.7	48	58.5	8	9.8	41	50.0
Grandparents (n=52)	39	75.0	16	30.8	9	17.3	22	42.3
Aunts/Uncles (n=69)	52	75.4	19	27.5	8	11.6	29	42.0
Cousins (n=64)	43	67.2	20	31.3	5	7.8	24	37.5
All children								
Mother (n=1,067)	92	8.6	973	91.2	23	2.2	208	19.5
Father (n=668)	82	12.3	581	87.0	19	2.8	106	15.9
Siblings (n=628)	156	24.8	478	76.1	42	6.7	91	14.5
Grandparents (n=720)	330	45.0	419	58.2	79	11.0	100	13.9
Aunts/Uncles (n=672)	424	63.1	280	41.7	63	9.4	78	11.6
Cousins (n=563)	322	57.2	242	43.0	36	6.4	61	10.8

1 Column percentages do not add up to 100%, as caregivers could respond affirmatively to more than one type of contact.

2 For example, telephone, mail, email or social networking.

Issues arising from birth family contact

Caregivers reflected on problems regarding the child's contact with their birth family, including interruptions to the child's sleeping routines, parent behaviour and hostility between the birth and caregiver families (Table 7.16).

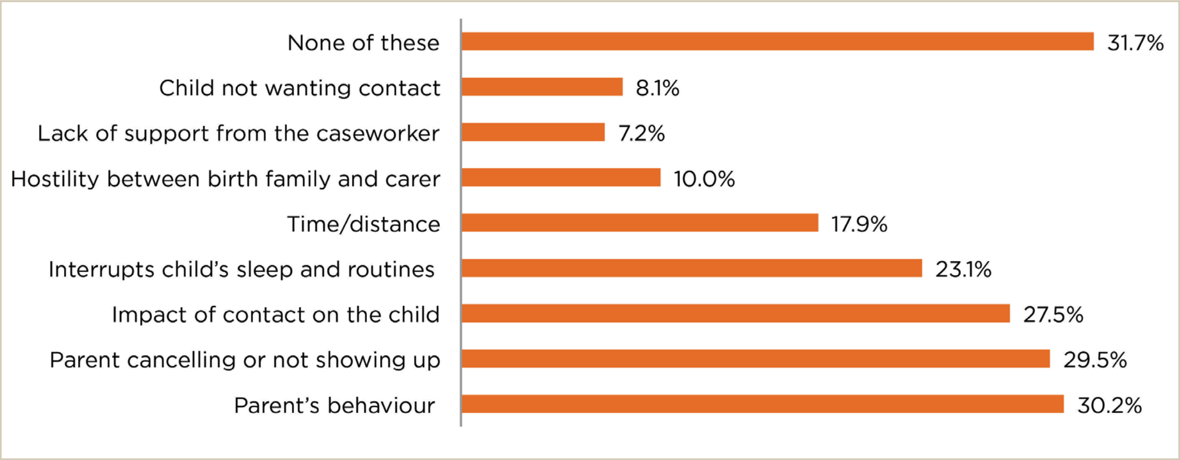
The most common reported problems were parents' behaviour (30%) and parents cancelling or not showing up (30%). Other issues that more than 20% of caregivers felt were a problem were the impact of contact on the child, and contact interrupting the child's sleeping patterns and routines. Nevertheless, 32% of caregivers reported none of these problems regarding contact.

Table 7.16 Caregiver reports of issues arising from birth family contact, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		All children	
	n	%	n	%	n	%	n	%	n	%
Parent's behaviour	149	27.8	85	33.2	104	32.8	31	27.2	369	30.2
Parent cancelling or not showing up	175	32.6	73	28.5	91	28.7	22	19.3	361	29.5
Impact of contact on the child	130	24.3	89	34.8	94	29.7	23	20.2	336	27.5
Interrupts child's sleep and routines	153	28.5	74	28.9	50	15.8	5	4.4	282	23.1
Time/Distance	97	18.1	45	17.6	54	17.0	23	20.2	219	17.9
Hostility between birth family and carer	49	9.1	29	11.3	34	10.7	10	8.8	122	10.0
Lack of support from the caseworker	47	8.8	20	7.8	19	6.0	2	1.8	88	7.2
Child not wanting contact	31	5.8	31	12.1	25	7.9	12	10.5	99	8.1
None of these	173	32.3	69	27.0	104	32.8	42	36.8	388	31.7
Total	536		256		317		114		1,223	

[1] Column percentages do not add up to 100%, as more than one type of issue could arise.

Figure 7.2: Caregiver reports of type of issues arising from birth family contact



[1] Percentages do not add up to 100%, as more than one type of issue could arise.

Differences in children's behaviour before and after contact according to caregivers are shown in Table 7.17 by placement type (due to a sample size less than 20, results for children in residential care are not discussed). Children in foster care less often showed positive behaviour before contact with birth parents (41%) than those in relative/kinship care according to caregivers (52-53%). Overall, children in both foster care and relative/kinship care appeared to display more positive behaviour before contact with their birth parents than after.

Table 7.17 Caregiver reports of the child's behaviour before and after last contact visit, by placement type[1]

	Positive/ Slightly positive		Neutral		Negative/ Slightly negative	
	n	%	n	%	n	%
Foster care						
Before access with mother (n=531)	217	40.9	255	48.0	59	11.1
After access with mother (n=531)	148	27.9	179	33.7	204	38.4
Before access with father (n=326)	133	40.8	154	47.2	39	12.0
After access with father (n=326)	104	31.9	103	31.6	119	36.5
Relative/Kinship care						
Before access with mother (n=491)	253	51.5	202	41.1	36	7.3
After access with mother (n=492)	177	36.0	157	31.9	158	32.1
Before access with father (n=317)	168	53.0	124	39.1	25	7.9
After access with father (n=316)	124	39.2	108	34.2	84	26.6
Residential care[2]						
Before access with mother (n=18)	17	-	0	-	1	-
After access with mother (n=17)	10	-	3	-	4	-
Before access with father (n=4)	3	-	0	-	1	-
After access with father (n=4)	3	-	0	-	1	-

1 Column percentages do not add up to 1005, as children may have contact with both parents.
2 Due to the very small of children who have data (n<20), percentages are not shown.

Table 7.18 shows caregivers' feelings about children's access to their birth families. Those caring for older children were somewhat more likely to have positive feelings compared with caregivers of younger age groups (e.g., 80% of caregivers of children aged 12–17 years had positive feelings compared with 66% of those caring for 9–35 month olds).

Table 7.18 Caregivers' reported feelings about child's access to birth family, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Feeling about child having access to birth family										
Positive or slightly positive	354	66.3	168	65.9	236	74.4	91	79.8	849	69.6
Neutral	68	12.7	30	11.8	33	10.4	12	10.5	143	11.7
Negative or slightly negative	112	21.0	57	22.4	48	15.1	11	9.6	228	18.7
Total	534		255		317		114		1,220	

7.6 Summary of key findings

Caregivers' parenting practices

- Caregivers tended to show high levels of warmth and monitoring of children's activities, and low levels of hostility.
- Caregivers reported a high level of self-efficacy in managing the child's difficult behaviours although this was lower among caregivers of older children.
- The reports from children corroborated caregivers' positive perceptions with most 7–17 year olds reporting that the adult who looked after them always helped them if they had a problem, that their caregiver always listened to them, that their caregiver always praised them for doing well and that their caregiver frequently knew about what the young person did with their free time and where the young person went when going out.

Child caregiver relationships

- Overall, caregivers appeared to have very positive perceptions of children's relationships with the caregiving family – almost all reporting having a close relationship with the child.
- Most caregivers also perceived the child's relationship with other children in the household to be close, although older age groups were somewhat less likely to have very positive relationships than younger age groups.

Child–peer relationships

- A large majority of 6–17 year olds had at least one good friend and almost three quarters had two or more close friends. Caregivers indicated that only 13% of children in their care had no close friends.
- Children aged 12–17 years tended to engage in more activities outside of school hours with friends than younger children.
- Compared with other children of the same age, around 85% of children were reported to have average or better relationships with birth/foster siblings.

- According to caregivers, approximately 90% of children's behaviour towards them was 'average' or 'better than average' when compared with that of other children of the same age.
- A large majority of caregivers also felt that the child played and worked alone better than peers of a similar age.

Contact with birth families

- Four fifths of children were in contact with their birth mothers and about half were in contact with birth fathers and siblings. Over half were in contact with grandparents and aunts/uncles. Only 1% of children had no contact with their birth family or relatives.
- In terms of frequency of contact, fewer than one in five children had frequent (i.e., weekly or more often) contact with their birth mother, father or siblings.
- Few children had face-to-face unsupervised contact with their birth mother or father, although this was more common among older than younger age groups.
- The great majority of children had face-to-face supervised contact with parents (91% with mothers and 87% with fathers) at least monthly.
- Approximately one fifth also communicated with birth parents by other means such as telephone, email, or social networking. This was more common for older than younger children.
- The most common problems arising for children from their contact with birth families were parents' behaviour, and parents cancelling or not showing up. However, 32% of caregivers reported that there had not been any problems from contact.
- Rates of positive behaviour for children were higher across all age groups before the last contact visit with their birth mother or father than after it. Older children tended to more often exhibit positive behaviour before the visit than younger children.
- The child's relationship with their birth mother and siblings tended to be better among older age groups.
- According to caregivers, four fifths of children's needs were very well or fairly well met in maintaining family relationships. More caregivers of older children had positive feelings about the child having access to their birth parents than those caring for younger age groups.
- Children in relative/kinship care were more often in touch with all types of birth family members than those in foster or residential care.
- Children in foster care tended have more infrequent contact with birth family members than children in relative/kinship care.
- Children in relative/kinship care more often had good relationships with all types of birth family members and relatives than children in foster care, and their needs in maintaining family relationships were more often viewed as being met.

7.7 Conclusion

This chapter provides a generally positive picture of children's relationships with their caregivers, caregiving family members, birth family and peers in the early years of being in OOHC. The great majority of children had close relationships with their primary caregivers and other children in the household, and most primary caregivers reported knowing the child well. At Wave 1, children in relative/kinship care tended to have closer relationships than children in foster and residential care. Most children aged 6–17 years had close relationships with peers and significant others. Approximately half had a good relationship with their birth siblings but fewer had a good relationship with birth parents. There were some consistent differences across age groups (e.g., closer carer and family relationships among younger children) and across placement types (e.g., better family and social relationships among those in relative/kinship care than other placement types).

8

Service provision and support

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Children in out-of-home care (OOHC) are a vulnerable group who have high levels of need, due to their experiences before coming into OOHC, the challenges of being a child in OOHC and, for some, ongoing physical and psychological conditions. The provision of services, ranging from the provision of medical services to case planning and caseworker support, is one of the most crucial ways that governments and non-government organisations can foster children's wellbeing in OOHC. Additionally, research has indicated that service use and support may differ between foster, relative/kinship and residential care, with relative/kinship carers potentially lacking access to support services (McHugh, 2013).

This chapter examines different types of services and support received by children and caregivers and the perceived adequacy of these resources among participants in the Pathways of Care Longitudinal Study (POCLS). It also investigates the degree of unmet need for services and support experienced by children and caregivers. The chapter addresses aspects of Key Research Question 4: 'What are the placement, service intervention and case planning pathways for children during their time in OOHC?'[1].

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[1] Please see Chapter 2 for a description of the data analysis undertaken in this report.

8.1 Services and support provided to children and caregivers

Access, adequacy and barriers to health services for children

Table 8.1 shows that, according to caregiver reports, the vast majority of children across all age groups had attended a general practitioner (92%), with the highest attendance among children aged 9–35 months (96%) and 3–5 years (92%). Over half (56%) of children of all ages had attended a paediatrician, with rates slightly higher among children aged 5 years or younger (58% of 3–5 year olds and 62% of 9–35 month olds). Higher proportions of younger children, particularly those aged 9–35 months (55%), had visited an Early Childhood Health Centre, and children aged 3–5 years were the most likely to have attended a speech pathology service (43%). Higher proportions of older children aged 6–11 years and 12–17 years had attended a dental hospital/local dentist (74% and 71%) and counsellor/psychologist (51% and 63%) than younger age groups. Overall, just over one in five (22%) children had accessed another type of specialist or service, and the most common services/specialists reported by caregivers were eye specialist/surgeon and/or having an eye test, having a hearing test, attending an occupational therapist and attending a physiotherapist.

Table 8.1: Caregiver reports of child health services attended, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
A general practitioner	546	96.3	244	92.1	291	88.4	105	84.7	1,186	92.3
A paediatrician	351	61.9	154	58.1	168	51.1	47	37.9	720	56.0
A dental hospital or local dentist	105	18.5	159	60.0	244	74.2	88	71.0	596	46.4
An Early Childhood Health Centre	314	55.4	71	26.8	26	7.9	3	2.4	414	32.2
A hospital emergency department (or casualty)	222	39.2	69	26.0	65	19.8	40	32.3	396	30.8
Counselling or a psychologist	30	5.3	72	27.2	169	51.4	78	62.9	349	27.2
A speech pathology service	76	13.4	115	43.4	77	23.4	10	8.1	278	21.6
An Aboriginal Medical Service	85	15.0	27	10.2	40	12.2	17	13.7	169	13.2
Hospital for an overnight stay or longer	104	18.3	22	8.3	24	7.3	16	12.9	166	12.9
Behaviour management services	10	1.8	21	7.9	25	7.6	18	14.5	74	5.8
Other specialist or service[1]	124	21.9	65	24.5	65	19.8	25	20.2	279	21.7
Total	567		265		329		124		1,285	

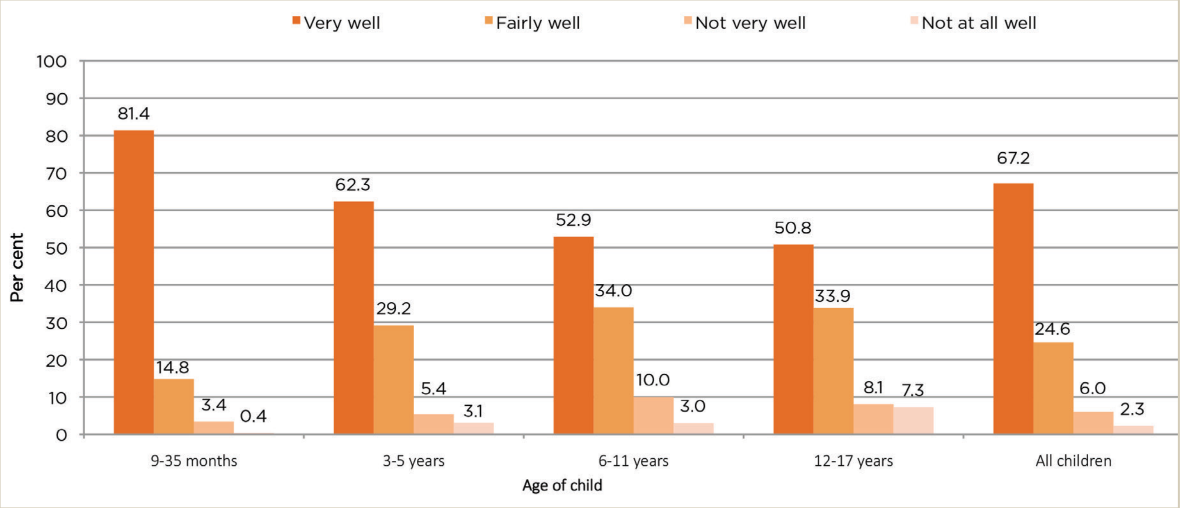
[1] This combines two variables: attendance by the study child since placement at 'other specialist' and 'other service'. The total frequency for this new variable is lower than that for these two individual variables combined, given that some caregivers identified both an 'other specialist' and 'other service'.

Overall, as shown in Table 8.2, approximately two thirds of caregivers felt that children's needs had been 'very well' met by professional services, and only 8% of caregivers felt that the children's health needs had not been well met (6% reporting 'not very well' and 2% reporting 'not at all well'). Perceptions that children's needs had been 'very well' met were most common among caregivers of the youngest children aged 9–35 months (81%) and decreased to 51% for children aged 12–17 years. The most common reason reported by caregivers for the children not receiving the professional services they needed was long waiting lists (24%).

Table 8.2: Caregiver reports of how well the child's needs were met and barriers to receiving professional support, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Health needs met by professional services										
Very well	456	81.4	162	62.3	174	52.9	63	50.8	855	67.2
Fairly well	83	14.8	76	29.2	112	34.0	42	33.9	313	24.6
Not very well	19	3.4	14	5.4	33	10.0	10	8.1	76	6.0
Not at all well	2	0.4	8	3.1	10	3.0	9	7.3	29	2.3
Total	560		260		329		124		1,273	
Barriers to receiving professional support										
Long waiting lists	44	17.3	46	30.9	63	29.0	17	20.2	170	24.1
Too far to travel	10	3.9	11	7.4	10	4.6	2	2.4	33	4.7
Cost of the service	13	5.1	10	6.7	8	3.7	1	1.2	32	4.5
No appropriate services	3	1.2	10	6.7	6	2.8	1	1.2	20	2.8
Problems with transport	5	2.0	6	4.0	6	2.8	1	1.2	18	2.6
Other reasons	19	7.5	13	8.7	21	9.7	14	16.7	67	9.5
Total	254		149		217		84		704	

Figure 8.1: Caregiver reports of how well the child's health needs were met, by child age



Caregivers' experiences of professional services and support for the child

For all caregivers (Table 8.3), the most common types of support received by caregivers to assist them in their caregiving role were childcare (27%), respite care (22%) and caregiver support organisations (20%). Caregivers of 3–5 year olds had higher rates of childcare or before/after school care (35%), while caregivers of both 3–5 year olds and 6–11 year olds were more likely to use counselling/psychologist services. Caregivers of 9–35 month olds were also less likely to have used respite care (16%) than the caregivers of children aged 3 years or older (25–30%). Overall, 60% of caregivers reported receiving at least one type of service or support, with caregivers of 3–5 year olds reporting the highest level of professional support (70%).

Table 8.3: Caregiver reports of professional support received, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Childcare/Before and after school care	133	26.2	92	34.9	86	26.2	12	12.5	323	27.0
Respite care	93	16.4	65	24.5	90	27.4	29	30.2	277	22.0
Carer support organisations and groups	107	21.1	54	20.5	61	18.6	16	16.7	238	19.9
Transport	92	16.2	49	18.5	47	14.3	14	14.6	202	16.1
Carer support teams	65	12.8	37	14.0	43	13.1	10	10.4	155	13.0
Counselling/ Psychologist services	39	6.9	41	15.5	52	15.8	10	10.4	142	11.3
Foster carer advisory groups	42	8.3	17	6.4	29	8.8	8	8.3	96	8.0
After hours and crisis support	27	5.3	21	8.0	24	7.3	5	5.2	77	6.4
Financial advice	7	1.2	2	0.8	4	1.2	0	0.0	13	1.0
Interpreters	2	0.4	0	0.0	0	0.0	1	1.0	3	0.3
Another type of support	13	2.3	6	2.3	8	2.4	1	1.0	28	2.2
At least one type of support received	308	54.5	183	69.6	210	64.2	52	53.6	753	59.9
Total	508–567		264–265		327–329		96–97		1,196–1,258	

[1] Column percentages do not add up to 100%, as caregivers may have received multiple types of professional support.

When comparing foster and relative/kinship carers (Table 8.4), foster carers reported receiving services and supports more frequently than relative/kinship carers, with 68% of foster carers receiving at least one of type of support compared to 51% of relative/kinship carers.

Table 8.4: Caregiver reports of professional support received, by placement type[1]

	Foster care		Relative/ Kinship care	
	n	%	n	%
Childcare/Before and after school care	162	26.4	161	27.7
Respite care	185	28.0	92	15.4
Carer support organisations and groups	192	31.3	46	7.9
Transport	135	20.4	67	11.2
Carer support teams	112	18.2	43	7.4
Counselling/Psychologist services	77	11.7	65	10.9
Foster carer advisory groups	79	12.9	17	2.9
After hours and crisis support	72	11.7	5	0.9
Financial advice	5	0.8	8	1.3
Interpreters	2	0.3	1	0.2
Another type of support	13	2.0	15	2.5
At least one type of support received	449	68.2	304	51.2
Total=1,257	614–661		582–596	

1 Column percentages do not add up to 100%, as caregivers may have received multiple types of professional support.

Table 8.5 shows that 64% of caregivers reported that they continued to require services or support, with caregivers of 3–5 year olds and 6–11 year olds having the highest rates (77% and 70% respectively). The greatest needs overall were for respite care (29%), childcare or before/after school care (28%) and support from carer support organisations/groups (20%). Not surprisingly, caregivers of children aged 9 months to 5 years had a greater need for childcare, while the need for respite care was lowest for children aged 9–35 months.

The most common reason caregivers selected for not being able to get the professional support that they felt they needed was long waiting lists (15%). Overall, 40% of caregivers indicated at least one reason for not obtaining the professional support required.

Table 8.5: Caregiver reports of professional support needed and reasons for not getting the support required, by child age[1]

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Whether support still needed from service										
Childcare/Before and after school care	158	30.8	85	32.3	81	24.8	14	14.7	338	28.2
Respite care	124	22.0	90	34.0	111	33.7	35	36.8	360	28.7
Carer support organisations and groups	103	20.0	54	20.5	65	19.9	17	17.9	239	19.9
Transport	86	15.2	49	18.5	46	14.0	14	14.7	195	15.6
Carer support teams	63	12.3	42	16.0	49	15.0	11	11.6	165	13.8
Counselling/Psychologist services	40	7.1	52	19.6	54	16.4	6	6.3	152	12.1
Foster carer advisory groups	49	9.6	25	9.5	29	8.9	8	8.4	111	9.3
After hours and crisis support	27	5.3	17	6.5	17	5.2	4	4.2	65	5.4
Financial advice	12	2.1	4	1.5	3	0.9	0	0.0	19	1.5
Interpreters	1	0.2	0	0.0	1	0.3	2	2.1	4	0.3
Another type of support	12	2.1	10	3.8	8	2.4	3	3.2	33	2.6
At least one type of support received	319	56.8	203	76.9	228	69.7	59	60.2	809	64.4
Total	**513–565**		**263–265**		**327–329**		**95–98**		**1,198–1,257**	
Reasons for not getting professional support needed										
Long waiting lists	39	10.3	37	16.9	51	21.3	9	15.0	136	15.2
No appropriate services	32	8.5	22	10.0	18	7.5	5	8.3	77	8.6
Too far to travel	23	6.1	18	8.2	22	9.2	3	5.0	66	7.4
Cost of the service	19	5.0	12	5.5	15	6.3	1	1.7	47	5.2
Problems with transport	10	2.6	11	5.0	14	5.8	1	1.7	36	4.0
Another reason identified	61	16.1	29	13.2	26	10.8	13	21.7	129	14.4
At least one reason identified	143	37.8	91	41.6	104	43.3	24	40.0	362	40.4
Total	**378**		**219**		**240**		**60**		**897**	

1 Column percentages do not add up to 100%, as caregivers may have required multiple types of professional support and/or had multiple reasons for not getting the support needed.

Overall, caregivers of children from culturally diverse backgrounds were less likely than caregivers of Aboriginal children and other Australian children to continue to require at least one form of professional support and to identify at least one reason for not receiving the professional support required (Table 8.6).

Table 8.6: Caregiver reports of professional support needed and reasons for not getting the support required, by child's cultural background[1]

	Aboriginal children		Culturally diverse children		Other Australian children	
	n	%	n	%	n	%
Whether support still needed from service						
Childcare/Before and after school care	128	29.0	39	39.0	155	26.4
Respite care	141	30.4	25	23.2	180	29.4
Carer support organisations and groups	83	18.8	20	20.0	118	20.0
Transport	75	16.2	24	22.2	91	14.9
Carer support teams	76	17.2	17	17.0	63	10.7
Counselling/Psychologist services	47	10.1	8	7.4	87	14.2
Foster carer advisory groups	43	9.8	8	8.0	56	9.5
After hours and crisis support	21	4.8	6	6.0	36	6.1
Financial advice	7	1.5	4	3.7	6	1.0
Interpreters	0	0.0	4	4.0	0	0.0
Another type of support	14	3.0	2	1.9	14	2.3
At least one type of support received	307	66.3	62	56.4	401	64.6
Total=1,195	441–464		100–110		587–621	
Reasons for not getting professional support needed						
Long waiting lists	55	16.2	7	9.5	68	15.5
No appropriate services	25	7.4	3	4.1	47	10.7
Too far to travel	24	7.1	5	6.8	34	7.7
Cost of the service	10	3.0	5	6.8	30	6.8
Problems with transport	22	6.5	2	2.7	12	2.7
Another reason identified	47	13.9	7	9.5	68	15.5
At least one reason identified	140	41.3	20	27.0	188	42.7
Total=853	339		74		440	

[1] Column percentages do not add up to 100%, as caregivers may have required multiple types of professional support and/or had multiple reasons for not getting the support needed.

Table 8.7: Caregiver reports of helpfulness of the professional support used

Service type	Very helpful		Fairly helpful		Not very helpful		Not at all helpful	
	n	%	n	%	n	%	n	%
Childcare/Before and after school care (n=323)	260	80.5	61	18.9	2	0.6	0	0.0
Respite care (n=277)	210	75.8	59	21.3	8	2.9	0	0.0
Carer support organisations and groups (n=236)	156	66.1	77	32.6	3	1.3	0	0.0
Transport (n=201)	148	73.6	48	23.9	5	2.5	0	0.0
Carer support teams (n=154)	117	76.0	32	20.8	5	3.3	0	0.0
Counselling/Psychologist services (n=141)	103	73.1	36	25.5	2	1.4	0	0.0
Foster carer advisory groups (n=96)	62	64.6	24	25.0	9	9.4	1	1.0
After hours and crisis support (n=77)	58	75.3	19	24.7	0	0.0	0	0.0
Financial advice (n=13)	12	92.3	1	7.7	0	0.0	0	0.0
Interpreters (n=3)	3	100.0	0	0.0	0	0.0	0	0.0
Another type of support (n=28)	20	71.4	8	28.6	0	0.0	0	0.0

Caregiver ratings of the helpfulness of professional services or supports received are shown in Table 8.7, with most of the services or types of support found to be ‘very helpful’ or ‘fairly helpful’ (over 90%).

Caregivers’ experiences of support in raising the child

For all caregivers, irrespective of child age (refer to ‘Total sample’ in Table 8.8), the majority (71%) ‘often’ or ‘always’ received support from their spouse/partner in raising the child, with this being not applicable (i.e., the carer did not have a spouse or partner) for 28% of caregivers. Therefore, for caregivers who did have a spouse/partner, the vast majority (98%), reported receiving their support ‘often’ or ‘always’. The majority of caregivers (69%) also indicated that they ‘often’ or ‘always’ received support from other family members, and just over half (53%) indicated that they ‘often’ or ‘always’ received support from friends (with 74% of carers indicating at least ‘sometimes’). Just under half (47%) of caregivers reported receiving support from their own parents at least ‘sometimes’.

When examined according to child age, caregivers of younger children (i.e., aged 5 years or younger) received more support from their spouse/partner, their own parents, and their spouse/partner’s parents, in comparison to caregivers of children aged 6 or more years, and most prominently in comparison to caregivers of 12–17 year olds. Caregivers of children aged 6–11 years were more likely than other caregivers, however, to ‘always’ or ‘often’ receive support from neighbours (at 27%, with the corresponding figures being 22% for caregivers of both 9–35 months and 3–5 year olds and 17% for carers of 12–17 year olds). While the levels of support caregivers reported receiving from various people/groups were often lower for caregivers of 12–17 year olds, almost one quarter of these caregivers reported that community organisations ‘always’ or ‘often’ provided support in raising their children, which, in comparison, was at 14–16% for caregivers of the younger age groups.

Table 8.8: Caregiver reports of support received in raising the child, by child age[1]

Person providing support	Never/ Rarely		Sometimes		Often/ Always		Not applicable		Total
	n	%	n	%	n	%	n	%	n
9–35 months (n=567)									
Spouse/Partner	0	0.0	6	1.1	425	75.0	136	24.0	567
Own parents	91	16.1	69	12.2	243	42.9	164	28.9	567
Spouse/Partner's parents	96	16.9	56	9.9	126	22.2	289	51.0	567
Other family members	52	9.2	80	14.1	412	72.7	23	4.1	567
Friends	99	17.5	121	21.3	326	57.5	21	3.7	567
Neighbours	326	57.5	70	12.4	124	21.9	47	8.3	567
Other carers	236	51.2	71	15.4	82	17.8	72	15.6	461
Community organisations	288	50.8	51	9.0	88	15.5	140	24.7	567
Church	193	34.0	40	7.1	69	12.2	265	46.7	567
3–5 years (n=265)									
Spouse/Partner	0	0.0	4	1.5	201	75.9	60	22.6	265
Own parents	42	15.9	20	7.6	108	40.9	94	35.6	264
Spouse/Partner's parents	50	18.9	28	10.6	46	17.4	141	53.2	265
Other family members	35	13.2	37	14.0	182	68.7	11	4.2	265
Friends	65	24.5	57	21.5	131	49.4	12	4.5	265
Neighbours	156	58.9	29	10.9	59	22.3	21	7.9	265
Other carers	149	56.7	29	11.0	50	19.0	35	13.3	263
Community organisations	142	53.6	23	8.7	38	14.3	62	23.4	265
Church	82	31.1	12	4.6	30	11.4	140	53.0	264
6–11 years (n=329)									
Spouse/Partner	0	0.0	6	1.8	224	68.5	97	29.7	327
Own parents	61	18.6	27	8.2	101	30.8	139	42.4	328
Spouse/Partner's parents	61	18.7	20	6.1	35	10.7	211	64.5	327
Other family members	51	15.5	47	14.3	225	68.4	6	1.8	329
Friends	70	21.3	73	22.2	171	52.0	15	4.6	329
Neighbours	169	51.4	43	13.1	90	27.4	27	8.2	329
Other carers	172	52.9	60	18.5	42	12.9	51	15.7	325
Community organisations	169	51.5	42	12.8	45	13.7	72	22.0	328
Church	82	25.0	18	5.5	39	11.9	189	57.6	202
12–17 years (n=124)									
Spouse/Partner	2	1.6	1	0.8	60	48.4	61	49.2	124
Own parents	14	11.5	8	6.6	28	23.0	72	59.0	122
Spouse/Partner's parents	23	18.6	6	4.8	12	9.7	83	66.9	124
Other family members	19	15.3	8	6.5	69	55.7	28	22.6	124
Friends	29	23.4	15	12.1	50	40.3	30	24.2	124
Neighbours	53	42.7	15	12.1	21	16.9	35	28.2	124
Other carers	52	52.5	19	19.2	12	12.1	16	16.2	99
Community organisations	54	43.6	16	12.9	30	24.2	24	19.4	124
Church	15	12.1	5	4.0	12	9.7	92	74.2	124

Person providing support	Never/ Rarely		Sometimes		Often/ Always		Not applicable		Total
	n	%	n	%	n	%	n	%	n
Total sample (n=1,285)									
Spouse/Partner	2	0.2	17	1.3	910	70.9	354	27.6	1,283
Own parents	208	16.2	124	9.7	480	37.5	469	36.6	1,281
Spouse/Partner's parents	230	17.9	110	8.6	219	17.1	724	56.4	1,283
Other family members	157	12.2	172	13.4	888	69.1	68	5.3	1,285
Friends	263	20.5	266	20.7	678	52.8	78	6.1	1,285
Neighbours	704	54.8	157	12.2	294	22.9	130	10.1	1,285
Other carers	609	53.1	179	15.6	186	16.2	174	15.2	1,148
Community organisations	653	50.9	132	10.3	201	15.7	298	23.2	1,284
Church	372	29.0	75	5.9	150	11.7	686	53.5	1,283

1 Column percentages do not add up to 100%, as support may have been received from multiple sources.

As can be observed in Table 8.9, caregivers of Aboriginal children more commonly reported that they 'often' or 'always' received the support of other family members (74%, in comparison to 63% and 68% of caregivers of children from culturally diverse and other Australian backgrounds), but were slightly less likely to report 'often' or 'always' receiving the support of their spouse/partner (68%, in comparison to almost three quarters of caregivers of children from culturally diverse and other Australian backgrounds). Caregivers of children from culturally diverse backgrounds less commonly reported 'often' or 'always' receiving support from their own parents, their partner/spouse's parents, other family members, friends and other caregivers, in comparison to caregivers of Aboriginal children and other Australian children. However, caregivers of children from culturally diverse backgrounds, as well as caregivers of Aboriginal children, more commonly reported 'often' or 'always' receiving support from their neighbours (28% and 25%), in comparison to caregivers of other Australian children (21%).

Table 8.9: Caregiver reports of support received in raising the child, by child's cultural background[1]

Person providing support	Never/ Rarely		Sometimes		Often/ Always		Not applicable	
	n	%	n	%	n	%	n	%
Aboriginal children (n=425–465)								
Spouse/Partner	0	0.0	5	1.1	316	68.0	144	31.0
Own parents	76	16.4	46	9.9	179	38.7	162	34.7
Spouse/Partner's parents	82	17.6	44	9.5	77	16.6	262	56.3
Other family members	53	11.4	59	12.7	345	74.2	8	1.7
Friends	100	21.5	93	20.0	244	52.5	28	6.0
Neighbours	262	56.8	38	8.2	115	24.7	48	10.3
Other carers	236	55.5	55	12.9	80	18.8	54	12.7
Community organisations	237	51.0	51	11.0	74	15.9	103	22.2
Church	133	28.6	19	4.1	61	13.1	252	54.2
Culturally diverse children (n=92–111)								
Spouse/Partner	1	0.9	3	2.7	82	73.9	25	22.5
Own parents	17	15.3	13	11.7	35	31.5	46	41.4
Spouse/Partner's parents	10	9.0	8	7.2	14	12.6	79	71.2
Other family members	7	6.3	28	25.2	70	63.1	6	5.4
Friends	28	25.2	27	24.3	50	45.1	6	5.4
Neighbours	54	48.7	14	12.6	31	27.9	12	10.8
Other carers	37	40.2	23	25.0	7	7.6	25	27.2
Community organisations	60	54.1	11	9.9	16	14.4	24	21.6
Church	51	46.0	16	14.4	15	13.5	29	26.1
Other Australian children (n=566–626)								
Spouse/Partner	1	0.2	8	1.3	458	73.4	157	25.2
Own parents	108	17.3	60	9.6	238	38.1	218	34.9
Spouse/Partner's parents	128	20.5	57	9.1	112	18.0	327	52.4
Other family members	87	13.9	75	12.0	427	68.2	37	5.9
Friends	122	19.5	132	21.1	343	54.8	29	4.6
Neighbours	344	55.0	93	14.9	133	21.3	56	9.0
Other carers	303	53.5	86	15.2	89	15.7	88	15.6
Community organisations	320	51.2	61	9.8	86	13.8	158	25.3
Church	165	26.4	36	5.8	64	10.2	361	57.7

1 Column percentages do not add up to 100%, as support may have been received from multiple sources.

Table 8.10 shows the support received from different people according to placement type. In general, greater proportions of foster carers reported receiving support from their spouse/partner and their spouse/partner's parents (although these results are likely to be primarily attributable to a higher proportion of relative/kinship carers not having a spouse/partner), as well as their own parents, friends and other carers. For example, almost half (46%) of foster carers 'often' or 'always' received support from their own parents compared to 30% of relative/kinship carers. In addition, there was also a tendency for foster carers, in comparison to relative/kinship carers, to more commonly receive support at least ‘sometimes’ from their neighbours (39% compared with 32%) and from community organisations (29% compared with 21%). Foster and relative/kinship carers did report relatively similar levels of support, however, from other family members and their church.

Table 8.10: Caregiver reports of support received in raising the child, by placement type[1]

Person providing support	Never/ Rarely		Sometimes		Often/ Always		Not applicable	
	n	%	n	%	n	%	n	%
Foster care (n=598–661)								
Spouse/Partner	2	0.3	10	1.5	515	78.0	133	20.2
Own parents	92	14.0	78	11.8	300	45.5	189	28.7
Spouse/Partner’s parents	126	19.1	82	12.4	156	23.6	296	44.9
Other family members	77	11.7	92	13.9	462	69.9	30	4.5
Friends	93	14.1	147	22.2	402	60.8	19	2.9
Neighbours	353	53.4	97	14.7	163	24.7	48	7.3
Other carers	268	44.8	126	21.1	139	23.2	65	10.9
Community organisations	326	49.4	79	12.0	109	16.5	146	22.1
Church	194	29.4	49	7.4	80	12.1	338	51.1
Relative/Kinship care (n=549–598)								
Spouse/Partner	0	0.0	7	1.2	395	66.2	195	32.7
Own parents	116	19.5	46	7.7	180	30.2	254	42.6
Spouse/Partner’s parents	104	17.4	28	4.7	63	10.6	402	67.3
Other family members	80	13.4	80	13.4	426	71.2	12	2.0
Friends	170	28.4	119	19.9	276	46.2	33	5.5
Neighbours	351	58.7	60	10.0	131	21.9	56	9.4
Other carers	341	62.1	53	9.7	46	8.4	109	19.9
Community organisations	321	53.7	48	8.0	79	13.2	150	25.1
Church	178	29.9	26	4.4	70	11.7	322	54.0

1 Column percentages do not add up to 100%, as support may have been received from multiple sources.

Caregivers’ experiences with caseworkers

Table 8.11 shows that across all children, the number of caseworkers seen by the caregivers since the study child’s placement varied from 1 to 10, with approximately equal proportions having seen one, two, or three or more caseworkers, according to caregiver reports. Almost three quarters (73%) of caregivers had face-to-face contact with the child’s caseworkers once a month or less, although the majority (58%) did have phone or email contact with caseworkers at least once a month, and 40% had fortnightly or more frequent phone/email contact. On the other hand, 12% of caregivers reported no face-to-face contact with caseworkers since the start of the placement, and 6% reported no phone or email contact (note that this may reflect aspects of how parental responsibility is allocated). While the majority of caregivers were ‘very satisfied’ or ‘satisfied’ with their access to caseworkers and with the assistance they had received from caseworkers, approximately a quarter of caregivers were dissatisfied with access to and assistance from caseworkers.

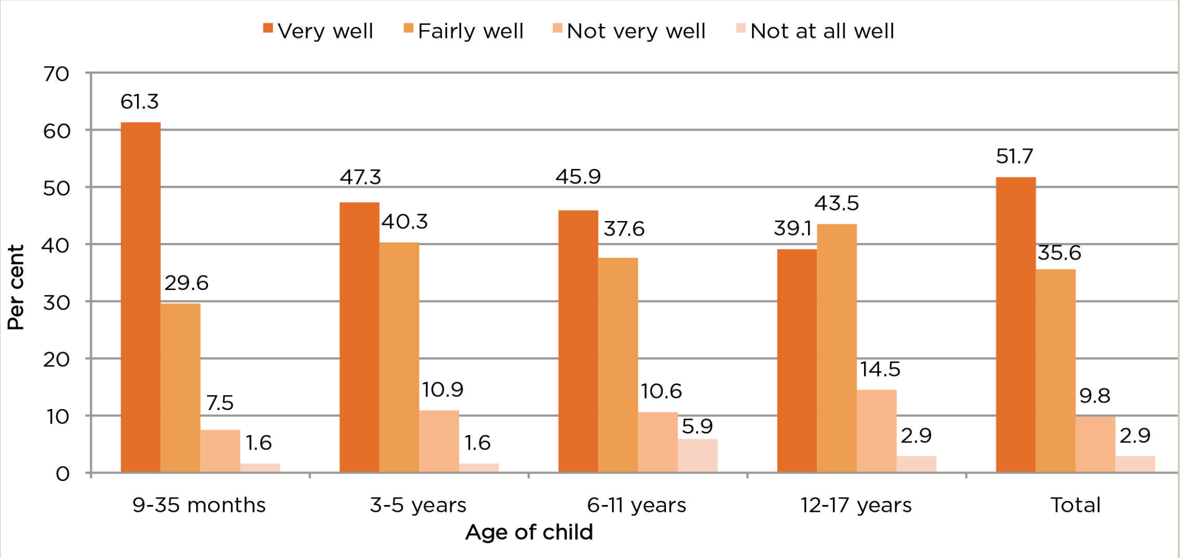
Table 8.11: Caregiver reports of caseworker assistance since the start of the placement, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Number of caseworkers seen since the child was placed										
One	221	39.2	87	33.0	113	34.4	42	34.2	463	36.2
Two	189	33.5	80	30.3	114	34.7	49	39.9	432	33.8
Three or more	154	27.3	97	36.7	102	31.0	32	26.0	385	30.1
Total	564		264		329		123		1,280	
Amount of face-to-face contact with caseworker										
At least weekly	43	7.6	10	3.8	11	3.3	12	9.8	76	5.9
About once a fortnight	60	10.6	21	8.0	28	8.5	12	9.8	121	9.4
About once a month	111	19.6	42	15.9	53	16.1	25	20.3	231	18.0
Less than once a month	286	50.4	160	60.6	193	58.7	62	50.4	701	54.6
Never	67	11.8	31	11.7	44	13.4	12	9.8	154	12.0
Total	567		264		329		123		1,283	
Phone or email contact with caseworker										
At least weekly	90	20.2	50	18.9	68	20.7	44	36.1	252	21.7
About once a fortnight	85	19.1	58	21.9	54	16.4	12	9.8	209	18.0
About once a month	80	18.0	49	18.5	56	17.0	23	18.9	208	17.9
Less than once a month	166	37.3	96	36.2	124	37.7	34	27.9	420	36.2
Never	24	5.4	12	4.5	27	8.2	9	7.4	72	6.2
Total	445		265		329		122		1,161	
Satisfaction with access to caseworkers when needed										
Very satisfied	209	36.9	98	37.1	118	35.9	46	37.7	471	36.8
Satisfied	175	30.9	70	26.5	102	31.0	42	34.4	389	30.4
Unsure	47	8.3	17	6.4	18	5.5	4	3.3	86	6.7
Dissatisfied	80	14.1	43	16.3	54	16.4	16	13.1	193	15.1
Very dissatisfied	55	9.7	36	13.6	37	11.2	14	11.5	142	11.1
Total	566		264		329		122		1,281	
Satisfaction with assistance from caseworkers										
Very satisfied	192	34.0	81	30.7	103	31.3	38	31.2	414	32.4
Satisfied	195	34.6	71	26.9	112	34.0	46	37.7	424	33.2
Unsure	47	8.3	24	9.1	36	10.9	7	5.7	114	8.9
Dissatisfied	82	14.5	51	19.3	45	13.7	21	17.2	199	15.6
Very dissatisfied	48	8.5	37	14.0	33	10.0	10	8.2	128	10.0
Total	564		264		329		122		1,279	

When examining caseworker assistance by child age, Table 8.11 shows that caregivers of children aged 3–5 years were the most likely to have seen three or more caseworkers since the study child had been placed with them (37%). With regard to the amount of face-to-face and phone/email contact with caseworkers, caregivers of children aged 12–17 years were more likely to have at least weekly contact with their caseworker. There were only minor variations for child age in regard to caregivers' satisfaction with access to caseworkers when needed and the assistance provided by caseworkers. A slightly higher proportion of caregivers of 12–17 year olds, however, were 'very satisfied' or 'satisfied' with access to caseworkers when needed (72%), in comparison with caregivers of children from other age groups (64–68%). For the amount of satisfaction with all assistance provided by caseworkers, a smaller proportion of caregivers of 3–5 year olds reported being 'very satisfied' or 'satisfied' (58%), in comparison with the other age groups (ranging from 65–69%).

A higher proportion of caregivers of the younger age groups thought that the case plan met their child's needs 'very well' or 'fairly well'. For example, 91% of carers of 9–35 month olds, compared with 83% of carers of 12–17 year olds, thought the case plan had met the child's needs 'very well' or 'fairly well' (Figure 8.2).

Figure 8.2: Caregiver reports of whether the case plan meets the child's needs, by child age (n=621)



As is shown in Table 8.12, almost nine out of ten caregivers (87%) reported being 'very satisfied' or 'satisfied' with the working relationship with the other agencies (e.g., education and counsellors) assisting their child. Only 3% were 'dissatisfied', and 1% were 'very dissatisfied'. When comparing satisfaction in these working relationships across child age, the differences were minimal, although one point of difference was that the caregivers of 12–17 year old children were slightly less likely to be 'very satisfied' (46%), than the caregivers of younger children, with the highest proportion of 'very satisfied' caregivers being for 3–5 year olds (56%).

Table 8.12: Caregiver reports of satisfaction with their working relationship with other agencies related to the child (e.g., education, health), by child age

	Very satisfied		Satisfied		Unsure		Dissatisfied		Very dissatisfied	
	n	%	n	%	n	%	n	%	n	%
9–35 months (n=476)	254	53.4	155	32.6	60	12.6	3	0.6	4	0.8
3–5 years (n=244)	137	56.1	81	33.2	17	7.0	7	2.9	2	0.8
6–11 years (n=312)	156	50.0	119	38.1	13	4.2	18	5.8	6	1.9
12–17 years (n=114)	52	45.6	46	40.4	9	7.9	7	6.1	0	0.0
Total (n=1,146)	599	52.3	401	35.0	99	8.6	35	3.1	12	1.0

Children's experiences with caseworkers

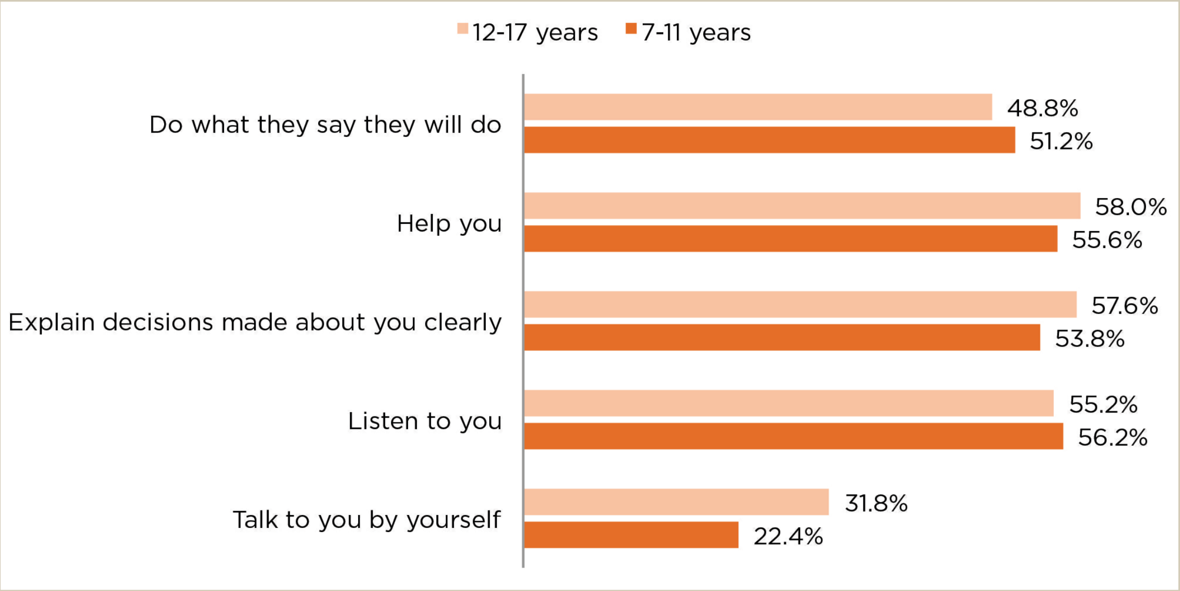
When asked about their experiences with caseworkers, Table 8.13 shows that at least half of the children aged 7 to 17 years interviewed reported that their caseworker 'always' or 'often' provided them with each of the forms of support, with the exception of talking to the child in private, which occurred less frequently (22% of 7–11 year olds and 32% of 12–17 year olds). In addition, just under half of 12–17 year olds thought that the caseworker 'did what they said they would do'. On the other hand, a sizeable minority felt they had 'rarely' or 'never' received support from their caseworker in these different areas.

For 7–11 year olds, the areas in which children had most frequently 'always' or 'often' received support were caseworkers listening to them (56%), the provision of help (56%), and explaining decisions made about them clearly (54%). For 12–17 year olds, the most common areas in which they had 'always' or 'often' received support were explaining decisions clearly (58%), receiving help (58%), and being listened to (55%).

Table 8.13: Child reports of support from their caseworker, by child age

	Always		Often		Sometimes		Rarely		Never	
	n	%	n	%	n	%	n	%	n	%
7–11 years old (n=197–201)										
Talk to you by yourself	24	11.9	21	10.5	47	23.4	37	18.4	72	35.8
Listen to you	89	44.3	24	11.9	24	11.9	13	6.5	51	25.4
Explain decisions made about you clearly	71	36.0	35	17.8	22	11.2	12	6.1	57	28.9
Help you	79	39.9	31	15.7	27	13.6	10	5.1	51	25.8
Do what they say they will do	82	41.6	19	9.6	30	15.2	10	5.1	56	28.4
12–17 years old (n=85–88)										
Talk to you by yourself	17	19.3	11	12.5	15	17.1	24	27.3	21	23.9
Listen to you	36	41.4	12	13.8	10	11.5	12	13.8	17	19.5
Explain decisions made about you clearly	37	43.5	12	14.1	9	10.6	11	12.9	16	18.8
Help you	38	43.2	13	14.8	12	13.6	10	11.4	15	17.1
Do what they say they will do	26	30.2	16	18.6	11	12.8	18	20.9	15	17.4

Figure 8.3: Child reports of 'Always' or 'Often' receiving support from caseworker, by child age



8.2 Caregiver experience, satisfaction and training to be a carer

Caregivers' length of experience at the time of interview and satisfaction in their role can have a large impact on children's ease of settling into the placement as well as the long-term stability of the placement. Table 8.14 shows that the most common length of experience as a caregiver (with any OOHC placement) was one year (27%), followed by two to three years (25%). Only 19% of caregivers had less than one year of experience, while 29% had four or more years of experience. More caregivers of 9–35 month old children had less than one year of experience than caregivers of older children (24% compared with 11%–19%). Conversely, a greater proportion of those caring for 12–17 year olds had over 10 years of experience (15%) in comparison to caregivers of 9–35 month olds (8%).

Over 90% were 'satisfied' or 'very satisfied' with being a caregiver, and only 3% were 'dissatisfied' or 'very dissatisfied' with being a caregiver. Similarly, almost all caregivers were either 'likely' or 'very likely' to continue as a caregiver (98%). Caregivers of older study children tended to have a larger number of their own children (i.e., 38% had raised four or more children compared to 27% of carers of 9–35 month old children). As displayed in Figure 8.4, the great majority of caregivers reported that they were 'satisfied' or 'very satisfied' with balancing care for the child with the family's schedule (93%), although the proportion that were 'very satisfied' was lower for carers of older children.

Table 8.14: Caregiver reports of their caregiving experience, by child age

	9–35 months		3–5 years		6–11 years		12–17 years		Total	
	n	%	n	%	n	%	n	%	n	%
Experience as a caregiver[1]										
1–3 months	15	2.7	5	1.9	6	1.8	0	0.0	26	2.0
4–6 months	44	7.8	15	5.7	19	5.8	8	6.5	86	6.7
7–11 months	74	13.1	30	11.3	28	8.5	5	4.0	137	10.7
1 year	133	23.5	84	31.7	109	33.1	24	19.4	350	27.2
2–3 years	136	24.0	58	21.9	72	21.9	53	42.7	319	24.8
4–10 years	118	20.8	40	15.1	55	16.7	15	12.1	228	17.7
11 or more years	47	8.3	33	12.5	40	12.2	19	15.3	139	10.8
Total	**567**		**265**		**329**		**124**		**1,285**	
Satisfaction with being a carer[2]										
Very satisfied	392	69.5	172	64.9	198	60.4	50	51.0	812	64.7
Satisfied	133	23.6	71	26.8	103	31.4	39	39.8	346	27.6
Unsure	24	4.3	15	5.7	20	6.1	7	7.1	66	5.3
Dissatisfied	11	2.0	5	1.9	4	1.2	1	1.0	21	1.7
Very dissatisfied	4	0.7	2	0.8	3	0.9	1	1.0	10	0.8
Total	**564**		**265**		**328**		**98**		**1,255**	
Whether likely to continue as carer[2]										
Very likely	515	91.3	244	92.1	294	90.5	80	86.0	1,133	90.9
Likely	38	6.7	14	5.3	29	8.9	11	11.8	92	7.4
Unlikely	5	0.9	4	1.5	0	0.0	2	2.2	11	0.9
Not at all likely	6	1.1	3	1.1	2	0.6	0	0.0	11	0.9
Total	**564**		**265**		**325**		**93**		**1,247**	
Number of own children raised[2]										
None	89	15.7	48	18.1	48	14.6	9	9.2	194	15.4
One	85	15.0	23	8.7	26	7.9	6	6.2	140	11.1
2–3	240	42.3	113	42.6	146	44.4	46	46.9	545	43.3
4 or more	153	27.0	81	30.6	109	33.1	37	37.8	380	30.2
Total	**567**		**265**		**329**		**98**		**1,259**	

1 Asked of both carers (foster and relative/kinship) and residential care workers.

2 Residential care workers excluded (n=26).

Figure 8.4: Caregiver reports of their satisfaction with balancing care for the child with the family's schedule, by child age (n=1,259)

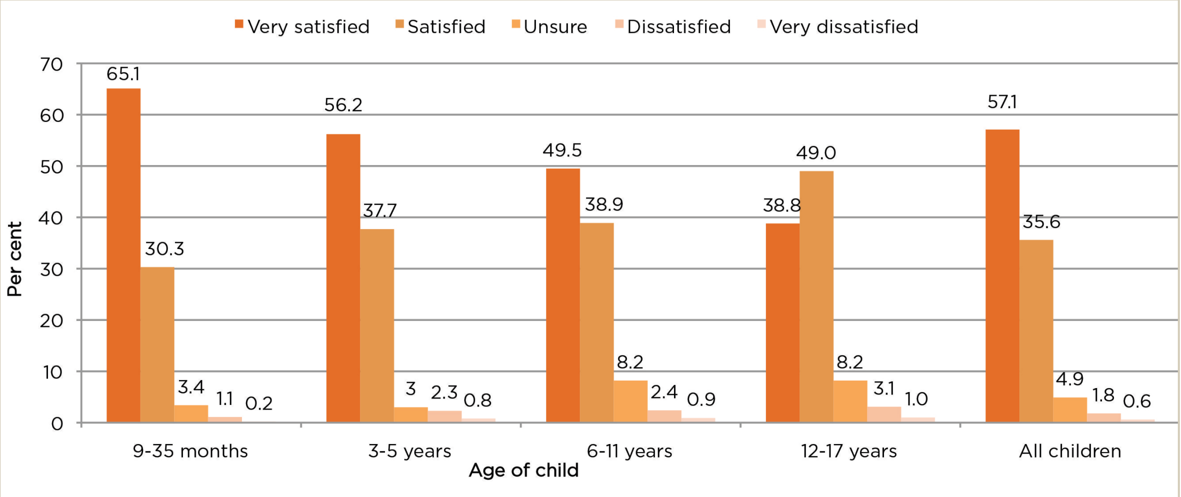


Table 8.15 shows that foster carers tended to have more experience in caring for a child in OOHC than relative/kinship carers. For example, 43% of foster carers had four or more years of experience compared with 14% of relative/kinship carers. Similarly, the most common length of experience as a carer across the placement types was one year for relative/kinship carers (39%) and 4–10 years for foster carers (28%). In general, foster and relative/kinship carers had similar levels of satisfaction with being a carer and their likelihood of continuing to be a carer in the future, although foster carers were more likely to report being 'very satisfied' with being a carer (70%) in comparison to relative/kinship carers (59%). On the other hand, relative/kinship carers reported raising a higher number of their own children in comparison to foster carers, with 37% of relative/kinship carers and 24% of foster carers having raised four or more children.

Table 8.15: Carer reports of their caregiving experience and satisfaction, by placement type

	Foster care		Relative/ Kinship care	
	n	%	n	%
Experience as a carer				
1–3 months	12	1.8	14	2.3
4–6 months	51	7.7	35	5.9
7–11 months	43	6.5	94	15.7
1 year	118	17.9	232	38.8
2–3 years	154	23.3	139	23.2
4–10 years	183	27.7	45	7.5
11 or more years	100	15.1	39	6.5
Total=1,259	661		598	

	Foster care		Relative/ Kinship care	
	n	%	n	%
Satisfaction with being a carer				
Very satisfied	460	69.6	352	59.3
Satisfied	165	25.0	181	30.5
Unsure	23	3.5	43	7.2
Dissatisfied	11	1.7	10	1.7
Very dissatisfied	2	0.3	8	1.4
Total=1,255	661		594	
Whether likely to continue as carer				
Very likely	587	90.0	546	91.9
Likely	56	8.6	36	6.1
Unlikely	6	0.9	5	0.8
Not at all likely	4	0.6	7	1.2
Total=1,247	653		594	
Number of own children raised				
None	160	24.2	34	5.7
One	104	15.7	36	6.0
2–3	239	36.2	306	51.2
4 or more	158	23.9	222	37.1
Total=1,259	661		598	
Balancing care for the child with their family's schedule				
Very satisfied	401	60.7	318	53.2
Satisfied	222	33.6	226	37.8
Unsure	22	3.3	40	6.7
Dissatisfied	12	1.8	11	1.8
Very dissatisfied	4	0.6	3	0.5
Total=1,259	661		598	

Caregiver training

Overall, 30% of carers reported having a carer development plan, with a higher proportion of foster carers having a plan (40%) compared to relative/kinship carers (19%) (Table 8.16). While 37% of caregivers reported attending a training program in the previous 12 months, there was a large discrepancy between foster carers (56%) and relative/kinship carers (14%). Figure 8.5 shows that of all the relative/kinship carers who had attended a training session in the previous 12 months, only 5% attended two or more sessions, while about one third of foster carers attended two or more sessions.

Overall, the most commonly attended types of training attended over the past 12 months were parenting programs (12%) and OOHC carer training/information (10%).

Not having enough time was the most common barrier to attending training (24%) followed by the training not being held at a convenient time (22%) and not having anyone else to care for the child (20%). When comparing across the placement types, greater proportions of relative/kinship carers than foster carers felt that appropriate training was not offered to them (25% compared with 13%), and a higher proportion of relative/kinship carers were not interested in participating in training (24% compared to 8% of foster carers). Not being able to find someone to care for their child, and the training being held at an inconvenient time and too far away were more salient barriers for foster carers.

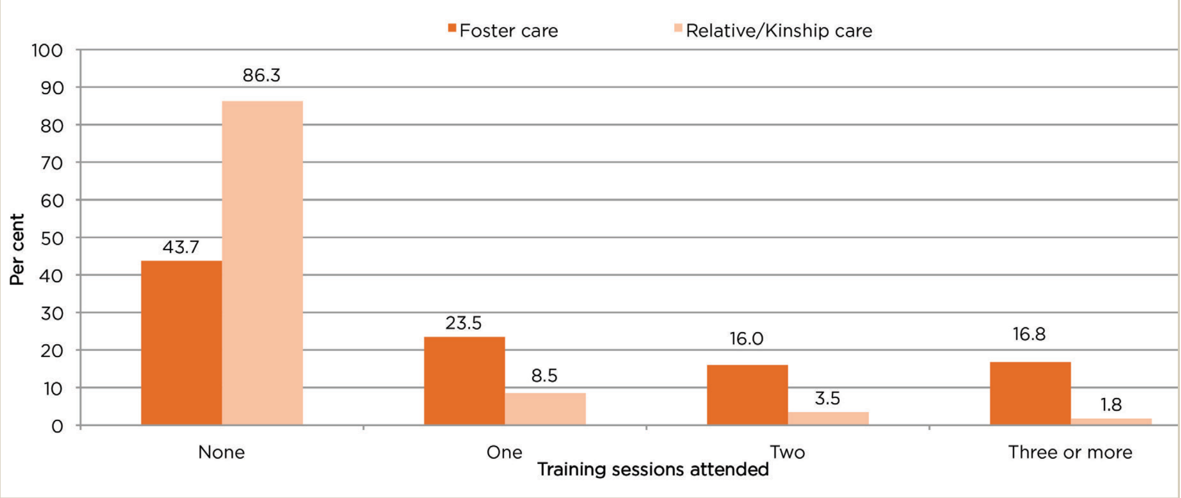
Table 8.16 Carer reports of carer development plans, carer training received and barriers to carer training, by placement type[1, 2]

Characteristic	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Carer development plan						
Yes	169	40.1	67	18.8	236	30.4
No	245	58.2	281	78.9	526	67.7
Don’t know	7	1.7	8	2.2	15	1.9
Total[3]	**421**		**356**		**777**	
Training sessions attended in last 12 months						
Parenting program	85	17.9	19	4.8	104	11.9
OOHC carer training/information	76	16.0	15	3.8	91	10.4
Trauma, attachment or impact of abuse	49	10.3	10	2.5	59	6.7
Behaviour management	43	9.0	7	1.8	50	5.7
Child and young person health development and wellbeing	38	8.0	6	1.5	44	5.0
Cultural understanding	35	7.4	2	0.5	37	4.2
First aid	25	5.3	4	1.0	29	3.3
Mental health/illness	24	5.0	3	0.8	27	3.1
Training through your OOHC agency	23	4.8	1	0.3	24	2.7
Life story work	21	4.4	2	0.5	23	2.6
Contact with birth family	19	4.0	1	0.3	20	2.3
Shared Stories Shared Lives	16	3.4	0	0.0	16	1.8
Adoption/Ageing out/Restoration	16	3.4	1	0.3	17	1.9
Autism and aspergers	16	3.4	0	0.0	16	1.8
Disabilities	12	2.5	0	0.0	12	1.4
Difficult conversations/Communication	11	2.3	1	0.3	12	1.4
Cyber-bullying/Computers	11	2.3	2	0.5	13	1.5
Drugs and alcohol	10	2.1	2	0.5	12	1.4
Legal information/Court processes	9	1.9	3	0.8	12	1.4
Impact of fostering on carers children and family	8	1.7	2	0.5	10	1.1
Stress management for carers	8	1.7	2	0.5	10	1.1
Other	34	7.1	6	1.5	21	2.4
Total	**476**		**400**		**876**	
At least one training session attended in last 12 months						
	268	56.3	55	13.7	323	36.9
Total	**476**		**400**		**876**	

Characteristic	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Reasons why hard to take part in training						
Not enough time	120	25.2	92	23.0	212	24.2
Not at a convenient time	140	29.4	54	13.5	194	22.1
No one else to care for the child	126	26.5	48	12.0	174	19.9
Appropriate training not offered	64	13.4	98	24.5	162	18.5
Not interested	36	7.6	97	24.3	133	15.2
Too far away	77	16.2	23	5.8	100	11.4
Other reason - Don't know what is available[4]	2	0.4	4	1.0	6	0.7
Other reason - Transport issues[4]	4	0.8	1	0.3	5	0.6
Other reason - Insufficient notice given[4]	5	1.1	1	0.3	6	0.7
At least one barrier	330	69.3	291	72.8	621	70.9
Total	476		400		876	

1 Column percentages do not add up to 100%, as caregivers may have attended multiple types of training and have multiple reasons for why it is hard to take part in training.
2 Unit of analysis is the carer.
3 Excludes missing cases (n=99).
4 Responses coded from 'Other (specify)'.

Figure 8.5: Carer reports of number of training sessions attended, by placement type (n=876)



8.3 Summary of key findings

Services and support provided to children and carers

- The most common health service provided to children was a general practitioner consultation followed by consultations with a paediatrician and receipt of dental services.
- Children aged 12–17 years attended dental and counselling/psychological services more often than younger age groups, while younger children aged 9–35 months attended a paediatrician consultation or an Early Childhood Health Centre more often than older children.
- The majority of carers felt that children's needs had been very well met by professional services, while fewer than one in 10 carers felt that their child's health needs had not been well met.
- The most common types of support received by carers to assist them in caring for the child were childcare, respite care, and carer support organisations/groups.
- In terms of services needed and not yet accessed, the greatest need overall was for childcare or before/after school care, respite care and support from carer support organisations/groups. The most frequently identified reason that prevented access to services was long waiting lists.
- Carers also commonly received support from their spouse/partner, family members and friends in raising the study children.

Caseworker support

- The number of different caseworkers seen by the child since starting the current placement varied from one to 10, with relatively similar proportions having been seen by one, two, or three or more caseworkers.
- The majority of carers had less than monthly face-to-face contact with their caseworker and approximately 1 in 8 carers never had face-to-face contact with their caseworker. However, phone or email contact with caseworkers was more frequent (40% had fortnightly or more frequent phone/email contact).
- Overall, approximately two thirds of carers were satisfied with their access to caseworkers when needed, and similar proportions were satisfied with the assistance they had received from caseworkers.
- Over half of children aged 7–17 years thought their caseworker frequently listened to, helped them and explained decisions clearly, but did not as frequently talk to them in private.

Carer experience, satisfaction and training

- Approximately half of carers had 1–3 years experience in caring for a child in OOHC, and over a quarter had four or more years of experience in caring for children in OOHC.
- Most carers were satisfied with being a carer and almost all carers were likely to continue as a carer.
- Overall, 93% were satisfied with balancing care for the child with the family's schedule, but satisfaction was slightly lower among carers of older children.
- Just over a third of carers had attended a training program in the previous 12 months, and just under a third had a carer development plan in place.
- More foster carers than relative/kinship carers reported having a carer development plan in place and had attended training in the past 12 months.

8.4 Conclusion

Children and caregivers participating in the POCLS had received a broad range of services, support and information since the start of the placement. Overall, caregivers felt that their needs and those of the study child had been well met by the services received. However, a number of service needs remained. Caregivers also identified a range of reasons that prevented their ability to access services for the child and themselves. Generally, caregivers were satisfied with their access to caseworkers and the assistance that had been provided. However, children were less likely to report being satisfied with caseworker support.

9

Characteristics of the caregiver, household and neighbourhood

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Despite the importance of the quality of care provided by caregivers to children in out-of-home care (OOHC), the literature is relatively sparse on the contribution of the caregiver or household characteristics, particularly in regard to the longer-term impacts of the OOHC household environment on children. The existing literature focuses on the differences between foster and relative/kinship caregivers, across areas such as demographics, economic resources, and physical and mental health. This research has indicated that relative/kinship carers tend to be more economically disadvantaged than foster carers (Berrick, 1997; Brandon, 2004), with their incomes, rates of home ownership, and education and employment levels tending to be lower (Harden et al, 2004). Higher rates of single parenthood have also been noted among relative/kinship carers, with these carers also tending to be older than foster carers (Harden et al, 2004). In NSW, OOHC placements for Aboriginal children are guided by the Aboriginal Placement Principle and relative/kinship care is preferred over foster care, thus understanding the factors that influence child outcomes is paramount. As indicated in the NSW and national standards for statutory OOHC, the experiences and quality of care can have a long-term impact on the wellbeing and future life opportunities offered to children (FaHCSIA, 2011; NSW Office of the Children's Guardian, 2013).

This chapter investigates the characteristics of the current caregiver, household and neighbourhood where the study child was placed at the time of the Wave 1 interview and provides baseline data that addresses the Key Research Question: '*In what ways do the characteristics of the child, carer, home/family and community affect the* *children's and young people's developmental pathways, and how do these differ from similarly situated children in the general population?'*[1]

9.1 Caregiver's demographic characteristics

The data reported in this chapter is primarily the characteristics of the caregiver interviewed at Wave 1[2]. The vast majority (91%) of interviewed caregivers were female with 9% being male. A total of 1,285 study children participated in the Wave 1 data collection; however, the number of households that took part was 897 as many foster carers, relative/kinship carers and residential care workers had more than one study child in their care. The majority of the analysis excludes those in residential care (n=26) either because the question was not applicable (e.g., if the carer has a spouse/partner) or the frequency counts were low.

Age, marital status and cultural background

Table 9.1 shows that just over one quarter (27%) of the caregivers interviewed were aged between 21 and 40 years, just over one third (36%) aged between 41–50 years and just over one quarter (27%) aged between 51–60 years. Eleven per cent of caregivers were aged 61 years or older (less than 2% were aged over 70 years and the oldest caregiver was 84 years old). Overall, relative/kinship carers were older when compared with foster carers.

Over three quarters (78%) of caregivers were either married or in a de-facto relationship, while 12% had divorced or separated and 7% had never been married. Overall, a higher proportion of foster carers interviewed were married (74%) in comparison with relative/kinship carers (60%), although a higher proportion of relative/kinship carers were in de-facto relationships (14% compared with 8% of foster carers).

Sixteen per cent of the caregivers interviewed identified as Aboriginal, and 15% were from CALD backgrounds. When compared with Australian Bureau of Statistics (ABS) data derived from the 2011 Australian Census, the proportion of caregivers in this study who identified as being Aboriginal was much higher than in the overall Australian adult population[3].

Overall, a higher proportion of the relative/kinship carers interviewed compared with the foster carers interviewed were Aboriginal (20% compared with 13%). A relatively similar proportion of foster and relative/kinship carers identified as CALD (i.e., 14% compared with 17% respectively). Please note, the non-interviewed caregiver could be from an Aboriginal or CALD background, and this data will be examined in subsequent reports.

Education and employment

As is also shown in Table 9.1, Certificate III/IV was the most commonly identified highest level of education by the caregivers interviewed (22%). A Bachelor degree

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[1] Please see Chapter 2 for a description of the data analysis undertaken in this report.

[2] In this chapter, the term 'caregiver' refers to the caregiver of the study child who was interviewed for Wave 1 of the POCLS. The POCLS attempted to interview the caregiver who knew the study child best so it cannot be assumed that the carer interviewed was the main caregiver of the study child in cases where there was a second caregiver in the household. The characteristics of the caregiver not interviewed will be described in subsequent reports.

[3] 16% of the POCLS caregivers interviewed compared with 2% of adults aged 20 years or older in the census population (Australian Bureau of Statistics, 2012a).

or higher (i.e., graduate diploma/certificate or postgraduate degree) had been achieved by 17% of the caregivers interviewed, while 11% of caregivers indicated an advanced diploma/diploma as their highest level of education. Year 10 (or equivalent) or below was reported by almost one third (33%) of caregivers as their highest level of education completed. Overall, foster carers were more likely than relative/kinship carers to have obtained a Bachelor degree (11% compared with 5%) or an advanced diploma/diploma (14% compared with 7%). When the highest level of caregiver education for the POCLS sample is compared with 2011 Australian Census data, the education levels are relatively comparable (although it should be noted that the Census results are for people aged 15 years and over while carers in the POCLS were aged 21 and over)[4].

It appears that a relatively similar proportion of the relative/kinship carers interviewed were in paid employment (38%) when compared with foster carers (35%). Almost all of those not in paid employment (i.e., undertaking unpaid work or did not have a job) did not look for work in the last week.

Table 9.1: Carer reports of their demographic characteristics, by placement type[1]

Demographic characteristic of the carers interviewed	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Age (years)						
21–30	20	4.5	27	7.0	47	5.6
31–40	124	27.7	50	13.0	174	20.9
41–50	189	42.2	110	28.7	299	35.9
51–60	91	20.3	131	34.1	222	26.7
61+	24	5.4	66	17.2	90	10.8
Total	448		384		832	
Marital status						
Not married/never married	37	8.2	20	5.7	57	7.1
Married	330	73.5	210	59.5	540	67.3
De-facto	35	7.8	51	14.5	87	10.8
Divorced	25	5.6	34	9.6	59	7.4
Separated	15	3.3	22	6.2	37	4.6
Widowed	7	1.6	16	4.5	23	2.9
Total	449		353		803	

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[4] For example, 18% of caregivers interviewed had a highest education level of a Bachelor degree or above compared with 16% of the Census population, whereas the highest education level for 34% of caregivers interviewed was Year 11 or below, in comparison to 32% of the Census population (Australian Bureau of Statistics, 2011b).
A key difference between the POCLS carers interviewed and 2011 Census samples, however, was that the minimum carer age was 21 years at Wave 1, while the census data was based on all persons aged 15 years and over. Hence, a certain proportion of the Census population (i.e., who were aged under 18 years) would not have completed secondary school as yet, much less higher education, as a direct result of their age.

Demographic characteristic of the carers interviewed	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Cultural background[2]						
Aboriginal[3]	54	13.0	74	19.6	128	16.1
CALD[4]	57	13.7	63	16.7	120	15.1
Other Australian[5]	306	73.4	241	63.8	548	68.8
Total	417		378		796	
Highest level of education						
Postgraduate degree	28	5.9	17	4.3	45	5.1
Graduate diploma/certificate	20	4.2	15	3.8	35	4.0
Bachelor degree	53	11.1	19	4.8	72	8.2
Advanced diploma/diploma	65	13.7	30	7.5	95	10.8
Certificate III/IV	101	21.2	90	22.5	191	21.8
Certificate I/II	28	5.9	23	5.8	51	5.8
Other non-school qualification	10	2.1	12	3.0	22	2.5
Year 12 or equivalent	30	6.3	27	6.8	57	6.5
Year 11 or equivalent	7	1.5	11	2.8	18	2.1
Year 10 or equivalent	83	17.4	82	20.5	165	18.8
Year 9 or below	51	10.7	74	18.5	125	14.3
Total	476		400		876	
Employment status (in past week)						
In paid employment	182	38.3	139	34.8	321	36.6
Undertaking unpaid work	13	2.7	9	2.3	22	2.5
Did not have a job	280	59.0	251	62.9	531	60.8
Total	475		399		874	
Did not look for full-time or part-time work (in past week)[6]						
	290	99.0	257	98.9	547	98.9
Total	293		260		553	

1 Excludes residential care workers.

2 This variable was comprised of variables assessing Aboriginal status, LOTE (Language Other Than English) and primary cultural identity. The 'culture unspecified' category, however, was excluded from the analysis.

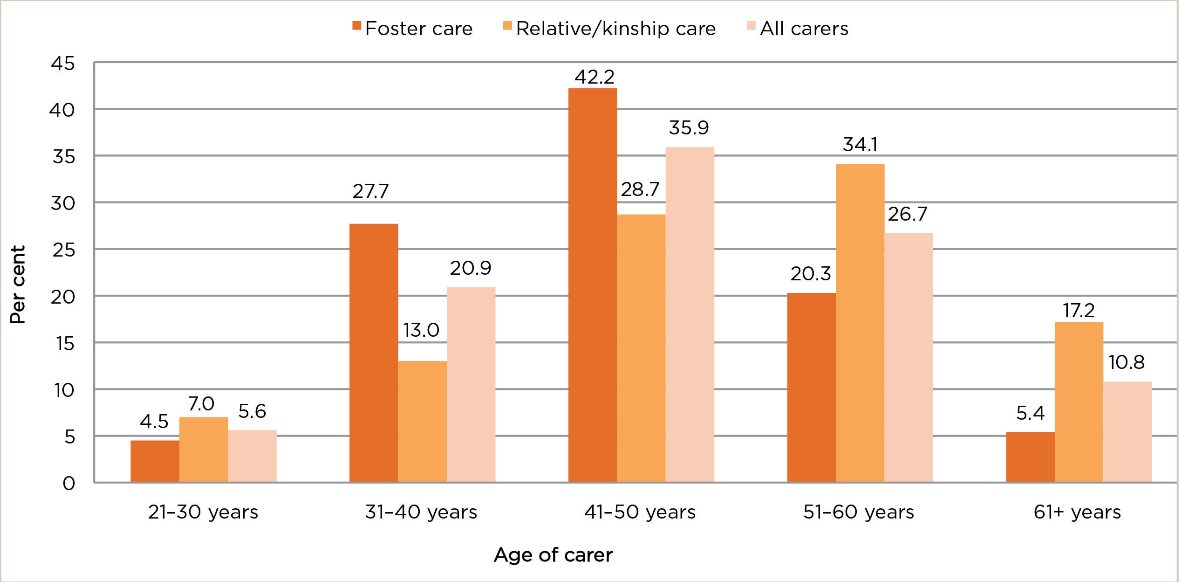
3 'Aboriginal' refers to whether the caregiver was of Aboriginal and/or Torres Strait Islander origin.

4 CALD = Culturally and Linguistically Diverse.

5 The 'Other Australian' category applies to caregivers who identified as being Australian, but not of an Aboriginal or CALD origin.

6 Only asked of those who were undertaking unpaid work or did not have a job.

Figure 9.1: Age of carers[1]



1 Excludes residential care workers.

Health and wellbeing

Table 9.2 shows that approximately two thirds (67%) of the caregivers interviewed considered themselves to be in excellent or very good health, with a further 22% rating their physical health as 'good'. There were 11% of caregivers who believed that their physical health was fair, poor or very poor. While 29% of caregivers indicated that they had a medical condition or disability that had already lasted, or was likely to last, at least six months, a lower proportion (8%) indicated they had a health condition that was impacting on caregiving of their study child(ren).

Caregiver reports of their physical health over the past four weeks shows some differences between foster and relative/kinship carers. While the same proportion indicated an 'excellent' level of physical health (both at 31%), a higher proportion of foster carers indicated 'very good' physical health (41% compared with 31% for relative/kinship carers), whereas a higher proportion of relative/kinship carers indicated 'good' (24% compared with 20%) or 'fair' (11% compared with 7%) levels of physical health over the past month. A higher proportion of relative/kinship carers reported a medical condition or disability that had already lasted or was likely to last at least six months, in comparison with foster carers (33% compared with 25%).

Caregivers' mental health was measured using the Kessler Psychological Distress Scale (K-10) scores (Table 9.2). Just fewer than 80% of caregivers reported experiencing low psychological distress at the time of the interview. Sixteen per cent of caregivers were experiencing moderate psychological distress, and 6% were experiencing high or very high levels of psychological distress. There were some moderate differences between foster and relative/kinship carers on mental health, with 85% of foster carers experiencing low psychological distress according to their K10 score, in comparison with 71% of relative/kinship carers. This difference between the caregiver types was predominately accounted for by 20% of relative/kinship carers being likely to be experiencing moderate psychological distress, in comparison to 12% of foster carers interviewed.

The mental health of the POCLS caregivers compared relatively favourably to that of the general population (Australian Bureau of Statistics, 2012b)[5].

Table 9.2: Caregiver reports of their physical and mental health, by placement type

Carers' physical and mental health characteristic	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Physical health in the past four weeks						
Excellent	147	30.9	123	30.9	270	30.9
Very good	194	40.8	123	30.9	317	36.3
Good	94	19.7	95	23.9	189	21.6
Fair	32	6.7	45	11.3	77	8.8
Poor or very poor[1]	9	1.9	12	3.0	21	2.4
Any medical conditions or disabilities that have lasted or are likely to last for at least six months						
Yes	121	25.4	133	33.4	254	29.1
No	355	74.6	265	66.6	620	70.9
Health condition that impacts caregiving of the study child[2]						
Yes	31	6.5	39	9.8	70	8.0
No	445	93.5	359	90.2	804	92.0
Overall mental health – K-10[3] cut-offs[4]						
Low psychological distress	398	84.5	275	71.1	673	78.6
Moderate psychological distress	58	12.3	78	20.2	136	15.7
High psychological distress	13	2.8	24	6.2	37	4.3
Very high psychological distress	2	0.4	10	2.6	12	1.4
Total	**476**		**398**		**874**	

1 Poor and very poor were combined, given that there was only an overall frequency of four cases for 'very poor'.
2 Given that the variables in this table have been analysed at the household level (i.e., where there is only one case per household and carer interviewed), for this item, which refers to whether the carer interviewed had a health condition that impacts caregiving for the study child, only the response provided for the first study child recorded in the database is presented here. It is highly likely, however, that caregivers would have provided the same response in cases where there were multiple study children in the household, and hence, this variable as presented here is satisfactory for examination at the household level.
3 K-10 = Kessler Psychological Distress Scale.
4 n=858 respondents for the Kessler Psychological Distress Scale (K-10) including 471 foster carers and 387 relative/kinship carers.

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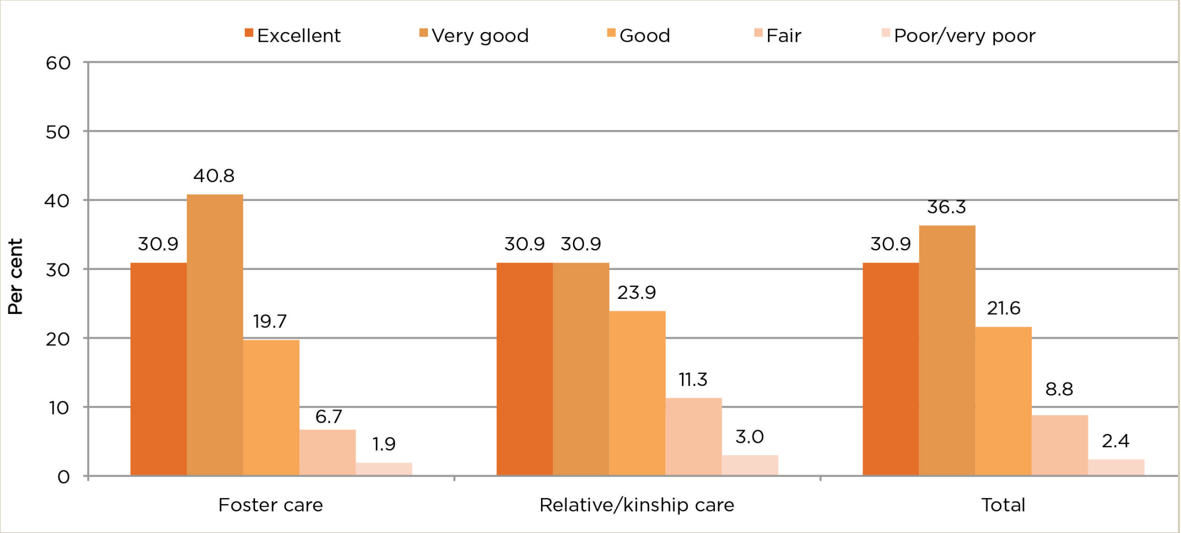
[5] The 2007/08 National Health Survey (NHS) (aged 18 years and over) collected K-10 scores and the results for adults (and females only given that the majority of caregivers interviewed at Wave 1 were females) are presented as a comparison with the general population. In the NHS K-10 scores, 67% of adults (63% females only) were experiencing low psychological distress, 21% of adults (23% females only) were experiencing moderate levels of psychological distress, and 12% of adults (14% of females) were likely to be experiencing high or very high psychological distress.

Figure 9.2: Caregiver reports of their physical health[1] in the past four weeks, by placement type



1 Poor and very poor were combined, given that there was only an overall frequency of four cases for ‘very poor’.

As shown in Table 9.3, the overwhelming majority (96%) of caregivers reported that their households were smoke free, and if there were smokers present in the household, they were not permitted to smoke inside the house. Slightly more foster carers reported their home to be smoke free (99%) in comparison to relative/kinship carers (92%).

Almost half (49%) of the caregivers reported that they occasionally drank alcohol, 43% indicated they did not drink alcohol, 7% were moderate consumers of alcohol, 2% were ‘ex-drinkers’ and no caregivers reported that they were high consumers of alcohol. There appeared to be few differences in regard to alcohol consumption when comparing relative/kinship carers with foster carers.

Table 9.3: Caregiver reports of smoking and alcohol consumption, by placement type

Caregiver reports of:	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Level of smoking						
My home is smoke free (includes smoking is allowed outside only)	465	98.9	363	92.1	829	95.8
People occasionally or frequently smoke inside the house[1]	5	1.1	31	7.9	36	4.2
Total	470		394		865	
Alcohol consumption[2]						
Non-drinker	208	43.8	163	41.3	371	42.6
Ex-drinker	2	0.4	18	4.6	20	2.3
Occasional drinker	237	49.9	185	46.8	423	48.6
Moderate drinker	28	5.9	29	7.3	57	6.5
Heavy drinker	0	0.0	0	0.0	0	0.0
Total	475		395		871	

1 People 'occasionally' and 'frequently' smoking in the house were combined, given that there was only an overall frequency of three cases for 'frequently'.
2 'Heavy drinker' was not included as a response option, given that the overall frequency for this variable was zero.

Table 9.4 shows that the majority (84%) of caregivers with a spouse/partner reported that there was never or rarely anger/hostility between them and less than a fifth (16%) indicated that there was sometimes or often anger/hostility between them. Only two caregivers reported that there was often anger/hostility between themselves and their spouse/partner (and no-one answered 'always'). The vast majority of caregivers also indicated that they were at least 'happy' in their relationship with their spouse/partner (91%); however, 7% did indicate that they were 'extremely unhappy'. There were only minor differences between placement types for the frequency of anger or hostility between the caregivers interviewed and their spouse/partner.

Table 9.4: Caregiver reports of their relationship with their spouse/partner, by placement type

Caregiver reports on their relationship[1]	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Frequency of anger or hostility between carer interviewed and spouse/partner[2]						
Never	91	24.4	64	24.6	155	24.5
Rarely	226	60.6	148	56.9	374	59.1
Sometimes or often[3]	56	15.0	48	18.5	104	16.4
Total	373		260		633	
Degree of happiness with spouse/partner						
Extremely unhappy	25	6.7	18	6.9	43	6.8
Fairly unhappy	2	0.5	3	1.2	5	0.8
A little unhappy	7	1.9	5	1.9	12	1.9
Happy	33	8.9	30	11.5	63	10.0
Very happy	78	21.0	68	26.2	146	23.1
Extremely happy	144	38.7	81	31.2	225	35.6
Perfectly happy	83	22.3	55	21.2	138	21.8
Total	372		260		632	

1 Caregivers responding to the face-to-face interview were asked the two questions included in this table if it was verified that there was another caregiver present in the household, or if there was not another caregiver, if the caregiver interviewed indicated that they had a spouse/partner living with them in the household.
2 'Always' was not included as a response option, given that the overall frequency for this variable was zero.
3 Sometimes and often were combined, given that there was only an overall frequency of two cases for 'often'.

9.2 Caregiving household demographic characteristics

This section provides an overview of the demographic characteristics of the study child's current caregiving family. These analyses were conducted at the 'child-level' (n=1,285), so that the household characteristics reported relate to findings for all individual study children at Wave 1.

Household membership

Table 9.5 shows that three quarters of the study children (74%) were living in a household with a caregiver and there spouse/partner. This was more common in foster care placements (80%) than in relative/kinship care placements (68%).

In regard to the number of children living in the household, almost half of the study children (49%) were the only study child in the household, although the majority were living with at least one other non-study child who could have been another child in OOHC, or a birth child of the caregiver interviewed. When considering the total number of children (both study and non-study) in the caregiver household, almost two thirds of study children were living with at least two other children (62%). Overall, only 15% of study children were the only child living in the caregiver household.

Study children in foster care placements were slightly more likely than relative/kinship care placements to be the only study child in the household (51% compared with 45%). In 18% of relative/kinship care placements, the study child was the only child in the household in comparison to 12% in foster care placements. When comparing the total number of children (study and non-study) in the families, foster care families were more likely to have five or more other children residing in the household (13%, M=3.1, SD=1.7) than relative/kinship care families (7%, M=2.7, SD=1.6).

Study children were reported as having their own bedroom in 58% of cases, with this figure being similar for children in relative/kinship care and foster care placements.

There were some differences between children in foster and relative/kinship care placements in regard to their Aboriginal status and that of the interviewed caregivers, with both the study child and their caregiver being of Aboriginal origin in 20% of relative/kinship care cases, in comparison to 13% of foster care cases. On 27% of occasions, study children in foster care were identified as being Aboriginal but the caregivers interviewed were not, in comparison to 19% of study children in relative/kinship care. Neither the study child nor the caregiver interviewed was Aboriginal for approximately 60% of both relative/kinship care and foster care cases. It was very uncommon for the caregiver to be Aboriginal but the study child not to be Aboriginal (1% of cases, n=14).

When considering whether the study child or their carer was identified as being from a culturally diverse background, in the vast majority (82%) of cases, neither the study child nor their carer was from a culturally diverse background whereas 8% of study children were not culturally diverse, but their carer was. This was similar for children in both foster care and relative/kinship care. In a further 6% of cases, both the study child and their carer were from culturally diverse backgrounds and this was somewhat more likely for children in relative/kinship care (8%) than children in foster care (4%). Finally, on 4% of occasions, the study child was from a culturally diverse background, but their carer was not and this was more likely for children in foster care (6%) than children in relative/kinship care (2%).

Table 9.5: Caregiver reports of the household characteristics at the child level, by placement type

Caregiver household characteristic	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Spouse/Partner of carer interviewed present in the household[5]						
Yes	528	80.0	403	67.7	931	74.2
No	132	20.0	192	32.3	324	25.8
Total	660		595		1,255	
Number of other study children in the household[1]						
None	335	50.7	269	45.0	624	48.6
One other study child	218	33.0	172	28.8	396	30.8
Two other study children	69	10.4	78	13.0	147	11.4
Three or more other study children	39	5.9	79	13.2	118	9.2
Total	661		598		1,285	
Number of children in the household[2]						
Study child is the only child	78	11.8	105	17.6	191	14.9
One other child	144	21.8	150	25.1	304	23.7
Two other children	170	25.7	139	23.2	313	24.4
Three other children	104	15.7	82	13.7	189	14.7
Four other children	78	11.8	80	13.4	159	12.4
Five or more other children	87	13.2	42	7.0	129	10.0
Total	661		598		1,285	
Study child's sibling also lives in the household[3]						
No	282	42.7	203	34.0	506	39.4
Yes	379	57.3	395	66.1	779	60.6
Total	661		598		1,285	
Does the study child have their own bedroom?						
Yes, study child has own bedroom	378	57.2	342	57.2	746	58.1
No, study child does not have own bedroom	283	42.8	256	42.8	539	42.0
Total	661		598		1,285	
Aboriginal status of study child and the carer interviewed[4, 5]						
Study child and carer are both Aboriginal	69	12.5	103	19.5	172	15.9
Study child is Aboriginal, but the carer not Aboriginal	147	26.5	99	18.8	246	22.7
Study child is not Aboriginal, but carer is Aboriginal	8	1.4	6	1.1	14	1.3
Neither the study child nor carer are Aboriginal	330	59.6	319	60.5	650	60.1
Total	554		527		1,082	
CALD status of the study child and the carer interviewed[5]						
Study child and carer are both CALD	20	3.6	40	7.6	60	5.5
Study child is CALD, but carer not CALD	32	5.8	11	2.1	43	4.0
Study child not CALD, but carer is CALD	48	8.7	43	8.2	91	8.4
Neither study child nor carer are CALD	454	81.9	433	82.2	888	82.1
Total[5]	554		527		1,082	

1 Study children are classified as such due to the carer completing an interview for that child. However, there may be other children in the household that were eligible for an interview, but one was not completed. Hence, these particular children have been classified as non-study children and have not been included in this variable.
2 This variable was created by adding up the number of study children and non-study children in the household. Please note that this variable includes all people aged under 18 years who were residing in the household at the time of interview.
3 Please note that step-siblings have been included as siblings for this variable.
4 Aboriginal status refers to whether the study child and/or the caregiver interviewed were of Aboriginal and/or Torres Strait Islander origin. Please note that this does not take into account the Aboriginal status of the caregiver not interviewed (if present).
5 N=1,255 if item not asked of residential care workers or 1,285 if asked of all caregivers; in the above table, only 'spouse/partner of carer interviewed' was not asked of residential care workers. N=1,082 for Aboriginal and CALD status variables due to excluding cases (N=97) where culture was 'unspecified'.

Financial status of the household[6]

Table 9.6 shows that almost half (48%) of the participating family households had annual incomes of less than $60,000 (before tax). When compared with 2011 Australian Census data, 37% of families with children aged under 15 years had annual household incomes of under $65,000 (Australian Bureau of Statistics, 2011a). At the other end of the spectrum, 15% of the POCLS Wave 1 households had annual incomes of $120,000 or more.

Just over half (55%) of caregivers interviewed indicated they were reasonably comfortable, when asked how well they believed their family was getting on financially, given their current needs and financial responsibilities. A further one quarter (24%) thought they were prosperous or very comfortable, while one fifth (21%) indicated they were 'just getting by' or poor/very poor.

When asked if they would be able to raise $2,000 for an emergency in one week, over half (56%) of caregivers interviewed indicated that they could easily raise the money, while a further quarter (24%) indicated that they could do so with some sacrifices. One fifth (20%) of carers, however, indicated that they would have to do something drastic to raise the money, or did not think that they would be able to do so. In regard to the seven financial stress items, at least one was reported to have occurred to 14% of households in the past 12 months.

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[6] The unit of analysis is the household, n=876.

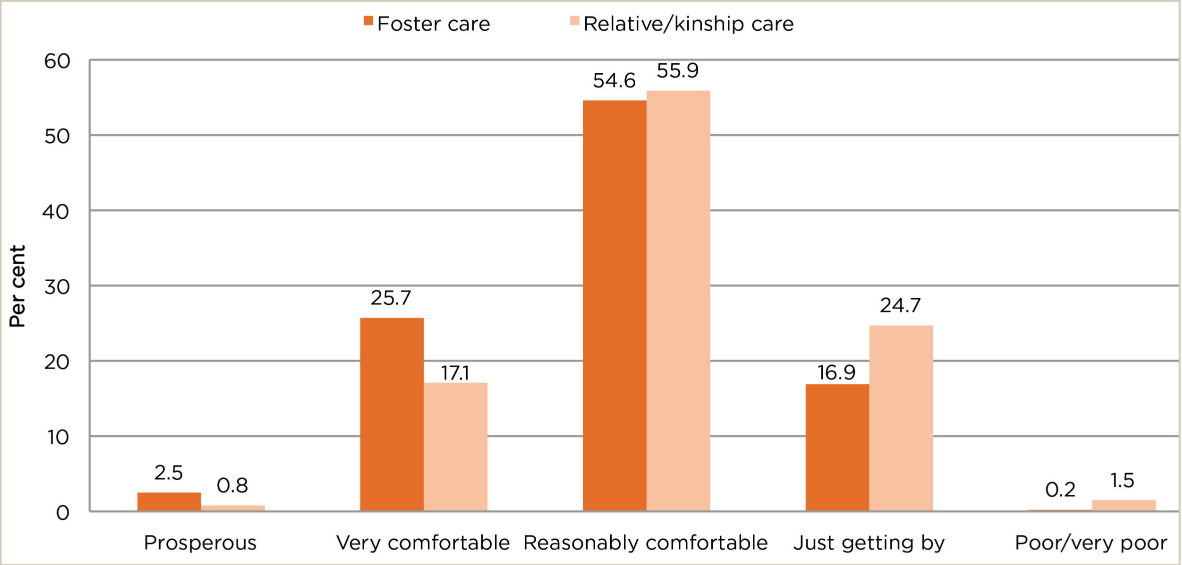
Table 9.6: Caregiver reports of the household's financial status, by placement type

Household financial status characteristic	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Annual household income before tax						
Less than $20,000	13	2.9	36	9.8	49	6.1
$20,000–$39,999	82	18.6	95	25.9	177	21.9
$40,000–$59,999	76	17.2	83	22.6	159	19.7
$60,000–$79,999	71	16.1	58	15.8	129	16.0
$80,000–$99,999	67	15.2	36	9.8	103	12.7
$100,000–$119,999	46	10.4	28	7.6	74	9.1
$120,000 or more	87	19.7	31	8.5	118	14.6
Total	442		367		809	
How well getting on financially						
Prosperous	12	2.5	3	0.8	15	1.7
Very comfortable	122	25.7	68	17.1	190	21.8
Reasonably comfortable	259	54.6	222	55.9	481	55.2
Just getting by	80	16.9	98	24.7	178	20.4
Poor/very poor[1]	1	0.2	6	1.5	7	0.8
Total	474		397		871	
Ability to raise $2,000 for an emergency in one week						
Could easily raise the money	289	61.8	187	48.1	476	55.5
Could raise the money, but it would involve some sacrifices	107	22.9	101	26.0	208	24.3
Would have to do something drastic to raise the money	29	6.2	27	6.9	56	6.5
Could not raise the money	43	9.2	74	19.0	117	13.7
Total	468		389		857	
Did at least one financial stressor occur in the past 12 months due to a shortage of money[2]						
Yes	47	9.9	72	18.2	119	13.7
No	428	90.1	324	81.8	752	86.3
Total	475		396		871	

1 'Poor' and 'very poor' were combined, given that there was overall frequencies of n=3 and n=4 for these response options.

2 The seven financial stress items included: (1) Could not pay gas, electricity or telephone bills on time; (2) Could not pay the mortgage or rent payments on time; (3) Went without meals; (4) Were unable to heat or cool your home; (5) Pawned or sold something because you needed cash; (6) Sought assistance from a welfare or community organisation; and (7) Were unable to send your child to kindergarten/preschool/childcare for as much time as you would like. These were not included individually, as many had very low frequencies for 'Yes'; hence, reporting whether any of the seven items applied to the household was deemed the most relevant to include.

Figure 9.3: Caregiver reports of the household's financial status[1], by placement type



1 'Poor' and 'very poor' were combined, given that there was overall frequencies of n=3 and n=4 for these response options.

Table 9.6 indicates that household income varied quite considerably between foster care and relative/kinship care households. Ten per cent of relative/kinship care households reported annual incomes of less than $20,000 (before tax), in comparison to only 3% of foster care households. Furthermore, 58% of relative/kinship care households had incomes of less than $60,000, while this applied to 39% of foster care households. Conversely, a higher proportion of foster care households had annual incomes of between $60,000 and $119,999 (42% compared with 33%) and of $120,000 or more (20% compared with 9%), when compared with relative/kinship care households.

It is well established that Aboriginal households tend to have lower household incomes. Household income was triangulated by the Aboriginal status of the carer interviewed as well as by placement type (not shown in Table 9.6). Just over two thirds (68%) of relative/kinship care households with an Aboriginal carer participating in this study reported annual incomes of under $60,000 (58% for CALD and 55% for other Australian carer relative/kinship care households), compared with 46% of foster care households with an Aboriginal carer (39% for CALD and 35% for other Australian carer foster care households). Hence, Aboriginal carers tended to report lower incomes than CALD or other Australian carers, regardless of whether they were from relative/kinship or foster care households.

Despite these differences in household income between the placement types, just over half of caregivers interviewed in both foster (55%) and relative/kinship households (56%), indicated they were reasonably comfortable, when asked how well their family was getting on financially given their current needs and financial responsibilities (Table 9.6). There appeared to be some differences, however, between the placement types in relation to the proportion of caregivers interviewed who indicated that they were very comfortable (26% for foster care compared with 17% for relative/kinship care) and just getting by (25% for relative/kinship care compared with 17% for foster care).

There were also differences between foster and relative/kinship carers' responses in regard to their capacity to raise $2,000 for an emergency in one week. While 62% of carers interviewed in foster care households indicated that they could easily raise the money, fewer relative/kinship care households indicated this was the case; just under half (48%). Conversely, at the other end of the spectrum, 26% of relative/kinship carers reported they would have to do something drastic to raise the money or did not believe they could raise the money, compared with 15% of foster carers. Further, for the seven financial stress items, at least one was reported to occur in 18% of participating relative/kinship care households over the past year (according to the carer interviewed), with the corresponding figure for foster care households being 10%.

9.3 Housing and neighbourhood characteristics

Table 9.7 shows that the vast majority (92%) of participating households in Wave 1 resided in separate (free-standing) houses with little difference between foster and relative/kinship care families. The minority of families were living in a semi-detached/town house/terrace house/villa (5%), and living in a unit/flat/apartment/granny flat (3%).

In regard to home ownership, 45% of caregivers reported they were paying-off their dwelling, while 17% owned the dwelling outright and 37% were paying rent or board. In comparison, 35% of private dwellings in Australia are owned with a mortgage or being paid off, 32% are owned outright, and 30% are rented (Australian Bureau of Statistics, 2013).

While the vast majority of both foster and relative/kinship care families were living in a separate house (93% for foster care and 91% for relative/kinship care), there were differences between the placement types for current housing arrangements with 56% of carers in foster care households indicating that they were paying-off their dwelling, in comparison to 31% of carers in relative/kinship care households. A higher proportion of carers from relative/kinship care households indicated that they were the outright or full owners of their home (22%) compared to carers from foster care households (13%). Rent or board was being paid in a much higher proportion of relative/kinship care households (47%) than in foster care households (29%).

Two thirds (66%) of the caregivers reported that their home accommodated the family very well, with a further 26% indicating that it accommodated the family fairly well. Only 9% of caregivers said their current home accommodated the family not very well or not well at all. The majority (86%) of the caregivers interviewed indicated that their current car accommodated the family very or fairly well, with only 3% indicating that the family did not have a car.

There were also some discrepancies between the placement types for how well the primary carers perceived their current homes and cars to accommodate their family. As shown in Table 9.7, 70% of carers from foster care households believed that their current home accommodated the family very well, in comparison to 61% of carers from relative/kinship care households. At the other end of the spectrum, 13% of carers from relative/kinship care households thought their home accommodated the family not very well or not well at all, as did 5% of foster care households. A similar picture was present for how well the current car accommodated the family, with three quarters (75%) of foster care households responding 'very well', in comparison to two thirds (65%) of relative/kinship care households. Conversely, 15% of carers from relative/kinship care households and 7% from foster care households indicated that their current car accommodated the family not very well or not well at all.

Table 9.7: Caregiver reports of housing arrangements at Wave 1 interview, by placement type

Current arrangements	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
Type of accommodation[1]						
Separate house	442	93.1	363	91.4	805	92.3
Semi-detached/town house/ terraced house/villa	24	5.1	18	4.5	42	4.8
Unit, flat or apartment/granny flat	9	1.9	16	4.0	25	2.9
Total	475		397		872	
Housing ownership						
Paying-off this dwelling	266	56.4	120	30.5	386	44.6
Outright owner or full owner	59	12.5	87	22.1	146	16.9
Paying rent or board	138	29.2	184	46.7	322	37.2
Living rent free	9	1.9	3	0.8	12	1.4
Total	472		394		866	
How well the current house accommodates the family						
Very well	334	70.2	241	60.6	575	65.8
Fairly well	119	25.0	104	26.1	223	25.5
Not very well	20	4.2	44	11.1	64	7.3
Not well at all	3	0.6	9	2.3	12	1.4
Total	476		398		874	
How well the current car accommodates the family						
Very well	355	74.6	258	64.8	613	70.1
Fairly well	78	16.4	61	15.3	139	15.9
Not very well	15	3.2	28	7.0	43	4.9
Not well at all	19	4.0	30	7.5	49	5.6
Does not have a car	9	1.9	21	5.3	30	3.4
Total	476		398		874	

1 Response codes for two cases not included: 'other' (n=1) and 'improvised home, tent, sleepout' (n=1).

Overall, caregivers perceived the neighbourhood in which they lived in a positive way (Table 9.8). The majority of carers strongly agreed or agreed with the statements 'lived in a close-knit neighbourhood' (61%), 'people around here are willing to help their neighbours' (72%) and 'people in this neighbourhood can be trusted' (72%). Foster carers and relative/kinship carers differed somewhat in their perceptions of their neighbourhoods. Over three quarters (76%) of foster care households strongly agreed or agreed with the statement 'people around here are willing to help their neighbours', in comparison to 69% of relative/kinship care households. Again, over three quarters of foster care households strongly agreed or agreed with the statement 'people in this neighbourhood can be trusted' compared to 68% of relative/kinship care households. Finally, the overwhelming majority of foster carers interviewed felt that that their neighbourhood was a very good or good place to bring up children (94% with 69% indicating 'very good'), which was higher than that reported by relative/kinship carers (i.e., 87% with 57% indicating 'very good').

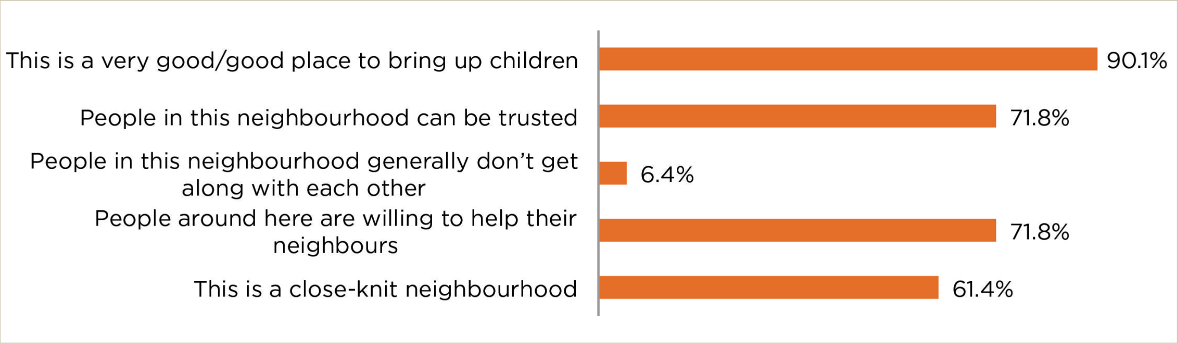
Table 9.8: Caregivers' perceptions of neighbourhood cohesion at Wave 1, by placement type

Statements about neighbourhood perceptions[1]	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
This is a close-knit neighbourhood						
Strongly agree	92	19.5	62	15.9	155	17.5
Agree	211	44.7	172	44.0	389	43.9
Neither agree nor disagree	100	21.2	93	23.8	203	22.9
Disagree	60	12.7	55	14.1	120	13.5
Strongly disagree	9	1.9	9	2.3	19	2.1
Total	472		391		886	
People around here are willing to help their neighbours						
Strongly agree	88	18.6	59	15.3	149	17.0
Agree	270	57.2	205	53.3	480	54.8
Neither agree nor disagree	75	15.9	80	20.8	163	18.6
Disagree	32	6.8	34	8.8	70	8.0
Strongly disagree	7	1.5	7	1.8	14	1.6
Total	472		385		876	
People in this neighbourhood generally don't get along with each other						
Strongly agree	6	1.3	4	1.0	11	1.3
Agree	17	3.6	25	6.4	45	5.1
Neither agree nor disagree	68	14.4	67	17.2	143	16.2
Disagree	296	62.8	241	62.0	547	62.0
Strongly disagree	84	17.8	52	13.4	136	15.4
Total	471		389		882	
People in this neighbourhood can be trusted						
Strongly agree	80	17.1	42	10.9	122	13.9
Agree	278	59.4	219	56.7	507	57.9
Neither agree nor disagree	82	17.5	96	24.9	183	20.9
Disagree	21	4.5	22	5.7	46	5.3
Strongly disagree	7	1.5	7	1.8	17	1.9
Total	468		386		875	

Statements about neighbourhood perceptions[1]	Foster care		Relative/ Kinship care		Total	
	n	%	n	%	n	%
How do you feel about your neighbourhood as a place to bring up children						
Very good	330	69.3	227	57.2	564	62.9
Good	117	24.6	117	29.5	244	27.2
Fair	26	5.5	39	9.8	67	7.5
Poor	2	0.4	6	1.5	11	1.2
Very poor	1	0.2	8	2.0	10	1.1
Total	476		397		866	

1 Social Cohesion and Trust Scale (Sampson, Raudenbush & Earls, 1997).

Figure 9.4: Caregivers who ‘Strongly agree’ or ‘Agree’ with aspects of neighbourhood cohesion



9.4 Summary of key findings

Caregiver demographic characteristics

- Almost three quarters of the carers interviewed were aged over 40 years, and just over three quarters were married or in a de-facto relationship.
- Approximately two thirds of the POCLS carers interviewed reported a minimum of Year 12 as their highest level of education completed, while almost one in five carers had achieved a Bachelor degree or higher. Conversely, approximately one third of carers interviewed identified Year 10 or below as their highest education level.
- The majority of carers interviewed were not in paid employment (nor looking for work) at the time of the Wave 1 carer interview, although it is difficult to draw conclusions from this result, given that the employment status of carer not interviewed (when present) has not been considered; hence, household employment rates could not be derived.
- The vast majority (almost 90%) of carers interviewed generally perceived their physical health to be at least good.
- Although around one in three carers interviewed indicated that they had a medical condition or disability that had already or was likely to last for at least six months, less than 10% believed they had a health condition which impacted caregiving of the study child.

- Only a minority (5%) of carers interviewed were likely to be experiencing high or very high levels of psychological distress. Household smoking rates were low (i.e., only 4% of carers indicated people occasionally or frequently smoked inside the home), and the self-reported alcohol consumption of carers was also modest, with the vast majority of carers interviewed considering themselves to be occasional or non-drinkers.
- Generally, carers interviewed appeared to be relatively satisfied in their relationships, with the vast majority reporting that there was rarely or never anger/hostility between themselves and their partner, and 91% indicating that they were at least ‘happy’ with their partner. However, 7% of carers did indicate that they were ‘extremely unhappy’ with their partner.
- Anger or hostility between carers interviewed and their partner was slightly more frequent among relative/kinship carers than foster carers.
- Relative/kinship carers tended to be older (although a relatively low proportion of caregivers interviewed were aged over 70 years), and reported slightly worse physical and mental health, slightly higher levels of household smoking and slightly less positive relationships with their partners, in comparison to foster carers.
- The proportion of caregivers interviewed that identified as Aboriginal was much higher than the general Australian adult population, with relative/kinship carers more likely than foster carers to be Aboriginal. Just under one in six carers interviewed identified as Aboriginal and a similar proportion (15%) identified as being from a CALD background.

Caregiving household demographic characteristics

- The most common situation was for the study children to be living in a household where the caregivers interviewed had a spouse or partner who was also living in the household.
- Although about half of the children did not have another study child residing in their POCLS household, the vast majority did have at least one other child (e.g., offspring of the carer) residing in the household. Over half (six in 10) of children also had a sibling living with them. Around a quarter of the POCLS households contained four or more other children aside from the study child, but over half of the children still had their own bedroom.
- Sixteen per cent of children were Aboriginal and placed with a caregiver who was Aboriginal while 23% of children were Aboriginal and placed with a non-Aboriginal caregiver.
- The likelihood of the study child’s carer having a partner/spouse living in the household was higher in foster care (80%) than relative/kinship care households (68%).
- Most carers interviewed tended to be satisfied with their current financial situation, despite, at an overall level, tending to be less well off than the general Australian population in regard to their annual household income.

- While a higher proportion of relative/kinship care households had annual incomes of under $60,000, the majority of relative/kinship carers interviewed believed they were at least reasonably comfortable financially.
- Only a minority of carers reported experiencing financial stressors over the past year, such as an inability to pay utility bills or their mortgage/rent on time, or going without meals.

Housing and neighbourhood characteristics

- The vast majority of the POCLS carers interviewed and their children were residing in a separate house, with approximately six in ten owning their property outright or paying off a mortgage.
- Caregivers tended to be fairly satisfied with how well their current homes and cars were accommodating the family.
- A higher proportion of relative/kinship care households were renting their residences in comparison to foster care households, and relative/kinship carers also tended to be slightly less satisfied with how well their current homes and cars accommodated the family.
- The majority of carers interviewed also had positive perceptions of their neighbourhood, with 90% of carers believing that their neighbourhood was a good or very good place to bring up children.

9.5 Conclusion

In conclusion, the results presented here indicate that the POCLS households were, on the whole, somewhat financially disadvantaged in comparison to the general Australian population – a finding that was more characteristic of relative/kinship care households in comparison to foster care households. Despite these findings, according to carers the majority of children appeared to be placed in households where there were low reported incidences of financial hardship and psychological distress, as well as potentially harmful behaviours such as heavy alcohol consumption and smoking inside the household. In future waves, the trends identified here can be tracked and, ultimately, child-related outcomes relating to these factors investigated.

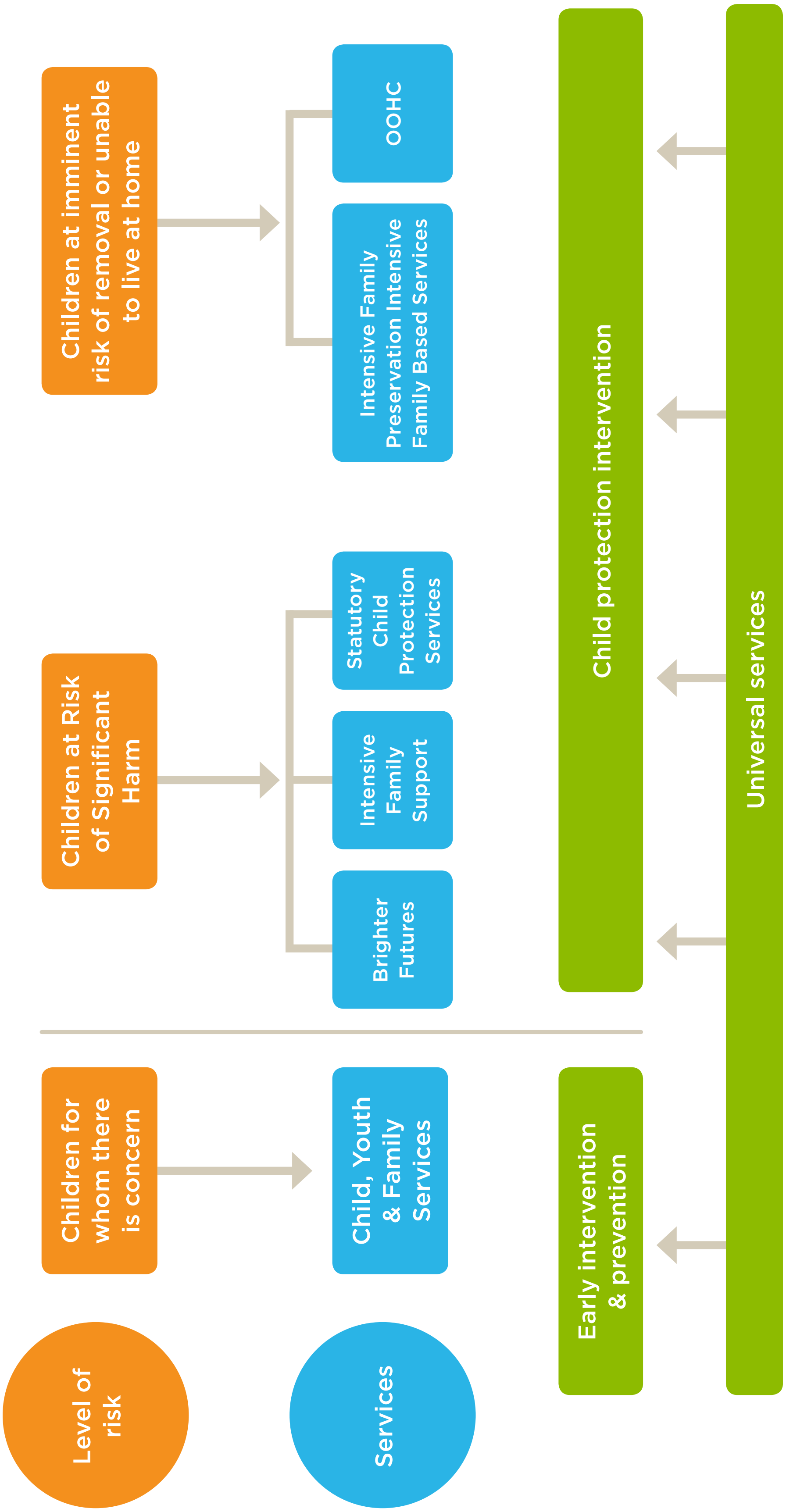
Appendices

Appendix 1 System of assessment and intervention for children and young people at risk

Children and young people at risk and their families are offered a spectrum of services provided by the Department of Family and Community Services (FACS), other government departments and non-Government Organisations (NGOs). The Structured Decision Making (SDM) system has enhanced the capacity of FACS to undertake comprehensive child protection assessments while ensuring that appropriate referrals are tailored to meet the individual needs of the child or young person concerned. The services range from intervention for families to ensure that children at risk of significant harm (ROSH) are safer, to a responsive out-of-home care (OOHC) system which gives children a better future.

These services fit along a continuum ranging from universal services through to intensive support for the most vulnerable families, as shown in Figure A.1.

Figure A.1 Continuum of services for children and young people at risk



Note: Sourced from the NSW Department of Family and Community Services, 2014 and updated for this report.

Universal services aim to provide access to all families and are designed to reduce the number of vulnerable children and young people from birth and at critical life stages and transitions. Families NSW is the population-based prevention and early intervention strategy for families expecting a child or with children up to 8 years of age. It is jointly implemented by FACS, NSW Health and the Department of Education and Communities (DEC), together with local government and NGOs. Under the strategy, FACS continues to implement the Triple P positive parenting program, which in 2013 provided programs to approximately 800 parents across NSW.

The NSW Ministry of Health and the Department of Education and Communities (DEC) receive separate funding allocations from NSW Treasury to provide universal services under the Families NSW strategy. The Ministry of Health administered Families NSW funding in 2012/13 to provide Universal Health Home Visiting, Safe Start (perinatal mental health screening and support), Statewide Eyesight Preschooler Screening and the My Health Record and Having a Baby publications. DEC was funded through Families NSW to implement Schools as Community Centre services in a range of primary schools.

Child, Youth and Family Support (CYFS) services are funded by FACS and delivered through NGOs. The CYFS service model aims to deliver a broader range of less intensive services to meet the needs of vulnerable children, young people and families who fall below the threshold for statutory child protection intervention. There are two streams of service delivery, the Child and Family Support (CFS) stream, which targets families with children aged 0 to 12 years, and the Youth and Family Support (YFS) stream, which targets young people aged12 to 18 years. The services provided under this model include: advice and referral services, assessment, case planning and management, parenting programs and parent support groups, skills focused groups for young people, counselling and home visiting. During 2012/13, approximately 55,000 instances of service were provided to people participating in the CYFS program including children, young people, young adults and parents/carers.

Where family needs are greater, early intervention services, such as Family Support Services, offer specialised assistance. The Brighter Futures program delivers targeted early intervention services to families with children aged under 9 years, or who are expecting a child, where the child/children are at high risk of entering or escalating within the statutory child protection system. Families participating in Brighter Futures will experience vulnerabilities known to place children at greater risk of abuse or neglect, including domestic violence, drug and alcohol abuse, parental mental health issues, lack of parenting skills or inadequate supervision, and parents with significant learning difficulties or intellectual disability. By 2016 Brighter Futures services will work mainly with families where a child has been identified as at Risk of Significant Harm.

The Intensive Family Support (IFS) and Intensive Family Preservation (IFP) programs aim to keep children with their families or restore them to family care as soon as possible, thus avoiding long-term out-of-home care placements. IFS and IFP adopt a whole-of-family focus, working with the parents, children and other members of the family/kinship network, as deemed appropriate. The programs offer interventions to address the most critical and priority needs of the family and aim to change behaviours, teach skills and connect families to community supports. IFS and IFP NGO service providers complete child assessments and provide services and support after referral by FACS. Families receive up to 12 weeks of intensive support, including home visits and 24-hour on call assistance. Up to 40 weeks of continuous, individually tailored casework follows.

The FACS Statistical Analysis, Reporting and Evaluation unit conducted an evaluation of the IFS and IFP programs providing a final report in October 2013 and recommended that the programs be amalgamated. The process to amalgamate the programs commenced in 2015 including consultation with the sector and agreement on proposed service model changes.

Appendix 2 Classification of reported issues

Primary reported issue	Characteristics of issue
Carer: mental health	Emotional state of carer
	Psychiatric disability, carer
	Suicide risk/attempt of carer
Carer: other issues	Carer in prison
	Developmental disability, carer
	Financial problems of carer
	Gambling problem of carer
	Legal guardianship issues
	Non-compliance under s156A(3)
	Physical disability of carer
	Unauthorised out-of-home care (OOHC) arrangement
Child inappropriate sexual behaviour	Child inappropriate sexual behaviour
Domestic Violence (DV)	Domestic Violence
	DV, children exposed to violence
	DV, children harmed intervening
Drug/alcohol use by carer	Alcohol abuse by carer
	Drug abuse by carer
Drug/alcohol use by child or young person	Alcohol use by child or young person
	Drug use by child or young person
Emotional abuse	Persistent caregiver hostility
	Psychological mistreatment
	Risk of psychological harm
Neglect	Child/n left unattended in car
	Child/n or YP/s abandoned
	Failure to thrive, non-organic
	Inadequate clothing
	Inadequate nutrition
	Inadequate shelter or homeless
	Inadequate supervision for age
	Medical treatment not provided
	Neglect EDU:C/YP Not Enrolled
	Neglect EDU: Habitual Absence
	Neglect: Hygiene
Physical abuse	Physical: hit, kick, strike
	Physical: poisoning
	Physical: shaking baby/child
	Physical: strangle/suffocate
	Physical: throwing baby/child
	Physical: other
	Risk of physical harm/injury

Primary reported issue	Characteristics of issue
Prenatal Report	Prenatal Report
Runaway child or young person	Runaway child or young person
Sexual abuse	Risk of sexual harm/injury
	Sexual: penetration
	Sexual: exposure pornography
	Sexual: indecent acts/molestation
	Sexual: non-physical exploitation
Suicide risk for child or young person	Suicide risk for child or young person
Other issues	Death of child, non-accident
	Death of sibling, non accident
	Hague Convention, kidnapping
	Request for Supported Care
No harm or risk issues	No harm or risk issues

Appendix 3 Client administrative data measuring children's safety, permanency and wellbeing outcomes in the POCLS through record linkage (n=4,126).

Domains	Administrative data source	Study age range
OUTCOMES		
Child Safety		
	Risk of significant harm reports[1]	0–17 years
	Substantiated abuse and/or neglect reports[1]	0–17 years
	Emergency Department Data Collection[2]	0–17 years
	Admitted Patient Data Collection[2]	0–17 years
Child Permanency		
	Number of OOHC placements[1]	0–17 years
	Number of carers[1]	0–17 years
	Number of re-entries to OOHC[1]	0–17 years
	Length of time in an OOHC placement[1]	0–17 years
Child Wellbeing		
Physical health and development	Admitted Patient Data Collection[2]	0–17 years
	Australian Early Development Checklist[5]	First year of school
Socio-emotional development	Risk of significant harm reports[1]	0–17 years
	Australian Early Development Checklist[5]	First year of school
	Mental Health – Ambulatory Collection (MH-A)[2]	0–17 years
	Admitted Patient Data Collection (AP-Psy)[2]	0–17 years
	Emergency Department Data Collection (EDDC)[2]	0–17 years
	Re-offending Data[4]	10–17 years
Cognitive development	Australian Early Development Checklist[5]	First year of school
	National Assessment Program: Literacy and Numeracy[3]	Grade 3, 5, 7 and 9
RISK FACTORS FOR POOR DEVELOPMENTAL OUTCOMES		
Child Wellbeing		
Physical health	Perinatal Data Collection [2]	0–17 years
Social factors	Perinatal Data Collection [2]	0–17 years

1 NSW Department of Family and Community Services (FACS) Key Information Directory System (KiDS)
2 NSW Ministry of Health administrative data
3 NSW Department of Education and Communities (DEC) National Assessment Program: Literacy and Numeracy (NAPLAN) tests cover proficiency levels in reading, writing, language conventions (spelling, grammar and punctuation) and numeracy at the unit-record level.
4 Bureau of Crime Statistics and Research (BOCSAR) re-offending data (ROD)
5 Commonwealth Department of Education Australian Early Development Checklist (AEDC) conducted in 2009, 2012 and 2015 measures five areas of early child development (teacher completed) including physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge.
Record linkage will be performed by an authorised linking agency – the Centre for Health Record Linkage (CHeReL).

Appendix 4 Definitions of sub-populations presented in this report

The definitions of subpopulations presented in the Wave 1 Baseline Statistical Report are outlined in this Appendix.

Age

Due to the range in ages of the children (from 9 months to 17 years), differing measures were needed to investigate the wellbeing and circumstances of children at differing developmental stages (see Table 2.6). To parallel the major childhood and adolescent developmental stages, four broad age bands are used in this report:

- 9–35 months, covering infancy and toddlerhood; n=567;
- 3–5 years, covering early childhood; n=265;
- 6–11 years, covering mid/late childhood and the primary school period; n=329;
- 12–17 years, covering adolescence and the secondary school period; n=124.

These groupings enable comparison of children of differing ages to examine whether the experiences and wellbeing of children who entered care for the first time differ across developmental stages. The only exception to these age groupings occurred when analysing data from the child and young person interview that commenced at 7 years of age. Thus, 7–11 years and 12–17 years were the two age bands used to examine interview data from children.

Cultural background

The report presents findings for children from differing cultural backgrounds based on FACS administrative data in the Key Information and Directory System (KiDS):

- Aboriginal children: These children (n=469) were identified as being Aboriginal (also includes a small number of children (n<10) whose background was Torres Strait Islander.
- Culturally diverse children: These children (n=112) were identified as having a cultural identity that was other than ‘Australian child’, ‘Aboriginal child’ or ‘Missing’.
- All other Australian children: This refers to all other children (n=640) whose cultural background was specified as Australian.

There were 64 children for whom cultural backgrounds were not specified in FACS administrative data (KiDS). These children were excluded from analyses examining cultural background, but they are included in all other analyses.

The characteristics of the interviewed caregivers include cultural background. The same categories as per the child, including ‘Language other than English’ (LOTE), were used to form this group.

There are a number of data variables that indicate culturally and linguistically diverse (CALD) status and Aboriginal status in FACS administrative data (KiDS); hence, future analysis of these sub-populations may be slightly different in subsequent reports depending on the definition adopted.

Placement types

To investigate differences across placement type, three groups were used:

1. Foster care: These children (n=661) were placed with caregivers with whom they were not biologically related.
2. Relative/Kinship care: These children (n=598) were biologically related to or shared a community connection with the caregivers with whom they were placed.
3. Residential care: these children (n=26) were placed in small community-based residences.Appendix 5 Details of the POCLS measures of child wellbeing reported in chapter 5.

Appendix 5 Details of the POCLS measures of child wellbeing reported in chapter 5

Children's Wellbeing	Measure used in POCLS	Study age range	Information about the measure
Physical health and development	Ages and Stages Questionnaire[1]	9–66 months	The ASQ-3 completed by caregivers measures child development across five domains: communication, gross motor skills, fine motor skills, problem solving and personal-social capacities based on 30-items that are rated on a scale as: *10 (yes), 5 (sometimes), 0 (not yet)*. The measure has 19 different versions to assess development at differing ages. Normative cut-offs are provided which enable differentiation of children developing typically from those who are not.
Socio-emotional development	Brief Infant Toddler Social Emotional Assessment Scale[2]	12–35 months	The BITSEA completed by caregivers assesses social-emotional/behavioural problems and social-emotional competencies and yields a total problem behaviour score and a total competency score based on 42-items that are rated on a scale from 0 to 2: *0 not true/rarely, 1 somewhat true/sometimes, 2 very true/often*. Normative cut-offs are provided which enable identification of children showing very high levels of behaviour problems, or very low levels of competencies: • A total behaviour problem score that is in the highest 25% of the US normative sample may be used to identify a child as being in the possible problem range • A total competency score in the lowest 15% of the US normative sample indicates the child is in the possible deficit/delay range.
	Child Behaviour Checklist[3]	3–17 years	The CBCL completed by caregivers measures a range of childhood/adolescent externalising and internalising behaviour problems and interpersonal competencies and provides composite internalising, externalising and total problems scales. The CBCL has two versions: 99-items for 1½–5 year olds; 138-items for 6–18 year olds (including a Competence scale). Both versions are rated on a scale from 0 to 2: *0 not true, 1 somewhat or sometimes true, 2 very true or often true*. The CBCL provides eight syndrome scales for 1½–18 year olds, five DSM-Oriented Scales for the 1½–5 year olds, and six DSM-Oriented Scales for the 6–18 year olds. The cut-offs to identify children showing differing levels of problems are: • 'clinical range' score indicates that the child has high levels of problems of similar severity to children who are receiving clinical treatment for a diagnosed behavioural or mental disorder • 'borderline range' score indicates that the child has elevated, but less severe, levels of problems • 'normal range' score indicates that the child is in the normal range of the general child population.
Cognitive and language development	Communication and Symbolic Behaviour Scales Infant and Toddler Checklist [4]	9–23 months	The CSBS-ITC completed by caregivers measures language development based on 24 item checklist and consists of three sub-scales (social, speech and symbolic) which combine to form a total score. The scales yield standard scores and percentiles, with percentile scores at or below the 10th percentile considered of concern.

Children's Wellbeing	Name of measure	Study age range	Information about the measure
Cognitive and language development	Macarthur-Bates Communicative Developmental Inventories III[5]	24–35 months	The MCDI-III assesses child communication skills and has two versions: MacArthur Communicative Development Inventories Short Form for children aged 24–29 months; and MacArthur-Bates Communicative Developmental Inventories for children aged 30–35 months. For both versions, caregivers were asked, using the list provided, which words they had heard the child use in daily speech. This measure consists of 100 vocabulary words for children aged 24–35 months (plus one item about word combinations for 24–29 month olds). The number of words is summed to give a total out of 100 which can be converted to percentile ranks. Caregivers of the older group of children (30–35 months) were also asked whether children used sentences varying in complexity. Percentiles are provided that can be used to identify children showing slower than average language development. The recommendation of Heilman, Weismer, Evans and Hollar (2005) has been followed in applying a cut-off of 'below the 15th percentile' to identify children as having significantly poorer language skills.
	Peabody Picture Vocabulary Test Version 4[6]	3–17 years	The PPVT-IV completed by children measures understanding of spoken words (receptive language skills) based on 228–items, but covering a wide age range so children complete a smaller number of items. The mean standard score for the US normative sample is 100 and the standard deviation is 15 (placing children in the lowest and highest 15% of the normative US sample distribution): • scores below 85 may be interpreted as indicating language skills below the normal range • scores above 115 may be interpreted as language skills above the normal range.
	Matrix Reasoning Test (MR) from the Wechsler Intelligence Test for Children Version 4[7]	6–16 years	The MR completed by children measures general non-verbal intelligence based on 35-items, but covering a wide age range so children complete a smaller number of items, and yields a standard score with a possible range of one to 19. The normative mean is 10 with a standard deviation of 3: • Scores below 7 are indicative of 'below normal range' cognitive abilities (i.e., in the lowest 15% of the normative population of children) • Scores above 13 are indicative of 'above normal range' cognitive abilities (i.e., in the highest 15% of the normative population of children).

1ASQ-3; Squires & Bricker, 2009.
2 BITSEA, Briggs-Gowan & Carter, 2006.
3 CBCL, Achenbach & Rescorla, 2000, 2001.
4 CSBS-ITC; Wetherby & Prizant, 2003.
5 MCDI-III; Fenson, Marchman, Thal, Dale, Bates & Reznick, 2007; Fenson, Pethick, Renda, Cox, Dale & Reznick, 2000.
6 PPVT-IV; Dunn & Dunn, 2007.
7 WISC-IV; Wechsler, 2003.
Note: Please see Table 2.6 for a full list of POCLS study questions and measures.

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Glossary of terms

Adoption

A legal order that transfers the parental rights and responsibilities from the birth parents to the adoptive parents. The adoptee then becomes the child of the adoptive parents as if born to them.

After-care support

Support provided to young people aged 15–24 years after they leave OOHC.

Ageing out

See *Leaving care plan, Leaving care services, After-care support*

Agency

Non-government organisation contracted by FACS to provide OOHC services.

Assessment

The process of gathering, organising, analysing and evaluating accurate and relevant information to inform decision making.

Authorised carer

A person authorised by a designated agency, or the principal officer of a designated agency, or according to the Regulations under section 137(1) of the Act.

Behaviour management plan

A plan detailing behaviour management strategies (when required) developed by the caseworker together with the child or young person, carer, parents (when appropriate) and relevant specialists.

Brighter Futures

Brighter Futures is a voluntary targeted early intervention program for families with children aged under nine years, or who are expecting a child, where the child/ren are at risk of entering or escalating within the child protection system. Brighter Futures services provide intervention and support that will achieve long-term benefits for children. The program is delivered by non-government lead agencies across NSW who provide a range of tailored services including case management, casework focused on parent vulnerabilities, structured home visiting, quality children's services, parenting programs and brokerage funds.

Eligible families will have at least one of the following program vulnerabilities which impact adversely on their capacity to parent and/or the child's safety and wellbeing:

- Domestic Violence
- Drug or alcohol misuse
- Parental mental health issues
- Lack of parenting skills or inadequate supervision
- Parent(s) with significant learning difficulties or intellectual disability.

From July 2014 Brighter Futures commenced working with children and families identified at Risk of Significant Harm (ROSH). This realignment seeks to deliver locally integrated, flexible services that are efficiently targeted and can effectively increase safety and reduce risk for vulnerable children living at home.

Birth parents

The biological parents of a child. Also referred to as the 'original', 'natural', 'first' or 'real' parents.

Carer

The term carer is used when referring to foster or relative/kinship carers. Excludes residential care workers.

Caregiver

The term caregiver is used when referring to foster and relative/kinship carers, residential care workers, adoptive parents and/or parents.

See *Foster care, Kin, Relative/Kinship care, Residential care*

Care and protection

‘In need of care and protection’ is a term Community Services uses under two different circumstances and according to two different standards of proof. They are when:

- following a secondary assessment, Community Services forms an opinion on reasonable grounds that the level of future risk to a child or young person is sufficient to warrant protective action, which may include the provision of support services, protective intervention or court action
- a matter is placed before the Children’s Court for a care order, and the Court must be satisfied on the balance of probabilities that the child is in need of care and protection.

Care plan

A tool that may be used in casework to formalise agreements made with the family to meet the care and protection needs of a child or young person, or within a legal context to enable the Children’s Court to allocate parental responsibility.

Case meetings

Held to help with information-sharing, case review, decision making and interagency coordination. The meeting’s purpose will depend on the particular type of plan or action needed and is the main way of carrying out case planning. May be held with people attending or via telephone.

Case plan

An accurate and up-to-date record of the decisions, services and actions to meet the needs of a child or young person. Case plans are developed from the start of involvement and reviewed at regular intervals.

Case planning

Identifies strategies that will meet the physical, emotional, educational, social, religious and cultural needs of a child or young person. An interactive process that ensures all parties participate and are clear about the goal and objectives of intervention, the issues to be addressed and their responsibilities for the tasks involved.

Case plan review

Enables caseworkers to include changes to the assessment of the child and family, validate plans and review ongoing support needs. The review meeting should also involve the child, parent and their advocates whenever possible.

Caseworker

FACS officer or agency worker with day-to-day case coordination responsibilities for working with children, carers and families.

Challenging behaviours

Includes verbal and/or physical assault, sexual offences, absconding and antisocial behaviour.

Child

In this report child includes ages 0–17 years.

Child protection system

The child protection system provides for those children and young people whose parents, caregivers or guardians are unable or unwilling to protect them against significant harm through the provision of services that range from family support to the placement of children in OOHC. The provision of services and strategies for the ongoing protection of children and young people through prevention and early intervention services and OOHC is done in collaboration with community organisations.

‘Child/young person concern’ contact

A ‘child/young person (C/YP) concern’ contact is based on unique contact records recorded on KiDS where the primary contact reason was ‘reporting concern about a child or young person’. A contact record is used to record information received by FACS. A contact record may relate to one or more persons. A contact record may record information provided in one or more calls/faxes/eReports. A single call/fax/eReport may result in multiple contact records. The contact outcome occurs after the Helpline assesses whether child/young person concern reports reach the ROSH threshold, incorporating the use of the SDM screening tool.

‘Child/young person concern’ report

‘Child/young person (C/YP) concern’ reports are child/young person concern contacts multiplied out by the number of children and young people that the contact involved. For example, a contact involving three children would be counted as three reports.

Child Wellbeing Units

Child Wellbeing Units (CWU) have been established in four government agencies: Department of Education and Communities, NSW Police, FACS and NSW Health, and have been fully operational from 24 January 2010, when the new reporting threshold commenced. They rely upon the alternate reporting arrangements set out in section 27A, *Children and Young Persons (Care and Protection) Act 1998*.

Children and Young Persons (Care and Protection) Act 1998

The *Children and Young Persons (Care and Protection) Act 1998* governs the child protection system in NSW. It explains how children and young people, who are at risk or being abused, should be cared for in NSW and how vulnerable families should be helped. The legislation requires that specified professionals who in the course of their work have reasonable grounds to suspect that a child or young person is at risk of significant harm, report this to FACS. In addition to reports from these mandatory reporters, FACS also receives reports from non-mandatory reporters including family, neighbours and friends.

Children's Court

The court designated under the *Children's Court Act 1987* to hear care applications and criminal proceedings about children and young people.

Children's Court Clinic

Provides independent and expert assessment reports to the Children's Court about care matters. Run by the Attorney-General's Department.

Community Services Child and Family Regional Unit

A Community Services unit that matches referrals from a region's community services centres for out-of-home care services, including placements, with available vacancies in the care system.

Contact

All forms of communication between a child or young person, who cannot live at home, and their family members and/or significant others. Contact may occur through planned visits, letters, telephone conversations or other forms of communication.

Contingency payments

One-off payments that may be made in addition to an allowance for services and items, in excess of the day-to-day expenses covered by the statutory care allowance, and needed to carry out tasks in a child or young person's case plan.

Corporate Information Warehouse

The Corporate Information Warehouse (CIW) is a reporting tool used by FACS to meet the needs of internal and external stakeholders. Data from KiDS are incorporated into the CIW daily.

Districts There are 15 FACS Districts. Previously FACS had eight Regions. Within Districts are a number of Community Services Centres (CSCs).

Emergency placements

Care arrangements provided when children and young people need an immediate OOHC placement. It is an unplanned short-term placement arranged on the same day as required.

Felt Security Activity

An interviewer administered activity in the POCLS to collect data on the child's closeness to their OOHC family and other people they do not live with (adapted from the Kvebaek Family Sculpture Technique).

Foster care

Foster care is the mainstay of the OOHC system for children and young people. Foster carers, who must be authorised by a designated agency, provide a safe, nurturing and secure family environment in their own home for children and young people needing care. FACS and NGOs recruit and authorise eligible people interested in fostering. Carers are provided with ongoing support such as training, peer support and financial assistance. Some specialised services provide an intensive level of services for children and young people with high needs, significant disabilities, or large sibling groups. Long-term foster care is generally for children and young people placed in care, under an order from the Children's Court, for longer than 12 months. It usually refers to situations where they are not expected to return to their family.

Guardianship

The Care Act was amended in 2014 under the *Safe Home for Life* child protection reforms. As of 29 October 2014, relative or kinship carers who have full parental responsibility for a child or young person are guardians. All existing orders of the NSW Children's Court allocating all aspects of parental responsibility to relatives and kin under section 79(1)(a)(iii) (as in force before amendment of the Act) are taken to be guardianship orders.

Guardianship signifies a permanent home for a child or young person who is unable to live with their parents and this change will provide greater stability for such children and young people. During consultation about changes to the Care Act, many relative and kinship carers said they wanted less involvement from FACS with their families. Many of these carers are grandparents, aunties and uncles who wanted to raise their family without the need for a caseworker. The introduction of guardianship orders acknowledges this feedback.

The guardian will have responsibility for all decisions related to meeting the needs and ensuring the wellbeing of the child or young person in their care, without having to first gain approval from FACS. The child or young person will continue to remain in the care of their guardian until they turn at least 18.

Guardianship is specifically excluded from the definition of OOHC (s. 135(3)(b1) Care Act).

See *Supported out-of-home care*.

Independent living services

Independent living services may be provided to prepare eligible young people leaving statutory care for independent living through the provision of transitional accommodation, case management and support services. FACS works in partnership with relevant government service providers such as NSW Health and the Department of Education and Communities to help young people gain timely access to required services identified in the young person's leaving care plan.

Intensive Family Preservation

The primary intended outcome of an Intensive Family Preservation (IFP) service is that children at risk of significant harm and imminent risk of placement in OOHC can stay at home with their family in a safe, stable and nurturing environment. The IFP program is a program of up to 12 months duration with high intensity support within the first 12 weeks. Caseworkers have low caseloads to enable them to work intensively with families, and will have access to a broad spectrum of support services including brokerage funds for a variety of practical support, counselling and skills training that meet the assessed needs of parents and/or children. The IFP and IFS programs will be amalgamated commencing in 2015. This will result in changes to service provision for these programs.

Intensive Family Support

Intensive Family Support (IFS) adopts a whole-of-family focus, working with the parents and child/children and other members of the family/kinship network as deemed appropriate. The service will offer interventions to address the most critical and priority needs of the family as identified in the case plan. Support is to be goal directed, with a view to achieving definable and measurable improvements in parent strengths, attitudes, behaviour, values, skills knowledge and ability. The IFS program is a program of up to six months duration in most cases, but up to 12 months where needed, with high intensity support intervention within the first 12 weeks. Service delivery is coordinated and provided by NGOs primarily in the home or community. The IFP and IFS programs will be amalgamated commencing in 2015. This will result in changes to service provision for these programs.

Joint Investigation Response Team

The Joint Investigation Response Team (JIRT) program was implemented state-wide in 1997. The program has three equal partners in providing services to children: NSW Police, NSW Health and Community Services.

Key Information and Directory System

The Key Information and Directory System (KiDS) is the FACS electronic system for keeping records of its clients, which was introduced during 2003.

Kin

A person who is not a relative of the child but shares cultural, tribal and community connection that is recognised by that child's community. Also *see Relative/Kinship care; Caregiver.*

Leaving care plan

A plan that addresses the needs of the child or young person who is leaving OOHC.

Leaving care services

Leaving care and after-care services refer to the case planning and support provided to young people leaving statutory OOHC from 15 years and until the age of 25 years. The Minister also has discretion under the Act to provide or arrange for the appropriate after-care assistance for a care leaver over 25 years of age. Specialist after-care services may also provide ongoing support to eligible children and young people who have left OOHC.

Young people leaving OOHC may have a difficult time making the transition to independent living and adulthood. Many young people may need special help to ensure they overcome any barriers to successful transition to independence, maximise their opportunities for social integration, obtain a good education, skills and living conditions.

The *Children and Young Persons (Care and Protection) Act 1998* recognises support may be required for some young people, between the ages of 15 and 25 years, who are making a transition to independent living. This support may be provided by the same agency that supervised the OOHC placement or by an after-care service provider.

Leaving care planning helps children and young people make a smooth transition from care to independent living.

Legal order

See *Children's Court*

Maltreatment

In this report, maltreatment refers to childhood neglect and abuse including physical, emotional and sexual.

Mandatory reporter

A person who as part of their professional or paid work or as the supervisor/manager of a person who as part of their professional or paid work, delivers healthcare, welfare, education, children's services, residential services or law enforcement to children. Mandatory reporters are required under section 27 of the Act to make a report to FACS if they suspect that a child is at risk of harm as detailed in section 23 of the Act.

Matrix Reasoning Test from WISC-IV

Interviewer-administered test of the child's cognitive development used in the POCLS.

Out-of-home care (OOHC)

Care and control of a child or young person at a place other than their usual home, by a person who is not their parent. It includes care and control under an order of the Children's Court, or when they are a protected person, for more than 14 days.

OOHC placements can be:

- **emergency** in unplanned (or crisis) situations;
- **short term** following child protection intervention, usually when a child requires a placement because of a short-term need or as an interim measure such as the making of long-term orders by the Children's Court;
- **long term** foster care, permanent care, independent living or those for whom adoption is planned.

Parental responsibility

All of the duties, powers, responsibilities and authorities which parents generally have for their children.

Parental responsibility to the Minister

An order of the Children's Court placing the child or young person under the parental responsibility of the Minister.

Permanency planning

The making of a plan that aims to give a child or young person a stable placement (including restoration to family) that offers long-term security and that:

- meets their needs;
- avoids the instability and uncertainty that arises from a series of different placements or temporary care arrangements;
- aims to make arrangements in a timely manner, recognising their circumstances and that the younger the child, the greater the need for early decisions about a permanent placement.

Placement type

Identifies the type of placement in OOHC. For administrative and reporting purposes, the following major categories are used to differentiate placements in OOHC:

- Foster Care
- With Parents
- Relative & Aboriginal Kinship Care
- Non-related Person
- Supported Accommodation
- Residential Care (includes Juvenile Justice)
- Independent Living
- Others

Prenatal report

Defined under section 27, *Children and Young Persons (Care and Protection) Act 1998* which provides for reports to be made for unborn children where there are concerns that the child may be at risk of significant harm after his or her birth.

Privacy

Freedom from intrusions, public attention and unauthorised disclosures of personal information.

Relative/Kinship care

Relative/Kinship care is provided by an extended family member, friends or persons of significance to the child or young person. Relative and kinship care placements involve arrangements made with or between family members or kin to care for children or young people. Some may be informal arrangements while others may be as a result of court-ordered placements.

Support for a child in a voluntary placement may be considered where the child is considered to be at risk of coming into formal care. This is determined on a case-by-case basis.

Aboriginal and/or Torres Strait Islander children and young people are often placed with relatives or kin, in statutory or voluntary arrangements, in accordance with the Aboriginal and Torres Strait Islander Child and Young Person Placement Principle.

Placement of children or young people in the care of relatives or next of kin is increasing. This acknowledges the importance of the child or young person's identity and maintaining their links with family, culture and community.

Under the *Children and Young Persons (Care and Protection) Regulation 2000*, 'relative' refers to:

- parents, siblings, grandparents, step-parents, step-sisters, step-brothers, aunts, uncles, nieces and nephews (whether by blood relationship or marriage) of the child or young person;
- the person with parental responsibility (but not including the Minister or a person who has parental responsibility other than in their personal capacity);
- the person who the child or young person is placed in the care or custody of under the *Adoption of Children Act 1965*.

Reported issue

A matter for attention about a child, young person, parent, carer or significant other. Helpline caseworkers record the issues associated with ROSH reports.

Reporter (general)

Any person who conveys information to FACS concerning their reasonable grounds to suspect that a child, young person or unborn child (once born) is at risk of harm (as defined under section 23 of the Act).

Residential care

Residential care is provided to a small number of children and young people who have challenging behaviours and high support needs, for as long as required. It is provided in a property owned or rented by an agency and is staffed by direct care workers. Residential care units are small community-based residences for two to four young people, supported by rostered residential care staff.

Residential care is a placement option for older children and young people with medium to high needs. Such a placement aims to stabilise behaviour and address complex needs of the young person so they can move on to other care types, restoration or independent living.

Restoration

When a child returns to live in the care of a parent or parents for the long term.

Risk of Significant Harm (ROSH)

A child or young person is at risk of significant harm (ROSH) if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. This means it is sufficiently serious to warrant a response by a statutory authority irrespective of a family's consent.

From 24 January 2010, reports to the Child Protection Helpline must meet the threshold of 'risk of significant harm'. Where concerns of harm do not meet the significant harm threshold, the referring agency should offer and coordinate assistance or make a referral to other services, using normal referral networks.

Risk of Significant Harm (ROSH) status refers to the outcome of the screening at Helpline.

Forwarded for information/action

Reports that do not require a statutory child protection response from FACS (i.e. screened out as Non ROSH) are forwarded on to a CSC/JIRT for further action or the Brighter Futures Unit for a referral to be made if the family meet the program eligibility criteria. A proportion of these reports will relate to ROSH matters and do not require a child protection response for reasons such as: they contain information which has been previously reported (and classified as a ROSH report) or they relate to a historical event and the person causing harm no longer has access to the child or young person.

No response required

Reports that do not meet the ROSH threshold and are assessed as requiring no response at that point in time.

Safety Assessment, Risk Assessment and Risk Reassessment (SARA)

The Safety Assessment, Risk Assessment and Risk Reassessment (SARA) are three distinct tools used at CSCs by caseworkers. The Safety Assessment tool is used to determine whether there are any immediate dangers of significant harm to a child and what interventions should be put in place to provide immediate protection. The Risk Assessment tool is used to classify families into low, moderate, high and very high risk groups to determine the likelihood of future abuse or neglect to a child. This information is used to guide decisions about whether cases should be opened for ongoing services or not. The Risk Reassessment tool is used periodically to assess any changes to the family's risk level in order to guide decisions about whether the case can be closed or if services should continue.

Screening and Response Priority Tools

The Structured Decision Making (SDM) Screening and Response Priority Tools (SCRPT) are used at the Helpline by caseworkers to determine whether the report meets the risk of significant harm threshold and if so, to determine how quickly FACS should respond to the report.

Secondary assessment

Procedurally, secondary assessment follows an initial assessment where the outcome is that a child or young person is believed to be at risk of harm and may be in need of care and protection. The secondary assessment employs the Secondary Assessment Framework. Secondary assessment is usually conducted by the local Community Services Centre (CSC), or the Joint Investigation Response Team (JIRT).

Short Term Court Order, Family Preservation and Restoration

The Short Term Court Order, Family Preservation and Restoration pilot aimed to keep children with their families or restore them to family care as soon as possible, thus avoiding long-term care placements. Both FACS and NGOs are involved. It has now ceased.

Spell

A spell is defined as the time period that a child spends continuously in OOHC, and reflects an uninterrupted period in care, even though it might include a sequence of (physical) movements from one placement to another.

Statutory care

The care of a child or young person who is residing at a place other than their usual home, for more than 14 days, and the Minister or non-related person has parental responsibility for residency because of an order of the Children's Court or they are a protected person. This may include relative or kinship care where the Minister has parental responsibility for the child or young person by virtue of an order of the Children's Court.

Supported family group home care

Supported family group home care refers to medium to long-term care provided for a specific group of children or young people who have low to moderate support needs, including sibling groups and adolescents transitioning to independent living. It is provided in regular houses in the community in a family-like environment by carers who live in the home seven days a week.

Supported independent living services

Supported independent living services are provided for young people with low to moderate support needs who are in transition to independent living. The client group is young people aged 16 to 18 years in the parental responsibility of the Minister.

Supported out-of-home care

Care and control of a child or young person, other than at their usual home, where the child or young person is in need of care and protection. The placements can be:

- **kinship care** where the Minister does not hold any aspects of parental responsibility
- **temporary care arrangements** where the child or young person is in the care responsibility of the Director-General and placed with an authorised carer, where no court order has been made and parental responsibility remains with the parents. FACS can arrange temporary care for a child or young person for up to three months. If the child or young person subject to a temporary care arrangement is assessed to still be in need of care and protection at the end of three months, FACS may renew the arrangement for a further three months. Temporary care cannot be arranged for more than six months in any 12 month period
- Children's Court orders of less than 14 days duration.

FACS supports these care arrangements through payment of a Supported Care Allowance to the carers.

The Care Act was amended in 2014 under the *Safe Home for Life* child protection reforms. As of 29 October 2014, relative or kinship carers who have full parental responsibility for a child or young person are guardians. All existing orders of the NSW Children's Court allocating all aspects of parental responsibility to relatives and kin under section 79(1)(a)(iii) (as in force before amendment of the Act) are taken to be guardianship orders.

See *Guardianship*.

Transition

Preparing and supporting a child or young person moving to another service, placement (transfer of case management) or leaving care.

Types of care

When a child or young person enters OOHC, case planning decisions focus on permanency and stability for the child or young person. Permanent placements for children in OOHC can be achieved by:

- restoration to the care of a parent or parents
- placement with a member or members of the same kinship group as the child or young person (relative/kinship care)
- long-term placement with an authorised foster carer
- placement under an order for sole parental responsibility under section 149 of the *Children and Young Persons (Care and Protection) Act 1998*
- adoption.

OOHC placements may be provided on a short or long-term basis depending on needs and circumstances. FACS permanency planning policy is designed to achieve a permanent and stable home for every child. If this cannot be achieved with the birth family, decisions about alternative long-term placements must occur as early as possible.

Voluntary out-of-home care

Care arrangements voluntarily made by the parents or guardian of a child or young person with a placement provider. In these cases there is no court order from the Children's Court reassigning parental responsibility. FACS may assist in making these arrangements where the child or young person is at risk of significant harm or there are no other service providers such as in rural/remote areas. Agencies should supply no more than 2% of their FACS funded placements (on a care-days basis) to voluntary OOHC.

Wave

Periods of data collection. The interval between the first three waves of the POCLS was 18 months.

Wraparound support services

Services that support a child or young person in their care placement, such as counselling, allied health services and respite.

Young person

A 'young person' means a person who is aged 16 years or above but who is under the age of 18 years. Please note for this report young people are referred to as children.

Source: FACS Annual Statistical Report 2012/13 and FACS Caring For Kids Guide and updated for this report.

Family & Community Services

Family and Community Services

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