Socio-emotional outcomes of children in out of home care

FACSIAR Lunch and Learn

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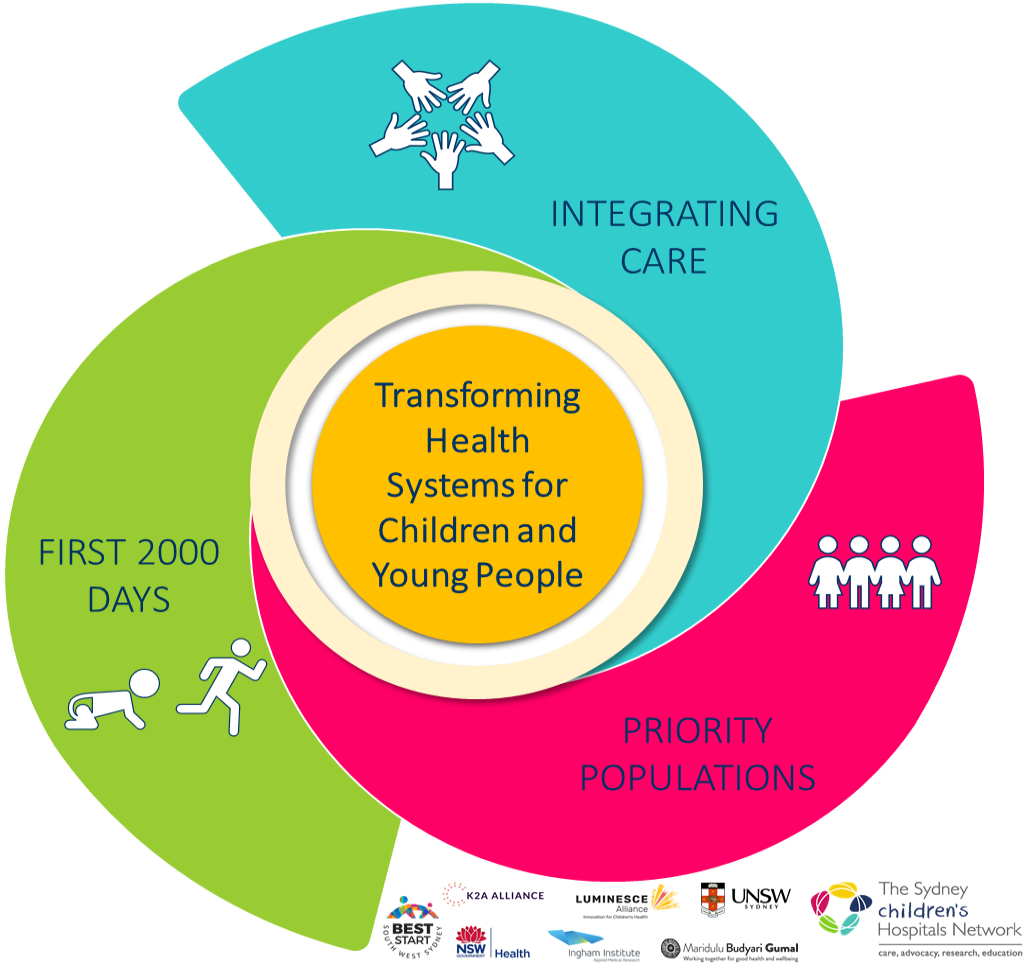
The Population Child Health Research Group



A multidisciplinary health systems research team working across the health services of NSW and University of New South Wales (UNSW). Our vision is to:

I. **Work with children and young people** to discover the factors affecting their health, wellbeing, and access to the care they need.

II. Conduct translational research that focuses on **sustainably tailoring health systems to the needs of children and young people**.

III. **Bridge the divide between research and service delivery** by supporting staff to upskill in research and implementation of scalable interventions.

Children and Young People in Out-of-Home Care (OOHC)

- Children who are in the care of the local authority or who are provided with accommodation by the local authority social services, mostly as a result of abuse and/or neglect.
- In 2019, there were 45,000 children and young people (0-17 years) in OOHC in Australia. This number has been growing.
- These children have been identified as at high risk for many health difficulties including mental health difficulties.
- These mental health difficulties have been associated with exposure to maltreatment, age at entry into care, placement instability, caregiver characteristics, and relationships with caregivers.
- We need more evidence on which of these factors has the most influence. This will enable practitioners to better target their limited resources towards the right factors to improve outcomes for children and young people in OOHC.

The Pathways of Care Longitudinal Study (POCLS)

- The first large-scale prospective longitudinal study of children and young people in OOHC in Australia (hosted by the NSW Department of Communities & Justice).
- Links data from multiple agencies on child protection backgrounds, OOHC placements, health, education, and offending with first-hand accounts from children, caregivers, caseworkers, and teachers.
- Enables analysis of children in OOHC in general, and of priority populations including Aboriginal children and young people, children and young people from culturally and linguistically diverse backgrounds, and children and young people with high needs and/or disabilities.
- Provides a strong evidence base to inform policy, practice, and professional development to improve decision making and support provided to children and young people who cannot live safely at home.

Study aim

- To identify children in OOHC who are at high risk of socio-emotional difficulties, both in early years after entry into OOHC and persistently over time, based on their demographic, pre-care, placement, and caregiver-related factors, using the POCLS data.

Factors examined in this study

(i) **child demographic factors**, including age at interview, sex, Aboriginality, and cultural background;

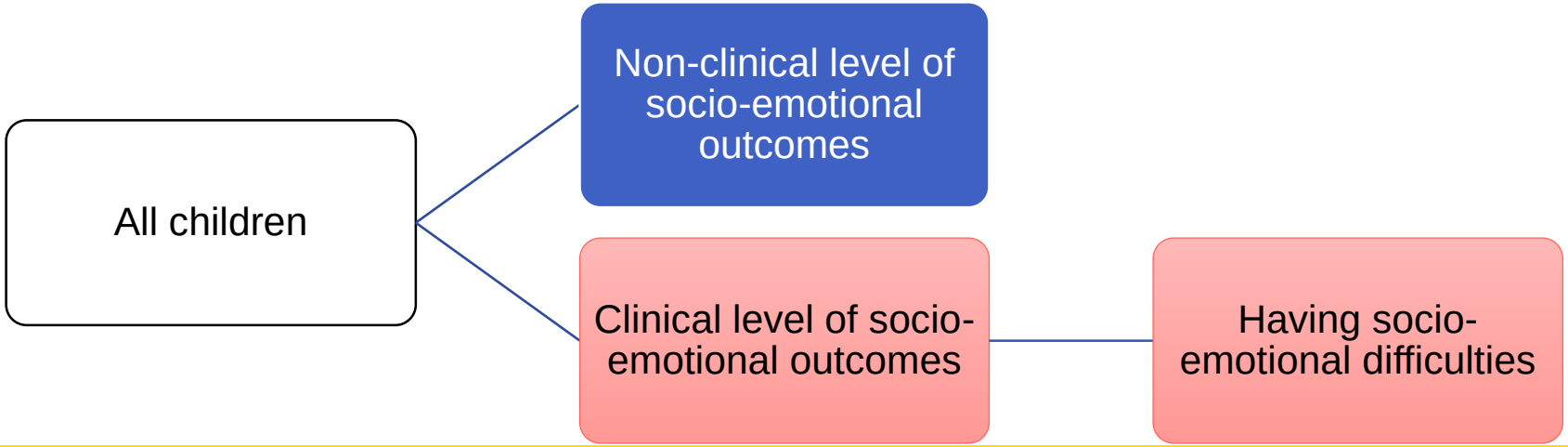
(ii) **pre-care maltreatment** (i.e., maltreatment before first entry into OOHC), including child's age at the first entry into OOHC, number of unsubstantiated and substantiated reports of risk of significant harm (ROSH), respectively, and the predominant type of maltreatment;

(iii) **placement-related factors**, including number of placement changes and duration in OOHC prior to the first interview, and placement type reported at the first interview;

(iv) **carer-related factors**, including carer (and their spouse if recorded) socio-demographics (i.e., education level; financial situation), medical conditions, psychological distress measured using the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002), and their satisfaction with support received from OOHC organisations.

Assessment of socio-emotional difficulties

- Children's socio-emotional outcomes were assessed at the first interview for each child (predominantly occurred within three years of first entry into OOHC)
  - the Brief Infant-Toddler Socio-emotional Assessment (BITSEA) for children aged 1-2 years
  - the Child Behaviour Check List (CBCL) for children aged 3-17 years



Children in OOHC at high risk of socio-emotional difficulties

- The overall proportion of children identified as having socio-emotional difficulties was 21.7% (95% CI, 19.6, 24.0).

- Two “high-risk” groups for socio-emotional difficulties

36% of children had socio-emotional difficulties if they

- are 3-5 years old, and
- live with a carer with high psychological stress, and
- 4+ placement changes

39% of children had socio-emotional difficulties if they

- are 6-17 years old, and
- live with a carer with high psychological stress, and
- experienced any substantiated allegation of child abuse, and
- were subject to emotional abuse alone or multiple types of abuse

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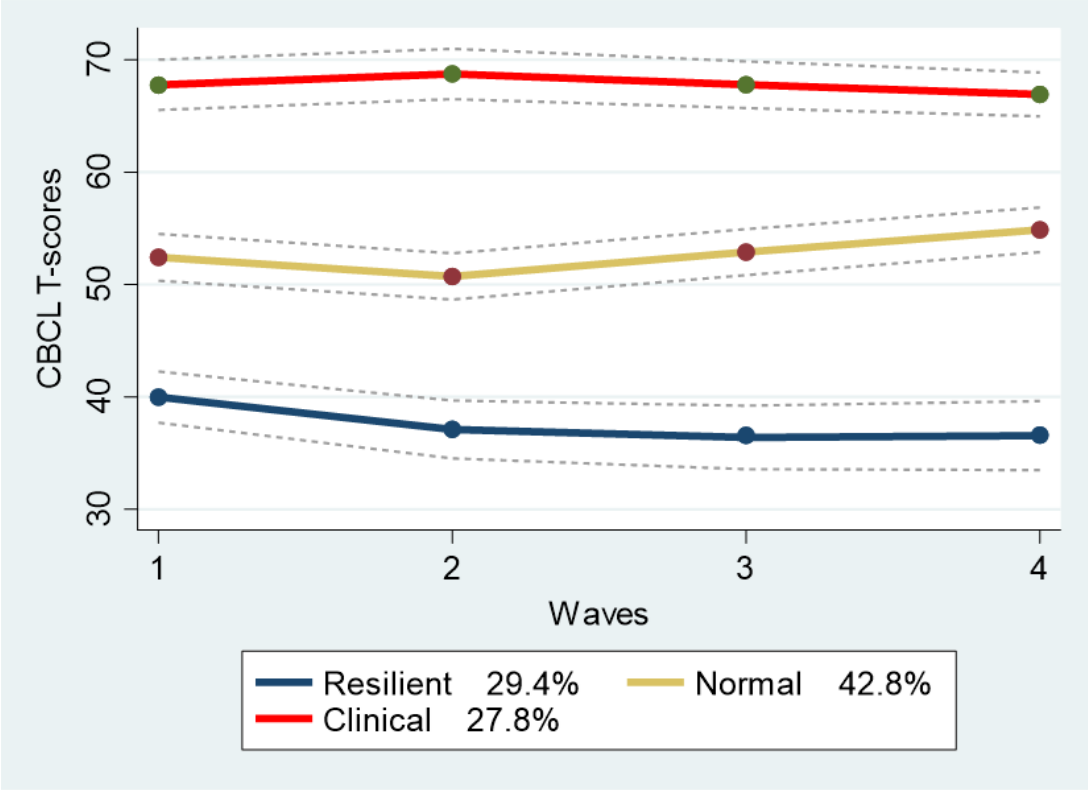
Developmental trajectories of socio-emotional difficulties of children in OOHC

- 345 children aged 3-17 years.
- In the clinical group, there were more children who experienced 4+ placements (54% vs 34%), and who had a carer with a moderate to a high level of psychological distress (45% vs 17%)



Study limitations

Cross-sectional

Sample size

Under-representation

- Study sample reflects younger children on long-term OOHC and protection orders. It under-represents adolescents aged 13-17 years who lived at home for a longer period before coming into OOHC.
- Thus, socio-emotional difficulties of the study sample may be lower than that of population who enter into OOHC and those who received final orders.

Study implications

Overall, our study showed that 1 in 5 children aged 12 months to 17 years had socio-emotional difficulties predominantly within three years of entering OOHC.

Study implications

This study identified five factors that identify children in OOHC who are at *high* risk of socio-emotional difficulties:

- age at assessment,
- living with a carer with high psychological distress,
- pre-care exposure to substantiated allegations,
- subject to multiple types of maltreatment, and
- 4+ placement changes.

Study implications

This study should not distract child protection services from the need to provide health screening, and sufficient resources and support to all children in OOHC.

The current study does not take away from the need for individual level screening but rather adds a more nuanced risk profile of factors such as pre-care maltreatment and placement experiences that can inform early intervention and support for children in care.

Study implications

Carer distress is an important indicator for the socio-emotional difficulties of the child they care that should be responded to with urgent support and interventions.

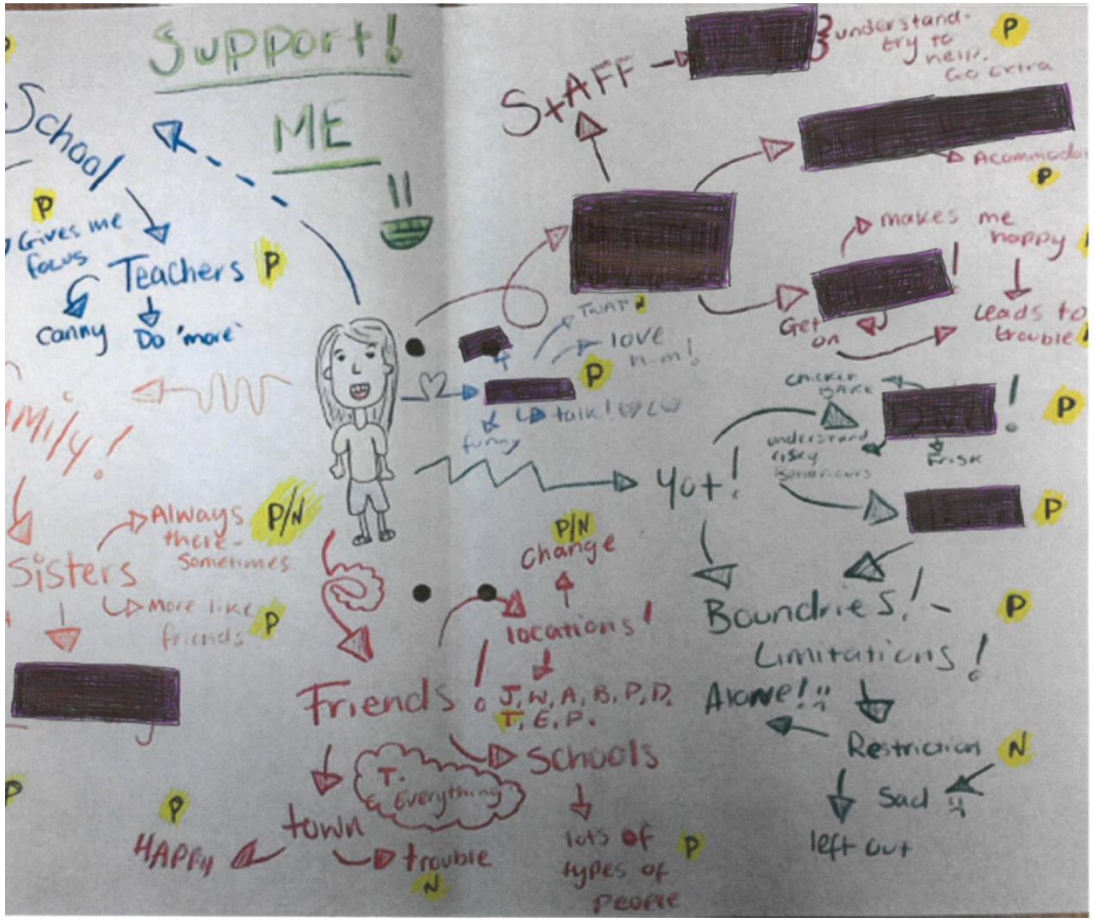
This finding highlights the importance of using a holistic approach to provide mental health support to both carers and children in need.

How can we help?

Need to think about models of care that will change practice

“stop describing start changing”

Supporting Looked After Children and Care Leavers in Decreasing Drugs and Alcohol (SOLID)



- A NIHR PHR research project that explores ways to decrease drug and alcohol use in children in OOHC and in care leavers aged 12-20 years in north-east England.

- References of articles by Alderson & Lingam et al.

- Alderson H, Kaner E, McColl E, Howel D, Fouweather T, et al. (2020) A pilot feasibility randomised controlled trial of two behaviour change interventions compared to usual care to reduce substance misuse in looked after children and care leavers aged 12-20 years: The SOLID study. PLOS ONE 15(9): e0238286. https://doi.org/10.1371/journal.pone.0238286

- Alderson, H, Brown, R, Smart, D, Lingam, R, Dovey-Pearce, G. 'You've come to children that are in care and given us the opportunity to get our voices heard': The journey of looked after children and researchers in developing a Patient and Public Involvement group. Health Expect. 2019; 22: 657- 665. https://doi.org/10.1111/hex.12904

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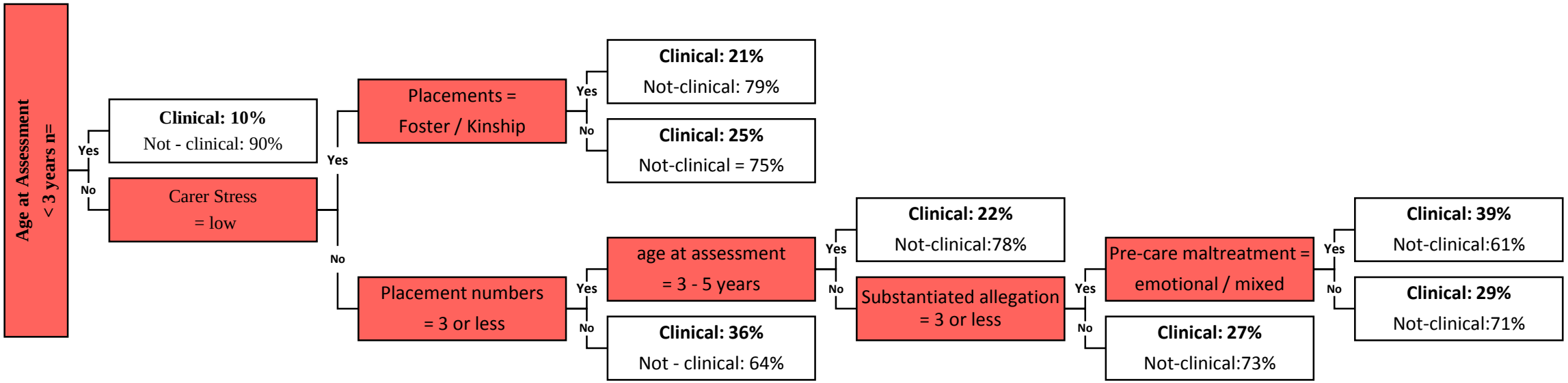
Next steps

- Priority population research
- Aboriginal led research
- OOHC research intervention based

Thank you!


Age at Assessment
< 3 years n=
Yes
Clinical: 10%
Not - clinical: 90%
No
Carer Stress
= low
Yes
Placements =
Foster / Kinship
Yes
Clinical: 21%
Not-clinical: 79%
No
Clinical: 25%
Not-clinical = 75%
No
Placement numbers
= 3 or less
Yes
age at assessment
= 3 - 5 years
Yes
Clinical: 22%
Not-clinical:78%
No
Substantiated allegation
= 3 or less
Yes
Pre-care maltreatment =
emotional / mixed
Yes
Clinical: 39%
Not-clinical:61%
No
Clinical: 29%
Not-clinical:71%
No
Clinical: 27%
Not-clinical:73%
No
Clinical: 36%
Not - clinical: 64%

SOLID Phase 1: Developing an intervention

Interviews/focus groups with children and young people, caregivers, social workers, and drug/alcohol workers to inform the intervention.

Key Themes

"You know she's listening. You know she cares. You know she wants to help….Her personality's just bright and she always has positive things to say". (JS, male, 18)

"Yeah they [D&A Service] tried to change me straight away and I didn't like it….like instead of saying right you have to do this, it could be, well try this or try that. It's not like, they were just straight like, you have to do this, you have to do that and I just didn't like getting told that. I was like nah, nah I'm not having it. So I just stopped doing it". (JL, male, 17)

"Writing it down or doing it like arts and crafts way because I don't like just talking and having conversations cause I just get a bit bored and lose track, then I'll start fiddling about and then I'll just be like, totally out, I won't be like in there almost. I won't be in that right frame of mind to be able to sit and talk to someone". (SW, female, 18)

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SOLID Phase 1: Developing an intervention

- **Motivational enhancement therapy (MET):** motivation and responsibility for change lie within the client, and it is the therapist's role to create an environment to enable the client to change.
- **Social Behaviour and Network Therapy (SBNT):** that social network support for change is key in helping people deal effectively with addictive behaviour.

SOLID Phase 2: External pilot randomised controlled trial

- Comparing MET, SBNT and usual care.
- 860 children and young people.

Types of substances used

Substance	Number of young people
Alcohol	354
Cannabis	168
NPR/Legal highs	37
'Other' (e.g., over the counter and prescription)	44

Number of substances used

Number of substances	Number of young people	Young people <16	Young people 16+
1	208	29	179
2	105	15	90
3	41	6	35
4	12	2	10

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SOLID Phase 2: External pilot randomised controlled trial

CRAFFT: assesses "risky" substance use

- 89 (10%) young people reported that they had been in a **car** driven by someone (including themselves) who was under the influence of alcohol or drugs.
- 141 (16%) young people stated they used alcohol or drugs to **relax**, feel better about themselves or fit in.
- 122 (14%) young people stated they used alcohol or drugs whilst they were **alone**.
- 144 (17%) young people stated they had **forgotten** things they did whilst under the influence of alcohol or drugs.
- 114 (13%) young people stated that **family or friends** have told them they should cut done on the drinking or drug use.
- 118 (14%) young people stated they had got into **trouble** due to their alcohol or drug use.
- In total, **209 (24%) of those screened were defined as having risky substance use**. This is less than predicted. US data 30% screen positive.

SOLID was found to not be feasible.

- Of 1450 eligible participants, 860 (59%) were screened for drug and alcohol use by social workers, 211 (24.5%) met inclusion criteria for the trial and 112 young people (7.7%) consented and were randomised. Sixty of these 112 participants (54%) completed 12-month follow-up questionnaires. Only 15 out of the 76 (20%) participants allocated to an intervention arm attended any of the offered MET or SBNT sessions.

- Despite co-designing procedures with staff and young people in care, the screening, referral and treatment pathway did not work here.

- A new, more responsive way of working to deliver these interventions is needed. One possible solution to facilitate a smoother transition might be to assign a drug and alcohol worker to be co-located within residential units and social care teams to help provide more integrated care