National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care 2006

Authors

Ms. Alexandra Osborn

Ph.D Candidate

Dr. Paul. H. Delfabbro

Senior Lecturer

THE UNIVERSITY OF ADELAIDE AUSTRALIA

SCHOOL OF PSYCHOLOGY
THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA
TELEPHONE 8303 5693
FACSIMILE 8303 3770

paul.delfabbro@psychology.adelaide.edu.au

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Executive Summary

Background and methodology

This is the final report of a national research project undertaken between November 2003 and August 2005. Previous longitudinal research by Barber and Delfabbro (2004) indicates that approximately 15-20% of young people in Australian out-of-home care have significant emotional and behavioural problems that often condemns them to a life of repeated placement instability and further psychosocial harm. The selection of 'high-support' children for the national comparative study was based on the objective and empirically derived selection criteria identified in the South Australian longitudinal study of children in care (Barber, Delfabbro, & Cooper, 2001; Delfabbro, Barber, & Cooper, 2001). The children were selected if they were aged between 4 and 18 years of age and referred for emergency, short-term or long-term placements. The children were only selected if they had experienced two or more placement breakdowns in the previous two years or had experienced a placement breakdown during their first four months in care. This final report presents the findings of Australia's first national comparative study of 364 children with this placement profile. Based on detailed interviews with case-workers, case-file reading, and comprehensive analysis of objective placement data, this study provides a detailed analysis of the social and family background of this population of children, their psychosocial profile, service history, and their placement experiences.

Sample Characteristics

The total national sample consisted of 364 children and young people (Mean age = 12.92, *SD* = 3.28) from South Australia, Victoria, Queensland and Western Australia. The mean age at entry into care of the total sample was 7.48 years (*SD* = 4.21) with a range of 0 to 16 years. On average, the number of years the children had spent in care was 4.80 years (*SD* = 3.76) with a range of 0 to 18 years in care. Several State differences were observed in the care histories of the children. The South Australian children had entered care at a significantly younger age than the QLD and VIC samples. SA and WA samples had spent significantly longer time in care than QLD and VIC samples.

Key findings

Placement history

The total sample had experienced a range of 2 to 55 placements (all types) during their time in care (M = 10.53, SD = 7.80). On average the children had experienced 4.95 (SD = 3.99) placement breakdowns in the previous two years with a range of 2 to 30 during that time. The children had spent close to a mean of five years in care (M = 4.80, SD = 3.76). Just under half of total sample (47.3%) had experienced at least one relative care placement and 56.5% of total sample had experienced at least one residential/group care placement.

Overall, the SA sample had a significantly higher number of previous placements than the other three States, whereas the QLD sample was observed as having had the lowest number of previous placements. Residential care was more widely utilised in Victoria and Western Australia than in South Australia and Queensland.

Social background

Children in the different States had similar histories of family disadvantage. Almost three quarters of the children came from households with domestic violence or physical abuse; two thirds had parents with substance abuse problems and almost 3 in 5 had been neglected. Half had parents with mental health problems, homelessness, or significant financial problems**.** The majority of the children and young people had suffered physical abuse (73.4%), sexual abuse (65.9%) and neglect (58.2%). Only a small number of children (9.9%) were identified as having experienced no form of abuse or neglect, whereas approximately 90% of the sample had experienced at least one form of abuse or neglect.

The SA and VIC samples had a significantly higher prevalence of abuse; the WA sample suffered higher rates of parental imprisonment whereas the QLD sample had a consistently lower prevalence of all compared with the other three States.

Education

Just under three-quarters of the children (73.1%) were attending school or TAFE/apprenticeship program at the time of review; 34% had been suspended from school in the previous six months and 12.7% had been excluded.

Family contact

Low levels of family contact were evident across the country. The results showed that children in South Australia had significantly lower levels of telephone contact with biological fathers and relatives than the other three States. However, no other significant differences were observed suggesting that the low levels of family contact described above for the sample as a whole was generally consistent across all the States.

No significant gender differences in the frequency of children's contact with their mothers, fathers or other relatives were noted, but a significant age difference between younger (4-12 years) and older (13-18 years) children was observed. Older children had significantly less telephone contact with their fathers and relatives than younger children and they also had significantly less frequent direct contact with their mothers and fathers. On the other hand, older children had significantly more phone and direct contact with their relatives (siblings, grandparents, aunts and uncles) than younger children.

Those children with significantly poorer behavioural and emotional functioning were also observed to have the highest level of direct supervised contact with their biological mothers. There were also relationships observed between the likelihood of contact with fathers and several social background variables. A higher proportion of children were having no telephone contact with their fathers if they had been imprisoned or had inflicted sexual abuse on the child. A higher proportion of children were having no direct unsupervised contact or overnight stays with their father if they had a parent who had been or was currently imprisoned or had a parent with mental health problems.

Psychological adjustment and social functioning

Behavioural and emotional functioning

The majority of children fell into the abnormal range for conduct disorder problems of the Strengths and Difficulties Questionnaire (SDQ). Close to half of the children fell into the abnormal range for hyperactivity and emotionality problems and close to two-thirds of the children fell into the abnormal range for peer functioning

problems. Overall, close to 60% of the children and young people fell into the 'abnormal' clinical range on the Total Difficulties Score for the SDQ for emotional and behavioural functioning. State comparisons revealed no significant differences in the overall level of emotional and behavioural functioning across the country, except for children in Western Australia who were found to have higher conduct disorder problems than the Victorian and South Australian children.

Social functioning

Poor social functioning was evident in the total sample. No gender or age differences were noted for this particular measure however a significant difference was observed between the Indigenous children and the non-Indigenous children with the non-Indigenous scoring significantly poorer on this measure. State differences were also observed. The Queensland children were found to have significantly poorer levels of social functioning as compared to the Victorian sample, but did not differ significantly from the South Australian and Western Australian children.

Attachment-related problems

The overall mean score for the attachment disorder checklist indicates a relatively high level of attachment-related problem behaviours in the total sample. Disrupted attachment refers to a child's inability to trust others and to form a close bond with another person, and an inability to regulate appropriate emotional and social responses. Commonly noted behaviours included: "being excessively demanding or bossy" and children showing "little guilt or remorse for their actions". Those children displaying disrupted attachment related behaviours were also found to display poor emotional and behavioural functioning. Those children with the highest levels of emotional and behavioural disturbance (abnormal range on SDQ) were also noted as having higher levels of previous placement breakdowns.

Services

A significantly higher proportion of the older children received certain services and interventions than the younger children. Boys were found to have received more behaviour management intervention services than girls and boys were also noted as receiving more child vocational support and guidance services than girls. Those children with the highest levels of emotional and behavioural disturbance

(abnormal range on SDQ) were noted as the most likely to receive services and/or interventions, suggesting some limited evidence for the matching of services.

1. Out-of-home care in Australia

Despite recent improvements in the Australian economy, many families nonetheless continue to experience significant social pressures. Broader economic factors such as poverty, unemployment, and homelessness continue to plague many communities, and there has also been a substantial growth in non-traditional family structures (e.g., sole parent families, teenage parents, or reconstituted families) all of which have made people more vulnerable to broader social and economic pressures. Individually, many more families are now affected by substance abuse, domestic violence, and poorer physical and mental health, all of which have greatly affected their capacity to provide adequate care for their children (Barber & Delfabbro, 2004; Department of Human Services, February, 2004; Layton, 2003; Victorian Department of Human Services, June 2003). Accordingly, most researchers agree that a substantial number of families will continue to require additional Government support to ensure the safety and well-being of their children, and that out-of-home care remains one of the most important options that should be available (Des Semple & Associates, March 2002; Layton, 2003).

Despite this recognition, out-of-home care is a service that has come to be placed increasingly under strain in recent years, making it increasingly difficult to find suitable placement for all children referred into care. As indicated by the Australian Institute for Health and Welfare (AIHW, 2005), the number of children in out-of-home care has steadily been increasing over the last decade. At June 30th 2005, there were 21,795 children in various forms of out-of-home care and this compares with only 13,979 in 1996 (a 70% increase over that time). From 2004 to 2005, the growth rate was 9%.

One of the principal reasons for this increase has been the rapid increase in the prevalence of child abuse reported and investigated in Australia. For example, during the seven year period from 30th June 1997 (15,718) to the 30th June 2003 (22,130), there has been a 41% increase in the number of children on care and protection orders in all jurisdictions (AIHW, 2004). Re-notifications and re-substantiations of abuse have also substantially increased in many jurisdictions (Layton, 2003). To a large extent, these increases are very likely to be attributable to important legislative and policy changes including mandatory reporting as well as greater awareness in child

abuse problems that were specifically designed to assist children and protect them from potentially harmful situations. However, it is also acknowledged that this increase in abuse reflects an intensification of the broader problems within Australian society described above, in particular, the concentration of poverty within specific geographical areas and cultural groups, and the effects of economic hardship, domestic violence, substance abuse and mental health problems. As Layton (2003) in South Australia has emphasised: the high level of re-notifications in child protection services is:

> *"just one social health measure that highlights the difficulty many agencies face in human service area when dealing with intractable long-term problems. Issues such as poverty, substance and alcohol abuse, mental health issues and domestic violence – these issues require long-term comprehensive and flexible approaches, that are coordinated and focused on increasing levels of safety and well-being for children, young people and their families" (Layton, 2003, p. 9.32).*

In addition to increases in the demand for placements, there have also been several "supply" factors that have made it more difficult to find placements for those children who receive referrals. For example, it has become increasingly difficult in Australia, as in many Western countries, to recruit suitable foster carers (Barbell, 1999; Barber & Gilbertson, 2001; Victorian Department of Human Services, June 2003), due to demographic factors such as the increasing participation of woman in the workforce, the ageing of the population, the low rates of remuneration for foster carer services, and the reduced interest in volunteering and community service within modern societies. Carers have also exited the system in greater numbers having been discouraged by the lack of social and Government support, and the adequacy of remuneration provided to them (Barber & Gilbertson, 2001). Placement options have also been reduced due to the substantial reduction in non-home-based forms of care including residential care and group homes across the country during the last 10 to 15 years (Barber, 2001).

The consequence of these changes, namely an increase in the demand for out-of-home care services and a reduction in the supply of suitable placement options, has been twofold. The first is the growing concern that out-of-home is now more likely to be used as a last option for children and families requiring support. Only those

children whose needs are most serious will be placed into care. Second, as a result of limited placement options, it will be increasingly difficult to find suitable placement for many children in care. Suitable placements will therefore become more difficult to obtain and so placements will be at greater risk of placement breakdown. Evidence in support these changes has been obtained in a number of studies (Delfabbro & Barber, 2004; Delfabbro, Barber, & Cooper, 2000; Victorian Department of Human Services, 2003). Placement instability or foster care drift continues to be a challenging feature of most care systems in Australia and many other Western countries, and one of the strongest symptoms of the failure of current out-of-home care systems.

In addition to the significant financial cost associated with instability, research has also shown a relationship between unstable placement histories and psychological disturbance (Fanshel, Finch, & Grundy, 1989b; Farmer, 1993; Palmer, 1996). For example, Holland and Gorey (2004) in Ontario Canada found that "strong relationships have been observed between child developmental and mental health problems, their familial precursors and foster placement instability" (p.119).

1.1 The Problem of Foster Care Drift or Placement Instability

1.1.1 Overview

Many researchers continue to debate the true definition of foster care drift, placement instability, placement breakdown, placement disruption or placement termination (Smith, Stormshak, Chamberlain, & Bridges Whaley, 2001). However, in most cases, these terms refer to the unplanned termination of a foster care or residential care placement. Regardless of the terminology, placement instability continues to be a challenging feature of most care systems in the Western world with similarly high rates of disruption having been observed by several researchers in different countries.

Several researchers have attempted to identify and disentangle the factors that increase a child's risk of experiencing placement instability. For example, Pardeck (1984) and Pardeck, Murphy and Fitzwater (1985) examined individual child factors. Their research showed that increased age and the presence and severity of behavioural and emotional problems were significantly related to higher rates of placement instability. Palmer (1996) also found evidence that boys may be at greater risk for

instability than girls. In Australia, research by Delfabbro, Barber and Cooper (2000) found that gender, location and placement history were the three most important factors that predicted placement disruption. They found that boys were four times more likely to experience disruption and children in the country were 3.35 times more likely to have this experience. Furthermore, if children had a history of previous multiple placement changes (6 or more), they were 3.38 times at greater risk of experiencing disruption. The results of this particular study suggest that problems increase as children grow older and the longer they remain in care.

In a recent longitudinal study in South Australia, Barber and Delfabbro (2004) found strong evidence for all of these phenomena. However, one encouraging feature of their findings was that these extreme levels of placement disruption were only confined to a subset of the overall population in out-of-home care. Whereas most children achieved stability within two years of a new referral, only 15-20% experienced very high levels of instability. Another encouraging outcome was that these children were relatively easy to identify and tended to share very similar characteristics. Consistent with Bath (1998), the results showed that such children very commonly have significant emotional and behavioural problems. These include property damage, aggressive behaviours, substance abuse, offending, and truancy from school, and a variety of other antisocial behaviours. (Barber, Delfabbro, & Cooper, 2002; Barber et al., 2001; Delfabbro, Barber, & Cooper, 2002) In support of this, Barber et al.'s (2001) work found that outcomes for children in South Australian foster care could be very reliably and efficiently predicted based upon baseline child characteristics alone, and that clear thresholds (e.g., criterion levels of instability, conduct disorder scores) can be identified that suggest a very poor prognosis for longer-term outcomes. For example, teenagers with high conduct scores coming into care had an 80% likelihood of placement breakdown due to behaviour within four months, and only a 5% of being stable two years later. Many children experienced up to forty placements within two years, clearly indicating that they were unsuitable for conventional out-of-home care placements.

Not surprisingly, this finding that high rates of placement instability are disproportionately concentrated in a small and relatively easily identifiable percentage of children, has led to a greater focus on this population of children in both policy

discussions and research studies. Often referred to as "high support needs" or "complex needs" children, it is now recognised that children in this group are particular unstable because they have more complex or challenging needs than others in the care system. Thus, it is argued that, if one could understand and address the needs of these children, one could therefore concentrate financial resources and services in a way that very efficiently targets the primary cause of strain in the care system. One would also therefore be able to free up valuable resources to provide better case-planning, greater service support and remuneration for carers and children in the remaining 80% of the out-of-home care population.

1.1.2 The need for further research into placement instability

Despite the recognition of the complex needs of many children in care, most care systems have few, if any, systematic processes or methodologies in place to allow for the early identification and ongoing monitoring of their needs. As a consequence, these children 'at risk' of placement breakdown impose considerable burdens on the foster care system and undermine its capacity to provide effective services for other children in care. Although admittedly these problems occur because there are limited resources and alternative arrangements for very challenging children in many jurisdictions, there is a growing recognition of the need to find: (a). More effective ways to meet the needs of challenging children in alternative care, and (b). Possible ways to identify these children when they enter foster care, so that more effective services and strategies can be put into place when children first come in contact with the service system.

Barber and Delfabbro's (2004) Australian study provided detailed information concerning the outcomes of these children in out-of-home care, but their analyses were confined solely to the South Australian system. Furthermore, relatively little information was obtained concerning the services provided to these young people, and the families from which they had come. For these reasons, there is a need to extend this research so that the causes of the placement disruption are considered in a broader social and demographic context. In other words, although Barber, Delfabbro and Cooper's (2001) recent work has tended to focus upon the characteristics of the children themselves and how this relates to outcomes, and how well the system has responded to their needs, it is important to recognise that many problems are brought

into care, rather than being caused by it. Accordingly, there may be considerable value in documenting young people's pathways into care, so as to identify possible intervention points, or service responses that might have been useful in preventing young people's entry into care. In addition, there may be considerable value in understanding what services are currently being used by existing services so as to determine what is effective and ineffective in meeting the needs of these young people.

1.1.3 Aims of the National Comparative Study

The national comparative profile study was undertaken in South Australia, Victoria, Queensland and Western Australia between November 2003 and August 2005. This was the first national project of its type to be undertaken in Australia, and was conducted to extend previous research conducted in South Australia (see Barber & Delfabbro, 2004; Barber et al., 2002; Barber et al., 2001; Delfabbro, Barber, & Cooper, 2000; Delfabbro et al., 2001; Delfabbro et al., 2002). The selection of "high-support" children was based on the objective and empirically derived selection criteria identified in the longitudinal study of children in care (Barber et al., 2001; Delfabbro et al., 2001). Using this method, it was therefore highly likely that that sample selected in the different States had a genuinely poor prognosis for achieving stability in care.

The first principal aim of this study was to extend Barber and Delfabbro's (2004) findings by conducting a more detailed national study of the needs, social background, and service responses to children who met the empirically derived criteria across four different Australian States. To do this, measures from the previous longitudinal study were supplemented by a wider range of measures, including the Strengths and Difficulties Questionnaire (SDQ) currently being used in the Australian Institute of Family Studies' national longitudinal study of children (LSAC). The SDQ was included to estimate the proportion of children with placement instability who fell into the abnormal or clinical range on key indicators of psychological and social adjustment, so as to highlight the potential need for specialist therapeutic services for this population.

A second aim was to place a greater emphasis on the utilisation of services both at the entry point into care as well as during placement. As indicated by Bath (1998), while much is written about the characteristics of children who experience considerable placement instability, there is also a strong need to understand the implications of these characteristics for practice and service delivery in order for progress to be made in finding appropriate solutions for these children. For example, in considering young people's entry into care, it is important to determine what service responses were, or could be utilised, to reduce the likelihood of young people having to leave home. On the other hand, once young people are in the care system, there is a need to ascertain which services have been used, and whether these were effective or ineffective, so that recommendations can be made concerning future service and treatment responses.

A third aim was to provide a national reference point for evaluations of intervention strategies conducted in different States. At the present time, it may be difficult to make best practice recommendations for children with challenging needs because different programs or jurisdictions are dealing with children with a variety of different characteristics, age range and placement histories. National data using standardised measures will provide a means by which to compare the needs of children in different jurisdictions so that treatment options that prove effective in one State can be replicated or considered by others faced with children with similar profiles.

Finally, because State Governments are often reluctant to publicise their own individual problems because of fear of condemnation by the local media and the public, the development of a national profile of these children may serve to strengthen national awareness and facilitate debate concerning these problems, and the need to address them in a unified way across the country.

Although this research was primarily of an exploratory and descriptive nature, it was nonetheless possible to investigate several broad hypotheses relating to the association between child characteristics and system outcomes; namely that: (a) Children with more complex family backgrounds would have poorer psychosocial functioning on a range of measures; (b) Psychological and social functioning would

be poorer in children with the most disrupted placement histories; (c) Children with more complex needs would receive more services because of the tendency for greater amounts of resources to be directed towards the most difficult cases.

1.1.4 Presentation of results

The findings from this study will be presented in a series of sections. The following section (2) will commence with a description of the placement history of the children and a description of their high support need as identified by their case-files. The next section (3) will provide a psychosocial profile of the children based on standardised measures followed by a section that will examine the relationship between psychosocial functioning and the children's placement history, social background and general high support needs (4). Section 5 will examine the relationship between certain measures. The following section (6) will examine the level and type of family contact and its relationship to child functioning. The next section (7) will examine children's service history and how this relates to the social background of the families and child characteristics. The final section (8) will discuss the conclusions, implications and recommendations arising from the results of the study.

1.2 Method

1.2.1 Sample characteristics

The study involved 364 children and young people purposively selected using Barber and Delfabbro's empirically derived objective criterion of placement instability from four Australian States (South Australia (N = 113, 31.0%), Victoria (N = 99, 27.2%), Queensland (N = 80, 22.0%) and Western Australia (N = 72, 19.8%). Of the 364 children and young people 58.2% were male and had a mean age of 12.92 (SD = 3.28, range 4-17 years). The majority of the total sample was identified as non-Indigenous, 17.9% as Aboriginal/Torres Strait Islander and 4.1% of 'other' nationality. Just over 70.0 % of the sample were placed on Guardianship of the Minister orders, 4.4% were on Care and Protection orders, 0.8% were on Voluntary orders and 24.7% were on 'other' court orders. Analysis of the order duration showed that just under half of the children were on Guardianship of the Minister orders until the age of 18 years (45.1%), 39.3% were on 'other' length orders and 15.7% of the sample were on twelve month orders.

1.2.2 State differences in sample characteristics

Table 1.1 summarises the significant differences in age, gender and ethnicity of children from the four Australian States. A significant difference was found between the age of the children from three States (F (df = 3, N = 364) = 6.03, p < 0.05). The children from South Australia were found to be significantly younger than the children from Western Australia and the children from Victoria. It was also found that the children from Queensland were significantly younger than the children from Western Australia. Pearson's chi-squared analysis revealed significant gender differences across the States (χ^2 (df = 1, N = 364) = 8.12, p < 0.05). The sample from Victoria had a higher percentage of male children than the South Australian sample. Pearson's chi-square cross-tabs also revealed significant ethnicity differences between the States, χ^2 (df = 1, N = 364) = 28.20, p < 0.05. The Victorian sample was found to have a significantly higher proportion of non-Indigenous children than the South Australian, Queensland and Western Australian samples.

Table 1.1 Summary of State differences of age, gender and ethnicity of children

	SA (N =113)	VIC (N = 99)	QLD (N = 80)	WA (N = 72)
Mean age (SD)	12.20 (3.49)	13.21 (3.50)	12.48 (3.14)	14.13 (2.29)
N (%) male	56 (49.6)	68 (68.7)	45 (56.3)	43 (59.7)
Ethnicity n (%)				
Non-Indigenous	87 (77.0)	91 (91.9)	56 (70.0)	50 (69.4)
Aboriginal	21 (18.6)	6 (6.1)	17 (21.3)	21 (29.2)
Other	5 (4.4)	2 (2.0)	7 (8.8)	1 (1.4)

1.2.3 Selection criteria

The children were selected if they were aged between 4 and 18 years of age and referred for emergency, short-term or long-term placements. The children were only selected if they had experienced two or more placement breakdowns in the previous two years or had experienced a placement breakdown during their first four months in care. According to Barber and Delfabbro (2004), placement instability was defined as two or more placement breakdowns due to behaviour due to the danger of false positives recorded in case-files. They noted "that it was common for social

workers to record 'disruptive behaviour' as the reason for terminating a placement when the situation was either more complex than that or was merely a case of incompatibility between the child and the foster carer. However, when disruptive behaviour was mentioned as the cause on more than one occasion false positives were extremely unlikely. Children less than four years of age were also not selected because the measures employed in this research were not appropriate for this age group (Delfabbro et al., 2000). Children on detention orders or those referred for family preservation services were also excluded because the primary focus was on children who could not be currently and effectively accommodated in out-of-home care.

1.2.4 Method of data collection

The data for this study were collected from case-files and face-to-face interviews with case-workers at community service departments in South Australia, (formerly the Department of Human Services (DHS) now known as Department for Families and Communities (DFC), Victoria (Department of Human Services (DHS), Queensland (Department for Families), Western Australia (Department for Community Development) between November 2003 and August 2005. Due to the privacy act (Privacy Amendment (Private Sector) Act, 2000), the case-file readings were only permitted to be undertaken by a paid employee of each of the community service departments. The project consisted of multiple studies conducted across the four States. The data were then combined to form the national sample.

Records at the central referral agency were monitored over a number of months in order to identify a sample of children meeting the specified selection criteria in each metropolitan area. A target sample of 100 was sought for each State. In the case of Western Australia and South Australia, it was possible to sample almost all children in the metropolitan area falling into this category, whereas a random selection was taken in Queensland and Victoria. The data collection was purposive in nature. Children were selected if they were referred for a new placement or if the child had two or more placement breakdown in the previous two years. If the child met the inclusion criteria, the respective case-worker at the district centre or non-Government agency were contacted with the intention of conducting a short interview, and for the purposes of gaining access to case-files. The list of children

who were identified as being suitable for inclusion in the study was recorded along with the contact details and location of the child's allocated case-worker. This information was collected from the central agency records, Government databases and verified with case-workers in interviews. Children selected using the method described above have been clearly shown to have greater difficulty in being accommodated than other children in care (Barber, Delfabbro & Cooper 2001; Barber & Delfabbro, 2004).

Using both qualitative and quantitative methods, a social history of each of the children was compiled from reviews and coding of case-file information (case-plans) developed when children first came into care. The information examined included: abuse and neglect notifications, alternative care history, reasons for being placed into care, family background, situation at time of referral (behavioural issues, needs, interventions, school attendance), and previous services. A second phase in the data recording involved documentation of the child's long-term placement history from both computer records (where these were available) and an interview with the child's case-worker, with a focus upon identifying the reasons for placement changes. To validate the information quickly, a sample of case-workers were asked to indicate how often they had telephone and direct contact with the children during the relevant period (i.e. the last 12 months, see section 1.3.1).

1.3 General survey design

A standardised protocol was developed in consultation with the Department of Human Services (DFC in South Australia), and in light of preliminary inspections of case-files to ascertain the validity of items. Previous research by the Delfabbro in conjunction with FAYS (Forward & Carver, 1999) suggests that case-file data is of variable quality, and that protocols need to be developed very carefully (Munro, 1999), and the best quality data is obtained by a combination of case-file reading and interviews with well-informed case-workers.

1.3.1 Frequency of case-worker contact with child and foster carers/staff

Taking into account that we were unable to interview the child or foster carers, we felt that due to the high needs of the children the case-workers were in a good position to comment on the level of social and psychological functioning of the

children. To confirm that case-workers were a reliable source of information, for a small proportion of children in total sample (*N* = 49, 13.46%), from South Australia only, information was collected concerning the type and frequency of contact that case-workers were having with the children and foster carers/unit staff in the previous six months. As can be seen in Table 1.2, over a third of case-workers were having telephone contact with the child 2 to 6 times per week; whereas, just over half of case-workers were having telephone contact with the foster carer/unit staff 2 to 6 times per week and 18.3% were having daily telephone contact. In respect to direct face-to-face contact, case-workers were seeing approximately a third of the children on a weekly basis and the case-workers were having direct face-to-face contact with the foster carers/unit staff at a similar rate to the children. The results therefore provide evidence that case-workers have a relatively high level of both telephone and direct contact with both the children and foster carers/unit staff and therefore should be in a good position to comment on the general social and psychological well-being of the foster children.

Table 1.2 Type and frequency of case-worker contact with children and foster carers/unit staff in the previous six months, (*N* = 49)

Contact type	Never (%)	1-3 times per month (%)	2-6 times per week (%)	Daily (%)
Telephone – Child	8.2	51.0	36.7	4.1
Telephone – Foster Carer/Unit staff	2.0	20.4	59.1	18.3
Direct – Child	0.0	65.3	34.7	0.0
Direct- Foster carer/ Unit staff	4.1	68.4	26.5	0.0

1.4 Measures

1.4.1 Case-file Audit

a) Demographics

Records were taken of the child's age, gender, ethnicity, and type and duration of order (e.g., Guardianship to 18).

b) Biological family/social background

Information was collected regarding the child and biological family's background and factors that were documented in the case-file that contributed to the child being placed into care. These factors included; financial problems, domestic violence, parental substance abuse, and parental physical illness and/or disability. Records were also taken on the forms of abuse or neglect that the child may have experienced, the number of siblings under 18 residing in the biological home and number of siblings also in the same placement as the child in question.

c) Critical events in the child and family's life

Extensive information was collected concerning the circumstances that contributed to the child's first contact with the Department, and what circumstances appeared to contribute to the child first being placed into care.

d) Care history

This section recorded the child's age at first entry to care; the primary reason for entry to care; number of all types of foster placements prior to entering current placement or program; the years spent in care; the number of previous reunifications with family; and whether the child had previously been placed in residential or relative care; the duration of longest reunification with the child's birth family; and the reasons for re-entry into care. Case-workers were asked to identify the factor(s) they felt that made it most difficult for the child to return to their biological parents.

e) Child's needs

This section related to high support needs of the child identified in their case-file. Such high support needs included; conduct disorder, hyperactivity, depression, anxiety, attention deficit hyperactivity disorder (ADHD), personality disorder/mental illness, physical/intellectual disability, and any other needs. If the case-file identified that the child was diagnosed with conduct disorder, then a specific section on conduct disorder symptoms was also completed. This section included items such as; damaging or destroying property, offending, substance abuse, temper tantrums, lying and cheating, fighting with or physically attacking others, persistent disobedience, severe school problems, school refusal, running away, harm to self, inappropriate sexualised behaviours towards others, sexually at-risk behaviour, interpersonal

conflict, attachment disorder and any other relevant information.

f) School/education based interventions before or since contact with the Department

This section included items relating to whether the child was attending school at time of the first placement into care and whether they were currently attending school at the time of data collection. The section also had a checklist of possible service supports that the child may have received in the past or may currently be receiving. Such service supports included; periodic meetings between teachers and carer(s), individually tailored curriculum, private tutor (at home or school), or general education worker at location, or any other educational support services.

g) Specific therapies or interventions provided to child or biological family since or before they came into contact with the Department

Extensive information was collected in regards to any specific therapies or interventions that the child or biological parents may have received before the child came into care or during the child's time in care. Information was collected on the type of therapy or intervention, when it was provided and who actually provided the service. The checklist included such services as; assertiveness training, self-esteem building, psychiatrist, psychologist, treatment for specific mental health issues, anger management, social skills training, dealing with grief and loss, behaviour management, employment training/apprenticeship, independent living, substance abuse treatment, safe sex practices, family mediation, family support worker visits home, mentor and any other services.

1.4.2 Psychosocial assessment - Interview with child's case-worker

a) The Child Behaviour Checklist (CBC) – (Boyle et al., 1987).

Psychosocial adjustment was measured using three sub-scales derived from Boyle's et al's (1987) child behaviour checklist. The Child Behaviour Checklist is an empirically designed measure of child behavioural problems and social competencies. The items are scored on a three-point scale ranging from 0 = "Never", to 1 = "Sometimes", to 2 = "Often". The questions were administered to the child's allocated case-worker who was asked to rate the child's behaviour over the last six months using the three response categories. The three main constructs that were measured included conduct, hyperactivity, and emotionality.

Conduct disorder scale

An abbreviated conduct disorder scale was used from Boyle et al.'s (1987) Child Behaviour Checklist. The items were those used by Barber and Delfabbro in their three-year longitudinal study (see Barber & Delfabbro, 2004). The items included satisfied the key criteria of the DSM classification for conduct disorder and each was scored (0 = "Never", 1 = "Sometimes", 2 = "Often") giving a score range of 0 (no problems) up to 12 (very severe problems). The six items referred to: "destroying property", "damaging property", "defiance at school", "lying and cheating", "stealing from outside the home" and "physically assaulting others". The Cronbach's Alpha for the conduct sub-scale (6 items) was acceptable at 0.79.

Hyperactivity scale

An abbreviated hyperactivity scale was also used based upon three items from Boyle et al.'s (1987) CBC. The three items included the key elements of the DSM classification for hyperactivity disorder and each item was scored the same way as the conduct disorder scale. The three items were: "couldn't sit still, restless or hyperactive"; "could not concentrate or pay attention for long"; "distractible, and distractible, has trouble sticking to things". The score range for the hyperactivity scale (3 items) was 0 (no problems) up to 6 (very severe problems). The Cronbach's Alpha for the hyperactivity (3 items) was 0.87.

Emotionality scale

An emotionality scale was again constructed from 5 items from Boyle et al.'s (1987) CBC. These items captured the key elements of DSM classification of 'overanxious disorder' and 'affective disorder'. Each of the five items was scored in the same way as the conduct disorder and hyperactivity scales. The total possible score for the scale was between 0 (no problems) and 10 (very severe problems). The items included: "not as happy as other children"; "unhappy, sad or depressed"; "too fearful or anxious"; "nervous highly strung or tense"; "worried a lot". Reliability analyses confirmed that the Cronbach's Alpha for the emotionality (5 items) sub-scale was also acceptable (0.71).

As discussed by Barber and Delfabbro (2004), the items selected from Boyle et al's. (1987) CBC to measure conduct disorder, hyperactivity and emotionality are those that were found to have the highest item-total correlations with their relevant sub-scales in a study of over two thousand Canadian adolescents (Barber, Bolitho, & Betrand, 1999a, 1999b). All three scales were used extensively by Barber and Delfabbro (2004) and have found to have very good psychometric properties in Australian foster care samples and to be highly predictive of relevant system outcomes, including the probability of placement breakdowns and the effects on sustained placement instability.

b) Strengths and Difficulties Questionnaire (SDQ)(Goodman, 1997).

The SDQ is a short behavioural screening questionnaire for children and young people 3-16 years of age. It comprises a mixture of 25 positive and negative attributes of the child. The attributes are divided between 4 sub-scales: Conduct problems (5 items), Emotional symptoms (5 items), Hyperactivity/inattention (5 items), and Peer Relationship Problems (5 items). Together the 20 items generate a Total Difficulties Score. Each item is scored on a 3-point scale, where 0 = "Never", 1 = "Sometimes", and 2 = "Often". The scale ranges for each of the four sub-scales was 0 -10 and the Total Difficulties Scores is a sum of the four sub-scales to give a score out of 40. Reliability analyses were also performed on Goodman's SDQ scales to ensure they possessed adequate levels of internal consistency. The Cronbach's alpha for the conduct problems scale (5 items) was slightly lower than Boyle's conduct scale at 0.73. Hyperactivity scale alpha was acceptable at 0.78 (5 items), but again was lower than Boyle's hyperactivity scale. The scale alpha for the emotionality problems scale (5 items) was acceptable at 0.79 which was higher than Boyle et al's. emotionality scale. The Alpha value for the peer problems (5 items) sub-scale was only just acceptable (0.66).

SDQ Conduct disorder scale

The conduct disorder scale comprised 5 items giving a score range of 0 (no problems up to 10 (very severe problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2.

The five items referred to: temper tantrums; general obedience; fighting with or bulling other children; lying and cheating; and, stealing from outside the home, school or elsewhere.

SDQ Hyperactivity scale

The hyperactivity scale consisted 5 items giving a score range of 0 (no problems up to 10 (very severe problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2. The five items included: 'restless or overactive, cannot sit still for long'; 'constantly fidgeting or squirming'; 'easily distracted, concentration wanders'; thinks things out before acting'; and 'see tasks through to the end, good attention span'.

SDQ Emotionality scale

The emotionality also consisted 5 items with a score range of 0 (no problems up to 10 (very sever problems). The total possible score of 10 was divided by the total number of items (five) to yield a mean conduct score of between 0 and 2. The items included: 'often complains of headaches, stomaches or sickness'; 'many worries, often seems worried'; 'often unhappy, downhearted or tearful'; 'nervous or clingy in new situations, easily loses confidence'; and 'many fears, easily scared'.

SDQ Peer functioning scale

The peer functioning scale comprised 5 items with the same score range and total possible score as the previous three scales. The items included: 'shares readily with other children, e.g., toys, treats, pencils'; 'rather solitary tends to play alone'; 'has at least one good friend'; 'generally liked by other children'; and 'gets on better with adults than with other children'.

The questions were administered to the child's allocated case-worker who was asked to rate the child's behaviour over the last six months using the three response categories. Even though the Boyle et al. (1987) checklist and the SDQ are similar clinical instruments, they were both included in the interview so as to allow comparisons with the findings of those of Barber and Delfabbro (2004) that relied solely on the Boyle et al. scales.

c) Social adjustment

The case-workers were also asked to comment on the child's social adjustment in the previous six months using a four-point scale with 7 items ranging from 1 = "Never", 2 = "Rarely" 3 = "Sometimes" and 4 = "Often". This scale was previously used and validated by Barber and Delfabbro (2004). The scale consisted of five items relating to social relationships ("Has been getting along well with people", "Has resented people telling him/her what to do", "Has felt persecuted or picked on", "Has been inconsiderate of other people's needs or feelings" and "Has blamed others for his/her mistakes"), and two items measuring social confidence ("Has looked forward to mixing with others" and "Has been willing to talk and express feelings"). Items were recoded so that lower scores on all items represented a better level of social adjustment. This generated a scale with a score range between 7 (high adjustment) and 28 (low adjustment). The Cronbach's alpha for the social adjustment scale (7 items) was acceptable at 0.71.

d) Educational adjustment

Information regarding the child's attendance at school or an education-based program was also gathered, including the current grade or achievement level. The case-worker was also asked to indicate whether the child had been suspended or excluded from the school or education program in the previous six months and, if so, the number of times.

e) General health issues

Information regarding the child's weight and physical coordination was collected along with whether the child had had any physical health problems (including dental) that had required attention in the previous six months and whether any action had been taken. The case-workers were also asked to indicate whether the child had any diagnosed psychological health problems and whether any action had been taken to address them.

f) Attachment disorder checklist

The attachment disorder checklist was developed based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 1994) classification for this disorder. Case-workers were asked to indicate how often children had exhibited

certain behaviours in the previous six months based on 10 items on a four-point scale ranging from 1 = "Never", 2 = "Rarely", 3 = "Sometimes" to 4 = "Often", giving a possible total score of between 0 – 40. The checklist included statements such as; "makes very little eye contact", "has been indiscriminately affectionate towards strangers", and "has produced incessant nonsense speech". The items were scored so that a high score on the scale indicated a higher level of attachment-related problem behaviours. Cronbach's alpha for the attachment disorder scale (10 items) was acceptable at 0.68.

g) Family Contact

The frequency and type of family contact the child had experienced in the previous six months was also recorded. Case-workers were asked to indicate how often the child had telephone, face to face supervised contact, face to face unsupervised contact and/or overnight stays with their biological mother, father or relatives.

h) Placement history

Case-workers were asked to indicate how many placement terminations the child had in the previous two years and also to specify the primary reasons for these decisions. In addition, the case-workers were asked how many of the moves were requested by carers due to the child's behaviour and what the main behaviours that had been the primary cause of the breakdowns. Case-workers were also asked to describe what critical incidents had led to recent placement breakdowns.

i) Frequency of case-worker contact with foster carer and child

Information was also collected concerning the type (telephone/ direct face-to face contact) and frequency of contact between case-workers and the foster carer/unit staff and the child in the previous six months. The case-workers were asked to indicate the frequency of each form of contact with each person on a six-point scale: 0 = "Never", 1 = "Once per month or less often", 2 = "2 - 3 times per month", 3 = "Weekly", 4 = "2 - 6 times per week" and 5 = "Daily".

Ethical Considerations

All information obtained from both case-files, case-workers and computer

records remained completely anonymous and confidential through the process of de-identification of all records by internal Departmental employees. The case-files were only viewed on site at the agency and were never removed by the researcher. Appropriate consent and approval procedures were followed in relation to obtaining information about the cases included. Managers and supervisors were contacted to inform them of the project prior to any attempt being made to contact case-workers.

2.1 Results of the National Profile Study

2.1.1 Placement and care history

2.1.2 Care history

As indicated, information concerning the care history of each of the children was collected in each of the four States. The mean age at entry into care of the total sample was 7.48 years (*SD* = 4.21) with a range of 0 to 16 years. On average, the number of years the children had spent in care was 4.80 years (*SD* = 3.76) with a range of 0 to 18 years in care. The mean number of previous placements (all types: foster, residential and/or relative) the children experienced prior to their current placement was just under eleven placements (*M* = 10.53, *SD* = 7.80) with a range of 2 to 55 placements.

Further analyses were conducted to establish whether there were any age, gender or State differences in regards to the children's care history. No significant gender differences were noted for the age at first entry to care, the years spent in care or the number of previous placements. As can be observed in Table 2.1, the Indigenous children entered care at a significantly younger age and had spent a significantly longer period of time in care in comparison to the non-Indigenous children. The Indigenous children did not differ from the non-Indigenous children in terms of the number of previous placements or number or duration of reunification attempts.

Table 2.1 Indigenous status and care history, *M* (*SD*)

	Non-Indigenous children (*N* = 285)	Indigenous children (*N* = 65)	*t*
Age at entry to care	7.70 (4.23)	6.30 (4.02)	2.41*
Years spent in care	4.62 (3.82)	5.78 (3.45)	2.20*
Years spent in care	9.99 (6.71)	11.72 (8.50)	1.77
Number of previous reunification attempts	0.87 (1.49)	0.78 (1.47)	< 1
Duration of longest reunification (months)	9.37 (13.58)	5.47 (10.42)	1.50

*$p < 0.05$

As can be seen in Table 2.2, significant State differences were evident for the mean age which children had entered care (F (df = 3, N= 361) = 5.24, $p < 0.01$), the number of previous placements (F (df = 3, N = 358) = 8.62, $p < 0.01$), and the mean number of years spent in care (F (df = 3, N = 359) = 6.75, $p < 0.01$).

Table 2.2 State differences in children's care histories, *M* (*SD*)

	SA	QLD	WA	VIC
Age at entry to care	6.23 (4.04)	7.92 (4.06)	7.68 (3.91)	8.36 (4.44)
Number of previous placements	13.56 (10.32)	8.72 (5.83)	9.45 (4.75)	9.39 (6.74)
Years spent in care	5.42 (4.36)	3.76 (3.23)	5.96 (3.63)	4.11 (3.19)
Number of previous reunification attempts	0.52 (1.69)	0.56 (1.05)	0.98 (1.36)	1.35 (1.41)
Duration of longest reunification (months)	2.83 (5.32)	7.24 (11.12)	8.53 (11.90)	13.07 (16.15)

Inspection of Table 2.2 shows that SA sample entered care at a significantly younger age than VIC and QLD samples. The SA and WA samples had spent significantly longer time in care than the QLD and VIC samples, whereas QLD sample had significantly spent the lowest number of years in care than the SA and WA samples. Overall, SA sample had a significantly higher number of previous placements than the other three States, whereas QLD sample was observed as having

had the lowest number of previous placements.

2.1.3 Reunification attempts

The mean number of reunification attempts on average experienced by the sample was relatively low with 0.85 (*SD* = 1.46) with a range of 0 to 16 attempts. The mean duration of the children's longest reunification attempt was 8.46 months (*SD* = 12.92) with a range of 0 to 60 months. A one-way ANOVA revealed significant differences between the State samples in regards to the mean number of previous reunification attempts (F (df = 3, N = 330) = 7.06, $p < 0.01$) and the duration of the longest reunification (F (df = 3, N = 183) = 6.82, $p < 0.01$). The Western Australian and the Victorian samples had the highest number of previous reunification attempts and the South Australian sample had the lowest number (see Table 2.2). However, it should be noted that the differences that were observed may be due to the different legislation and policies operating in each of the States. No significant gender differences were noted in relation to the number of previous reunification attempts or the period of reunification.

2.1.4 Reasons for re-entry into the care system

The reasons attributed to the re-entry of 132 (36.3% of the total sample) children back into the care system included; parent(s) inability to cope with the child's behaviour (33.4%), parental problems (28.8%), abuse (24.2%), neglect (7.6%), and other reasons such as the death of a parent (6.1%).

2.1.5 Relative care and residential care

Just under half of the total sample (47.3%) was identified as previously having been placed in relative care. Further analyses were conducted to determine whether the State samples differed in regards to placement into relative care. Pearson chi-square analyses revealed significant State differences ($\chi 2$ (df = 3, N = 352) = 81.54, $p < 0.01$). It was found that placement into relative care was higher in Western Australia and Victoria. This finding is not surprising considering that previous research has noted the South Australia care system as having the lowest level of relative care placements in Australia (Layton, 2003).

Just over half of the total sample (56.5%) had previously experienced a

placement in a residential/group care. Significant State differences were observed in relation to the frequency with which children had been placed into residential care ($\chi 2$ ($df = 3$, $N = 360$) = 64.07, $p < 0.01$). Residential care was more widely utilised in Victoria and Western Australia than in South Australia and Queensland. There were no associations between gender and the frequency of relative or residential care placements or any differences between the Indigenous sample and the non-Indigenous sample.

2.1.6 Family structure

Information was collected on the mean number of siblings, and the number of siblings (under 18 years) still residing in the family home and whether siblings were currently placed in the same placement or program. The mean number of siblings under the age of 18 years was $M = 2.59$ ($SD = 2.39$) with a range of 0 to 20 siblings. The average number of siblings currently in the same placement was 0.90 ($SD = 1.47$) with a range of 0 to 9 siblings accounting for a group home placement that housed all ten children. The mean number of siblings identified as still residing at home with the biological parent(s) was 0.96 ($SD = 1.36$). A one-way ANOVA was conducted to determine whether any within or between group differences existed. No within group differences were found but significant differences were noted between the four States on the mean number of siblings under 18 (F ($df = 3$, $N = 364$) = 3.53, $p < 0.05$). The South Australian sample ($M = 3.16$, $SD = 3.27$) was found to have a significantly higher mean number of siblings under 18 than the Queensland ($M = 2.11$, $SD = 1.69$), Western Australian ($M = 2.42$, $SD = 1.84$) and Victorian ($M = 2.43$, $SD = 1.88$) samples. Significant between group difference was found between the States on the mean number of siblings in the same placement with the child (F (1, 3) = 14.44, $p < 0.01$). It was found that South Australian sample ($M = 1.30$, $SD = 2.27$) had the highest mean number of siblings in the same placement in comparison to Queensland ($M = 0.15$, $SD = 0.45$), Western Australian ($M = 0.18$, $SD = 0.45$) and Victorian ($M = 0.48$, $SD = 1.00$) samples. A significant between groups difference was also noted on the mean number of siblings still residing at home with the biological parents (F ($df = 3$, $N = 364$) = 8.15, $p < 0.01$). The Victorian sample ($M = 1.37$, $SD = 1.63$) was noted as having a higher mean number of siblings currently residing at home than the Western Australian ($M = 0.73$, $SD = 1.06$), South Australian ($M = 0.79$, $SD = 1.16$) and Queensland ($M = 0.86$, $SD = 1.38$) samples.

2.1.7 Reason for first contact with department

Information was collected concerning the circumstances that contributed to the child and families' first contact and dealings with the department and the number of notifications the department received. The reason for collecting this data was to determine whether early dealings or contact with the department were then reflected in the reason for later entry into care. For example, was the presentation or allegations of problems similar to the presentation or allegations that actually led to removal of the child from the family home? The time interval between first contact and entry to care was also examined.

The mean age of children's first contact with the group was relatively young at 3.66 (*SD* = 3.67) with a range of 0 (birth) to 15 years of age compared with a mean age of 7.48 (SD = 4.21) when the child entered care. Table 2.2 indicates that the families came to the attention of the department for a variety of serious problems, issues and needs and that there was usually a considerable delay between the time of this initial contact and when children actually entered care. A paired samples t-test revealed a significant difference between when the children first had contact with the department to when they actually first entered care (t (df = 1, N = 355) = 19.86, p < 0.001). The mean number of notifications, where it was possible to obtain this information (N = 210, 57.7%), was 5.87 (SD = 5.02) with a range of 1 to 29 notifications. As can be seen below (Table 2.3), a variety of reasons were initially noted ranging from financial problems to allegations of neglect and abuse.

Table 2.3 Primary or main reason for first dealings/contact with department, $N = 364$

	N (%)
Abuse (physical and/or emotional and/or sexual)	93 (25.6)
Neglect	81 (22.3)
Abuse and neglect	72 (19.8)
Child's very difficult behaviours (and/or sexualised behaviours)	29 (8.0)
Domestic violence	27 (7.4)
Parental mental health problems	19 (5.2)
Parental substance abuse	16 (4.4)
Financial problems and/or homelessness	11 (3.0)
Parents not coping with child	6 (1.6)
Parental intellectual disability	2 (0.5)
Parents imprisoned	1 (0.3)

Further analyses were conducted to determine if any gender or State differences existed in relation to when the children first had contact with their respective departments. No gender differences were observed. A one-way ANOVA revealed a significant State difference, (F ($df = 3$, $N = 355$) = 6.14, $p < 0.001$). Fisher's LSD post-hoc comparisons showed that the Victorian sample first had contact with their department at a significantly older age than South Australian, Queensland or Western Australian children (Table 2.4).

Table 2.4 Mean age of children at first contact with department

	M (*SD*)
South Australia	2.96 (3.31)
Queensland	3.00 (3.62)
Western Australia	3.78 (3.79)
Victoria	4.91 (3.72)

2.1.8 Reason for entry to care and social background

Information was collected concerning the children's biological family and social background that may have contributed to the child being placed into care (Table 2.5). Although it is well known that children in care suffer from various experiences and forms of abuse, there is very little information available concerning multiple forms of abuse. Much debate had also surrounded whether children who suffer from one form of abuse are more likely to suffer or be victims of other types of abuse. In the following analyses, the frequency of different forms of abuse and also the prevalence of multiple forms of abuse in Australian care system will be examined.

As indicated in Table 2.5, a high proportion of children and families had histories of domestic violence and physical abuse of children by the parents. Just under 70% of families were noted as having parental substance abuse problems and a variety of other reasons (emotional abuse, death of a parent) that resulted in the placement of the child into care. Over half of the children had entered care due to neglect, financial problems and parental mental health problems. Homelessness or inadequate housing, sexual abuse and imprisonment of parent(s) also affected approximately half of the children and families. Physical illnesses or parental intellectual disabilities were less commonly identified in the children's case files.

Table 2.5 Biological family and social background factors associated with child's placement into care for total sample, *N* =364

Biological family/social background	*N* (%)
Domestic violence	270 (74.2)
Physical abuse	267 (73.4)
Parental substance abuse	240 (65.9)
Other reasons	224 (61.6)
Neglect	212 (58.2)
Financial problems	193 (53.0)
Parental mental health problems	183 (50.3)
Homelessness/Inadequate housing	178 (48.9)
Sexual abuse	175 (48.1)
Parental imprisonment	127 (34.9)
Parental physical illness	61 (16.8)
Parental intellectual disability	48 (13.2)
Parental physical disability	34 (9.3)

The primary or main reason for the child's entry into care as identified by case-workers in the children's case-files included: neglect (33.8%); abuse (all forms, 31.3%); parents unable to cope with the child's behaviour (15.4%); other reasons (14.3%); parental mental health problems (4.1%); or parental imprisonment (0.3%).

Pearson's chi-square analyses were conducted to determine whether the non-Indigenous children differed from the Indigenous children in respect to their social and family background histories. The Indigenous children differed significantly to the non-Indigenous sample on a number of social background variables including: parental homelessness, parental imprisonment, parental substance abuse, parental mental health problems, parental homelessness, exposure to domestic violence, and victim of physical abuse (see Table 2.6 below). The Indigenous children were observed to have a significantly higher prevalence of all but two of the social background variables (physical abuse and parental mental health problems).

Table 2.6 Prevalence of family and social background factors in Indigenous and non-Indigenous children

Biological family/social background	Non-Indigenous *N* (%)	Indigenous *N* (%)	χ^2 (*df* = 2, *N* = 364)
Domestic violence	204 (71.6)	60 (92.3)	19.33**
Physical abuse	215 (75.4)	40 (61.5)	6.37*
Parental substance abuse	179 (63.0)	58 (89.2)	29.29**
Parental mental health problems	160 (56.1)	17 (26.2)	19.36**
Homelessness/Inadequate housing	127 (44.6)	48 (73.8)	22.56**
Parental imprisonment	90 (31.6)	35 (53.8)	14.27**

*$p < 0.05$, **$p < 0.01$

Further analyses were conducted to investigate whether the factors that contributed to the children's involvement with the care system were similar across the country (Table 2.7). As can be observed, the children and families in different States experienced a similar range of problems across the country.

Table 2.7 Summary of State differences of children and their social and family background, *N* (%)

	SA (*N* =113)	VIC (*N* = 99)	QLD (*N*= 80)	WA (*N* = 72)
Financial problems	69 (61.1)	60 (60.6)	32 (40.0)	32 (44.4)
Homeless	56 (49.6)	55 (55.6)	33 (41.3)	34 (47.2)
Domestic Violence	89 (78.8)	85 (85.9)	47 (58.8)	49 (68.1)
Parents imprisoned	32 (28.3)	36 (36.4)	19 (23.8)	40 (55.6)
Parental substance abuse	73 (64.6)	73 (73.7)	44 (55.0)	50 (69.4)
Sexual abuse	57 (50.4)	56 (56.6)	29 (36.3)	33 (45.8)
Physical abuse	82 (72.6)	87 (87.9)	56 (70.0)	42 (58.3)
Parental mental health problems	53 (46.9)	76 (76.8)	26 (32.5)	28 (38.9)
Parental physical illness	13 (11.5)	26 (26.3)	7 (8.8)	15 (20.8)
Parental physical disability	7 (6.2)	17 (17.2)	7 (8.8)	3 (4.2)
Parental intellectual disability	15 (13.3)	21 (21.2)	6 (7.5)	6 (8.3)
Neglect	83 (73.5)	63 (63.6)	42 (52.5)	24 (33.3)
Other	34 (31.0)	76 (76.8)	9 (11.3)	25 (38.9)

Several significant State differences were observed in relation to the children's social and family backgrounds. Pearson chi-square analyses revealed that the States significantly differed on a number of family and social background variables including: financial problems (χ^2 (df = 3, N = 364) = 12.79, $p < 0.01$), domestic violence (χ^2 (df = 3, N = 364) = 19.64, $p < 0.001$), physical abuse of children (χ^2 (df = 3, N = 364) = 19.49, $p < 0.001$), neglect of children (χ^2 (df = 3, N = 364) = 31.39, $p < 0.001$), parental imprisonment (χ^2 (df = 3, N = 364) = 20.15, $p < 0.001$), parental mental health issues (χ^2 (df = 3, N = 364) = 42.15, $p < 0.001$), parental physical illness ($\chi 2$ (df = 3, N = 364) = 13.18, $p < 0.01$) and disability (χ^2 (df = 3, N = 364) = 10.80, $p < 0.05$), parental intellectual disability (χ^2 (df = 3, N = 362) = 9.51, $p < 0.05$) and a range of additional 'other' problems and issues (χ^2 (df = 3, N = 364) = 88.37, $p < 0.001$). No significant differences were found between the male and female children for the prevalence of social and background characteristics nor were any significant differences observed between the male and female children for the prevalence of abuse and neglect.

Overall, the findings indicate that the South Australian and Victorian samples have much higher rates of abuse, Western Australian sample appears to suffer from higher rates of parental imprisonment whereas the Queensland sample appears to have a lower prevalence of most social background factors listed in Table 2.7.

2.1.9 Multiple familial and social high-support needs analysis

Table 2.8 summarises the prevalence of multiple familial and social background factors identified as contributing to the placement of the child in the care system.

Table 2.8 Prevalence of multiple familial and social background factors coinciding with placement into care

No. of factors	*N* (%)
0	8 (2.2)
1-3	126 (34.6)
4-6	176 (48.3)
7-10	54 (14.8)

As can be observed, a high proportion of children were experiencing multiple problems. For example, only 8 children were noted as not experiencing any problematic family or social background factors and close to half of the children and families were suffering from between 4 to 6 social background problems and issues.

Table 2.9 Prevalence of physical abuse, sexual abuse and neglect

Multiple forms	*N* (%)
0	36 (9.9)
1	94 (25.8)
2	142 (39.0)
3	92 (25.3)

Similar trends are evidenced in Table 2.9 that summarises the prevalence of multiple forms of abuse and neglect experienced by children. Only a small number of children were identified as having experienced no form of abuse or neglect, whereas

the majority of the sample had experienced at least one form of abuse or neglect.

Further analyses were conducted to ascertain the prevalence of a combination of abuse and/or neglect variables. It was found that a high percentage of children had experienced a combination of abuse and neglect. For example 164 (45.1%) of children had experienced both neglect and physical abuse, 143 (39.3%) children had experienced physical and sexual abuse and just under a third of the sample had been victims of both neglect and sexual abuse (N = 111, 30.5%). Just over a quarter of the children had experienced all forms of maltreatment as noted in their case-files.

2.1.10 Conclusion

The current results highlight the extent to which families and children are suffering from multiple problems. Previous research, in particular, has indicated that children who live with domestic violence face an increased risk of exposure to traumatic events, neglect, of being directly abused and the risk of losing one or both of their parents (Carlson, 2000; Edleson, 1999; Rossman, 2001). However, the prevalence of domestic violence in the families of the children in the study is of concern as is the similar prevalence of abuse and neglect. Many researchers have directed attention to the relationship between domestic violence and subsequent abuse of children. For example, McKay (1994) found that children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average. Straus and Gelles (1990) found that between 53% and 70% of males who engage in physical abuse against their wives in America also frequently abused their children. Furthermore, other research has shown that women who have been hit by their husbands were twice as likely as other women to abuse a child (Child Welfare Partnership, 1995).

The co-morbidity of domestic violence and abuse is not the only major concern, but it is the adverse consequences of children's exposure and subsequent reactions to the violence in their home. For example, younger children often do not understand the meaning of the abuse and tend to believe they have done something wrong, or are to blame. As a result, children experience feelings of guilt, depression and anxiety. Furthermore, younger children generally do not have adequate verbal skills to express their feelings so that these emotions are often interpreted as challenging behaviours.

Such children may also exhibit behaviours such as withdrawal, exhibit regressed behaviours, eating and sleeping difficulties, concentration problems, anxiety, and physical complaints. In contrast, pre-adolescent children typically have better verbal skills and are therefore more likely to externalise negative emotions. Along with the symptoms commonly seen in younger children, pre-adolescent children may show signs of low self-esteem, poor peer relationships, delinquent and oppositional behaviour and school problems. Adolescents, on the other hand, are at a greater risk of experiencing severe school problems (delinquency, poor attendance and/or drop out) and substance abuse, and these adverse consequences may continue into later life. Long-term problems include higher levels of adult depression and trauma symptoms and increased tolerance for and use of violence in adult relationships (Carlson, 2000; Edleson, 1999; Hughes, Graham-Bermann, & Gruber, 2001). The consequences of early trauma and abuse are further explored in the following section which examines the psychosocial well-being of children in the sample.

3.1 Psychosocial well-being

This section examines the physical, psychosocial and educational status of children with high support needs in Australian out-of-home care. Included in the results are a summary of overall functioning scores, comparisons with relevant Australian normative data and other studies of out-of-home care, and State comparisons. In the sections following this one, more detailed analyses are provided of the relationship between psychosocial outcomes, placement history, service history and the children's social background.

3.1.1 Health issues

3.1.2 Physical health problems

The health issues of the children in care were obtained along with their current social and psychological functioning, so that comparisons could be made with current Australian population norms wherever possible. The results showed that close to sixty percent of the sample (59.1%) were identified by their case-workers as falling into the normal health weight range. 20.3 % of the sample were noted as 'slightly to very underweight' and 18.9 % as 'slightly to very overweight'. According to the Australian Bureau of Statistics (Australian Bureau of Statistics, 2005) Australian child obesity rates are at one of the highest among developed nations with approximately 25%

considered overweight or obese. Although these observations would need to be confirmed medically and using established indicators of weight status (e.g., Body Mass Indices), the current sample nevertheless appears likely to have a similar weight distribution to rest of Australian child population.

Over half of the sample (58.2%), were identified by their case-workers as requiring some form of professional attention for physical health problems in the previous six months. A variety of health issues required attention such as: a range of 'other' health problems (56.8% including chronic disabilities and disorders); dental problems (17.6%); eye problems (6.0%); allergies (2.1%); and pregnancies (1.4%). A number of health services were also accessed during this time period due to associated health problems. As can be seen in Table 3.1, almost half of the children had received services from general practitioners. Several children had received dental services in the previous six months and other general health services and supports including assistance and treatments from STD clinics.

A number of children had received optical services and a similar number of children had received attention from a medical specialist (i.e. cardiologist, urologist etc) and/or a paediatrician due to chronic health problems, disorders or developmental irregularities. It should be noted that not all physical health problems identified by case-workers had received attention due to many case-workers indicating that children refused to engage with services.

Table 3.1 The percentage of children accessing services in previous six months

Health service	*N* (%)
General practitioner	165 (45.3)
Dentist/Orthodontist	61 (16.8)
Other general health services (including STD clinics etc)	33 (9.1)
Optometrist	22 (6.0)
Medical specialist	21 (5.8)
Paediatrician	20 (5.5)

3.1.3 Psychological health problems

During the interview, case-workers were asked to indicate whether the children had any psychological health problems that required attention in the previous six months. The vast majority of children (89.5%) were noted as having some form of diagnosed psychological health problem that required attention in the past six months. Several psychological health problems were noted by the case-workers including; a variety of non-specific or undiagnosed psychological health problems (59.6%), behavioural issues/conduct disorder (35.7%), emotional issues (17.8%), attachment disorder (17.6%), depression (14.2%), trauma (13.5%), anxiety (9.6%), sexualised behaviours (7.4%), suicidal ideation (6.3%), post-traumatic stress disorder (5.4%), and oppositional defiance disorder (3.2%).

A number of psychological health services were accessed in the previous six months due to the presentation of psychological health problems. These included private psychologist/psychiatrist/counsellor services (54.6%); 'Other' psychological health services (48.5%, i.e. non-Government treatment programs (NADA in South Australia), day programs, school-run initiatives); Child and Adolescent Mental Health Services or equivalent (38.2%); Hospital Mental Health Unit (8.7%); Services provided specifically through District Offices (6.0%, i.e. Psychological assessments, Mentors, any form of assistance); and sexual health clinic or family planning service (0.6%, i.e. Second Storey in South Australia).

It should be noted here that not all identified psychological and physical health problems received attention during that time period. Unfortunately a limitation of the data is that the percentage of children that were not receiving required services was not collected so that it is difficult to draw any firm conclusions about the undersupply of services. Nevertheless, it is still of interest to see the type and variety of services accessed by this subpopulation of children and young people. Therefore it would be of interest in future research to examine the proportion of children in care receiving and not receiving required health and psychological services.

3.1.4 High support needs and family and social background

As part of the case-file reading information was collected concerning the child's characteristics and high support needs. A high percentage of children were

identified in their case-files as exhibiting symptoms associated with conduct disorder (65.4%), depression and/or anxiety (33.8%), Attention Deficit Hyperactivity Disorder (32.4%), an intellectual disability (30.5%), a personality disorder and/or mental illness (15.7%), hyperactivity (15.4%), a physical disability (12.9%), and other high support needs such as emotional issues (7.7%).

Analyses were conducted to determine whether the Indigenous children differed on any of the abovementioned child characteristics and high support needs in comparison to the non-Indigenous sample. A significantly lower proportion of Indigenous children were found to have depression/anxiety, ADHD and personality disorder/ mental illness.

Table 3.2 Comparison of Indigenous and non-Indigenous children on prevalence of high needs as noted in children's case-files

	Non-Indigenous *N* (%)	Indigenous *N* (%)	χ^2 $df = 2$, $N = 360$
Depression/Anxiety	110 (39.0)	11 (17.2)	13.60**
ADHD	108 (38.3)	10 (15.6)	19.27***
Personality disorder/ mental illness	53 (18.8)	3 (4.7)	8.62*

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

Analyses were conducted to establish whether the children from each State were experiencing a similar frequency and level of needs. Pearson chi-square analyses revealed significant State differences on the frequency of several high support needs (see Table 3.2). These included conduct disorder (χ^2 ($df = 3$, $N = 359$) $= 97.82$, $p < 0.01$), personality disorder/mental illness (χ^2 ($df = 3$, $N = 360$) $= 12.37$, $p < 0.05$), physical disability (χ^2 ($df = 3$, $N = 360$) $= 20.36$, $p < 0.05$), and intellectual disability (χ^2 ($df = 3$, $N = 360$) $= 16.07$, $p < 0.05$).

Table 3.3 Prevalence of high support needs by State as identified in children's case-files, *N* (%)

	SA (*N* = 109)	QLD (*N* = 79)	WA (*N* = 72)	VIC (*N* = 99)
Diagnosed Conduct disorder	77 (70.6)	75 (94.9)	15 (20.8)	71 (71.7)
Personality disorder/Mental illness	7 (6.4)	17 (21.5)	11 (15.3)	22 (22.2)
Physical disability	9 (8.2)	2 (2.5)	17 (23.6)	19 (19.2)
Intellectual disability	29 (26.4)	32 (40.5)	11 (15.3)	39 (39.4)

As can be seen in Table 3.3, the Western Australian sample had the lowest percentage of conduct disorder in comparison to the other three States. The Queensland sample was noted to have the highest prevalence of conduct disorder in comparison to Western Australian, Victorian and South Australian samples. The diagnosis of a personality disorder/mental illness of a child was less likely in the South Australian sample than the other three State samples. Physical disabilities were more likely to be noted in Victorian and Western Australian samples than the South Australian and Queensland samples. The Western Australian sample had a lower proportion of intellectual disability than was noted in Queensland and Victorian samples. Furthermore, the Queensland sample was noted as having a higher proportion of intellectual disability than the South Australian sample.

3.1.5 Social and family background and child characteristics

The previous section provides extensive information of the high support needs and characteristics of the children. A considerable amount of research has argued that maltreated children fare badly later in life as a direct result of early abusive and traumatic experiences. Due to this association several of the social and family background factors were collapsed to form more general factors and then compared to child characteristics (conduct disorder, hyperactivity, depression/anxiety, ADHD, personality disorder/mental illness, physical disability and intellectual disability/developmental delay) for the purposes of the analyses below. The four general factors were: economic deprivation (financial problems and homeless or no adequate housing); parental incapacity (mental health problems, intellectual disability

and physical disability and/or illness); abusive (physical abuse, sexual abuse and neglect); and antisocial behaviours (substance abuse and domestic violence). Table 3.4 provides a summary of the frequency of occurrence of one or more variables in each of the four parental factors.

Table 3.4 Prevalence of broad social background problems

	N (%)
Economic deprivation	244 (67.0)
Parental incapacity	233 (64.0)
Abusive	328 (90.1)
Antisocial behaviours	318 (87.4)

As indicated in Table 3.4, the vast majority of children and families were experiencing, or had experienced, a multitude of problems and issues. Over two-thirds of the sample had experienced some form of economic deprivation and/or parental incapacity that contributed to their placement into the care system. Furthermore, the majority of the sample had experienced some form of abuse and/or neglect and previously resided with parents involved in some sort of antisocial behaviour.

Analyses were conducted to determine whether the Indigenous children differed on the four social background difficulties in comparison to the non-Indigenous children. A significantly higher proportion of Indigenous children ($N = 59$, 90.8%) were found to have experienced some form of economic deprivation in comparison to the non-Indigenous children ($N = 178$, 62.5%), χ^2 ($df = 2$, $N = 364$) = 21.11, $p < 0.001$. A higher proportion of Indigenous children ($N = 63$, 96.9%) were also found to have parents that were involved in antisocial behaviours in comparison to the non-Indigenous children ($N = 248$, 87.0%) that contributed to their placement into care (χ^2 ($df = 2$, $N = 364$), 23.11, $p < 0.001$). A higher proportion of the non-Indigenous ($N = 198$, 69.5%) sample was found to have experienced some form of parental incapacity that contributed to their placement into care in comparison with the Indigenous sample ($N = 28$, 43.1%), χ^2 ($df = 2$, $N = 364$) = 17.25, $p < 0.001$.

The four parental factors were compared to certain child characteristics, as listed above, to determine if any relationships existed between the variables. A significant relationship was noted between the parental economic deprivation factor and ADHD in children (χ^2 (df = 1, N = 360 = 7.72, $p < 0.05$). ADHD in children was also significantly related to parental incapacity (χ^2 (df = 1, N = 360 = 4.72, $p < 0.05$). Parental incapacity was also related to intellectual disability in children χ^2 (df = 1, N = 360 = 7.85, $p < 0.05$). The antisocial behaviour parental factor was significantly related to conduct disorder, χ^2 (df = 1, N = 360 = 7.14, $p < 0.05$). Parental abuse was not significantly related to any of the child characteristics. The findings indicate that a significant relationship exists between ADHD in children and a number of family and social background factors, but it does not identify whether this relationship is causal. The only other child characteristic that was significantly related to the parental factors was intellectual disability. Intellectual disability of a child was related to parental incapacity factor but it was also related to parental antisocial behaviours. This finding may reflect that parents of intellectually disabled children may be more likely to be prone to antisocial behaviours or that they may be more likely to suffer from an intellectual disability or mental illness that makes them more vulnerable to involvement in substance abuse and have a history of domestic violence in the home (i.e. parental antisocial behaviour factor).

Based on the above four factors, a hierarchical cluster analysis was conducted to determine whether children and families differed in their background histories and subsequent psychosocial functioning. It was hypothesised that four distant clusters or 'profiles' of children would emerge. For example: 1) children who had histories of abuse and neglect; 2) children with a history of parental incapacity; 3) children with a history of economic deprivation; and 4) children with parent(s) with antisocial behaviours. Unfortunately due to the similarity between the children and their background histories no clearly identifiable and meaningful clusters solutions could be developed.

3.1.6 Standardised measure of behavioural and emotional functioning

The following section presents findings using two standardised measures of emotional and behavioural functioning; namely Boyle et al's. CBC and Goodman's SDQ. As mentioned earlier, even though the Boyle et al. checklist and the SDQ are

similar clinical instruments, they were both included in the interview so as to allow comparisons with the findings of those of Barber and Delfabbro (2004) longitudinal study of disruptive children identified using the same selection criteria and same measures (i.e., 2 or more behaviour breakdowns due to behaviour within two years). The purpose of collecting data on the behavioural and emotional functioning of the children was to determine whether the functioning of Australian children in foster care was as severe as other studies conducted in different States (Barber & Delfabbro, 2004; Layton, 2003; Victorian Department of Human Services, June 2003). Furthermore, the findings presented provide the first national profile of emotional and behavioural functioning of Australian children and young people in care.

Table 3.5 Mean (SD) of CBC sub-scales based on previous six months compared with Barber and Delfabbro's (2004) disruptive group

	Total	*M* (*SD*) as divided by item number	Barber & Delfabbro (2004)	Barber & Delfabbro (2004)
	M (*SD*)	*M* (*SD*)	*M* (*SD*) at intake	*M* (*SD*) at 2 years
Conduct	5.32 (2.98)	0.89 (0.50)	1.04 (0.33)	0.72 (0.52)
Hyperactivity	3.81 (1.89)	1.27 (0.63)	1.41 (0.50)	1.33 (0.66)
Emotionality	5.71 (2.63)	1.15 (0.57)	1.11 (0.38)	1.07 (0.57)

Table 3.5 presents mean item scores on the CBC sub-scales based on the child's behaviour in the previous six months according to their case-worker. The table presents the total mean scores for each of the three sub-scales in addition to the mean score which is the total mean score divided by the number of items in each of the sub-scales (the method used by Barber and Delfabbro, 2004 to present the results using the same score range for individual items). The abbreviated measure used in the research (14 items) had a total possible score range of 0 to 28, the total CBC mean score for the total sample was found to be 14.78 (*SD* = 5.43), which indicates a relatively high level of problems in the total sample based on this particular standardised measure. Table 3.4 also summarises the mean scores at intake and after two years in care for the group of 'disruptive' children identified in Barber and Delfabbro's (2004) longitudinal study of children in South Australian foster care. As can be seen, if one

considers the two scores obtained for South Australian children at intake and at the two year follow-up, the total Australian sample obtained in the current study had very similar scores. These findings indicate that the national sample, selected using the same selection criteria, was well matched to the Barber and Delfabbro study in terms of general psychosocial adjustment. The importance of this comparison is that it provides an indication of the likely placement trajectory of this cross-sectional sample of children if they were to be tracked longitudinally.

Further analyses were conducted to establish whether any gender or State differences existed between or within each of the States on Boyle et al's. CBC. No significant gender differences were found and no within group differences were found on each of the three sub-scales; however, a significant between group difference (F (df = 3, N = 352) = 6.06, $p < 0.05$) was noted for the hyperactivity sub-scale. Fisher's LSD post-hoc comparison revealed a significant difference between the South Australian (M = 4.08, SD = 1.75) and Victorian samples (M = 3.38, SD = 1.93) with South Australian sample exhibiting a significantly higher level of hyperactivity problems. Apart from this, the results showed that the children drawn from different States were generally well matched on the Boyle et al. measures.

Further analysis of these findings by ethnicity showed a significant difference for the CBC emotionality sub-scale with the non-Indigenous sample (M = 5.92, SD = 2.60) scoring higher on this measure than the Indigenous sample (M = 5.11, SD = 2.71), t (df = 1, N = 336) = 2.19, $p < 0.05$. No other significant Indigenous differences were observed.

A similar series of analyses was undertaken using SDQ scores. As indicated in previous chapters, the SDQ is becoming the most widely used or "gold-standard" of psychosocial adjustment in Australia and has been included in the Federal Government's national longitudinal study of children (LSAC). A second advantage of the SDQ is that recent normative data has been published by Mellor (2005) and therefore allows comparisons of children in the current sample with children in the general Australian population. A third advantage is that normative data is available for different informants (self-report, parents and teachers). Teacher reports are probably the most similar to the case-worker reports used in the current study because of the

greater similarity of knowledge and frequency of verbal contact between children and the informant.

Table 3.6 displays the mean scores for each of the 20 items of the SDQ and the mean score for each of the four sub-scales. In accordance with the standard scoring of the SDQ, five of the positive items have been reverse scored so that a higher mean score denotes a greater level of problem on the sub-scale, consistent with the other fifteen negative items. According to Mellor (2005), 20% of Australian children aged 7 to 17 years fall into a borderline or 'query' range and 10% fall into the abnormal or 'of concern' range. Mellor provides age and gender norms for children aged 7 to 17 years in Victoria, Australia. Each of the mean scores for the four sub-scales indicate that, in comparison to a teacher-rated sample of Australian children aged 7 to 17 years (Mellor, 2005), the national sample scored consistently higher on all four sub-scales and the Total Difficulties score (all independent t-test values, $p < 0.001$). Similarly, when the national sample is compared to non-clinical parent-rated American sample of 9878, 4 to 17 year olds (National Center for Health Statistics, 2001), the national Australian sample of high supports needs children scored significantly higher on all four sub-scales. The American norms were: Conduct ($M = 1.30$, $SD = 1.60$), hyperactivity/inattention ($M = 2.80$, $SD = 2.50$); peer functioning ($M = 1.40$, $SD = 1.50$); and emotionality problems ($M = 1.60$, $SD = 1.80$) sub-scales.

Table 3.6 Mean (*SD*) of SDQ sub-scales based on previous six months compared with Australian population norms (Mellor, 2005)

Mean score (SD)	(N = 319-356) *M* (*SD*)	Australian population norms (N = 910)* *M* (*SD*)
Conduct scale	5.37 (2.42)	1.00 (1.50)
Hyperactivity scale	6.21 (2.60)	2.50 (2.60)
Emotionality scale	4.24 (2.76)	1.40 (1.70)
Peer Functioning scale	5.06 (2.49)	1.60 (1.80)
Total Difficulties Score (N = 306)	21.07 (6.88)	6.51 (6.03)

*As the only available Australian normative data was available from Mellor's study teacher reports were used as the most valid comparison values for this sample

Additional analyses were conducted to determine the percentage of children that fell into the normal, borderline and abnormal range for each of the four sub-scales of the SDQ and the SDQ Total Difficulties score. Close to three quarters of the sample (77.7%) fell into the abnormal range for the conduct problems sub-scale and the peer problems sub-scale (61.5%), whereas under half of the sample were in the abnormal range for both the hyperactivity/inattention sub-scale (45.9%) and the emotional problems sub-scale (41.5%). Overall, close to two-thirds (61.8%) of the sample fell into the abnormal range for the Total difficulties score (see Table 3.7).

Table 3.7 Distribution of sample in normal, borderline and abnormal ranges for SDQ

	N (%)
Conduct problems (N = 346)	
Normal (0-2)	44 (12.1)
Borderline (3)	19 (5.2)
Abnormal (4-10)	283 (77.7)
Hyperactivity/Inattention (N = 355)	
Normal (0-5)	141 (38.7)
Borderline (6)	48 (13.2)
Abnormal (7-10)	167 (45.9)
Emotionality problems (N = 351)	
Normal (0-3)	153 (42.0)
Borderline (4)	47 (12.9)
Abnormal (5-10)	151 (41.5)
Peer problems (N = 320)	
Normal (0-2)	60 (16.5)
Borderline (3)	35 (9.6)
Abnormal (4-10)	224 (61.5)
Total Difficulties Score (N = 306)	
Normal (0-13)	43 (11.8)
Borderline (14-16)	38 (10.4)
Abnormal (17-40)	225 (61.8)

Independent samples t-tests were conducted to ascertain whether any significant gender differences existed or any differences existed between the Indigenous and non-Indigenous children on the SDQ measure. No significant gender differences were noted on the SDQ conduct sub-scale or the peer functioning sub-scale; however, significant gender differences were noted on the hyperactivity (t (df = 1, N = 354) = -3.02, $p < 0.01$) and emotionality (t (df = 1, N = 349) = 3.69, $p < 0.01$) sub-scales. Girls (M = 5.73, SD = 2.74) were found to perform better on the hyperactivity sub-scale than boys (M = 6.56, SD = 2.44) but worse on the emotionality sub-scale (Female: M = 4.86, SD = 2.68; Male: M = 3.78, SD = 2.73). An independent samples t-test also revealed that the Indigenous sample (M = 4.05, SD = 2.31) scored significantly lower on the SDQ peer problems sub-scale in comparison to the non-Indigenous sample (M = 5.32, SD = 2.50), t (df = 1, N = 304) = 3.51, $p < 0.01$). Indigenous children (M = 19.33, SD = 8.01) also scored significantly lower on the Total Difficulties Score in comparison to the non-Indigenous sample (M = 21.69, SD = 6.57), t (df = 1, N = 291) = 2.29, $p < 0.05$. These findings suggest that the current functioning of the Indigenous sample in respect to peer functioning and overall behavioural and emotional functioning was significantly better at the time of review than the non-Indigenous sample.

A one-way ANOVA was conducted to ascertain whether any differences existed between the four States on the standardised SDQ measure. No significant differences were found within each State for all States or between the States on three of the four sub-scales (hyperactivity problems, emotional problems and peer functioning). A significant difference was found between States on the conduct disorder sub-scale, F (df = 3, N = 346) = 3.45, $p < 0.05$. Fisher's LSD post-hoc comparisons revealed a significant difference between the South Australian (M = 5.15, SD = 2.54) and Western Australian (M = 6.14, SD = 2.25) samples on the conduct disorder sub-scale with Western Australian sample exhibiting a higher level of conduct disorder problems. A significant difference was also noted between Western Australian and Victorian (M = 4.97, SD = 2.46) samples with Western Australian sample again exhibiting a higher level of conduct disorder problems and behaviours. However, no significant differences were found within or between each of the four States on the Total difficulties score which indicates that each of the States are dealing with a similar level of behavioural and emotional disturbance as tested by the SDQ.

A potential criticism of these analyses is that the age profile of the current study differs significantly from that of Mellor (2005). In Mellor's normative sample, 39% of the sample were aged 7-10 years (vs. 18% in the current sample), 24% were 11-13 (vs. 24%) and 29% were 14-17 years (vs. 49%). A question therefore arises as to how much of the difference between the two samples is due to age. Careful inspection of Mellor's results shows that this age difference was unlikely to have greatly influenced the results for two reasons. First, if one examines the mean sub-scale scores for the different ages and genders, the scores in Mellor's sample differ by only a few decimal points. For example, the mean conduct score for 7-19 year old boys is 1.49 vs. 1.30 for 14-17 year old boys. The current comparisons reveal differences of 3-4 entire points. Second, Mellor showed that the age differences for teacher report data were generally non-significant for all sub-scales except hyperactivity. Hyperactivity scores were, in fact, higher in young children, which is in the opposite direction observed in the comparison of the current sample with the normative sample. In other words, the greater proportion of older children in the current sample is unlikely to explain the sheer magnitude of differences observed.

3.1.7 Social functioning

As discussed in the background to this report, good social functioning and adjustment of children in care is imperative to protect the child against future problems later in life. Many studies have identified the far reaching consequences of poor social functioning in childhood and adolescence. For example, Buehler, Orme, Post and Patterson (2000) recently showed that **"**when compared with adults in randomly selected comparison groups, adults who experienced family foster care were less adjusted on 20 of 36 indicators, particularly in areas of education, economic well-being, marital relationships and community involvements" (Buehler et al., 2000, p. 595). Taussig (2002) also recently reported previous findings that 12-18 months after leaving foster care (due to emancipation), 27% of male and 10% of females had been incarcerated, 37% had not finished high school and 50% were unemployed.

Delfabbro, Barber and Cooper (2001) in Australia showed that the majority of children in care settle into their placements and display improved social and psychological adjustment. However, they also identified a small percentage of children who experience repeated placement failure and a deterioration of social

adjustment. Amongst this sub-group of children there was little evidence of improvement over time. The findings suggest that those individuals displaying poor social functioning also are experiencing high levels of placement disruption. Barber, Delfabbro and Cooper (2001) "suggest that early placement disruption is not merely a symptom of adjusting to new surroundings, but a predictor of ongoing problems in the care system" (p. 211).

Information was collected on the children's level of social functioning and adjustment in the previous six months. As mentioned previously, the social adjustment measures used in the current study have been used and validated in several earlier studies conducted by a collection of researchers (Barber, et al., 2001, 2002; Barber & Delfabbro, 2004; Delfabbro et al., 2000, 2001). Each item on the 7-item social adjustment scale is scored on a 4-point Likert scale that ranges from 1 = "Never", 2 = "Rarely", 3 = "Sometimes" and 4 = "Often". The total possible score range for the 7-item measure is 0 = No problems to 28 = Very high level of problems.

The table below presents the mean scores on the social adjustment measure compared to Barber and Delfabbro's 'disruptive' group of children (N = 34) in the longitudinal study. As can be seen, the current sample is quite similar to their disruptive group and shares a similarly poor level of social functioning.

Table 3.8 Mean (*SD*) of social adjustment on previous six months compared with Barber and Delfabbro's (2004) disruptive group

	Total	Total Score/ No. of items	Barber & Delfabbro (2004)	Barber & Delfabbro (2004)
	M (*SD*)	*M* (*SD*)	*M* (*SD*) at intake	*M* (*SD*) at 2 years
Social adjustment	15.48 (3.43)	2.21 (0.49)	3.11 (0.36)	2.47 (0.46)

Table 3.8 indicates that the majority of children displayed a high rate of negative or poor social functioning behaviours including often "resenting people telling them what to do" and "blaming others for their mistakes". The overall mean for this measure indicates only a modest level of social adjustment functioning for the

total sample (see Table 3.8). Table 3.8 also presents mean scores for a normative sample of children in South Australia. Barber and Delfabbro's (2004) study coded their data in the opposite direction to the current study whereby higher scores on all items indicated a better level of social adjustment. As can be observed in Table 3.8, the national sample had a lower mean score for this measure than Barber and Delfabbro's disruptive sample indicating that the disruptive sample had a better level of social functioning than the national sample.

The scoring was also reversed for these measures so that comparisons could be made with Barber and Delfabbro's (2000) data. As can be observed in Table 3.9, the national sample has significantly lower mean on all the negative social adjustment behaviours indicating poorer social functioning than Barber and Delfabbro's (2000b) normative sample involving children randomly selected from the general Australian population.

Table 3.9 Frequency and mean scores for negative social adjustment behaviours in previous six months compared with Barber & Delfabbro's (2000) normative data

Social adjustment	'Never'-'Rarely' (%)	'Sometimes' (%)	'Often' (%)	*N = 354-360* *M* (*SD*)	*N* = 374 *M* (*SD*)*	*t***
Resented being told what to do	5.0	31.0	61.5	1.44 (0.63)	2.00 (0.83)	9.82
Felt persecuted or picked on	14.3	36.3	47.8	1.70 (0.83)	2.70 (0.97)	14.08
Blamed others for his/her mistakes	16.8	31.6	50.0	1.71 (0.87)	2.80 (0.98)	15.35
Inconsiderate of other people's needs or feelings	17.8	43.4	36.5	1.85 (0.82)	2.50 (0.88)	9.85

* based upon Parent ratings on a 1-4 scale where: 1= "Often", 2= "Sometimes", 3= "Rarely", 4= "Never", ** all *t* scores significant at $p < 0.001$

The Table (3.10) below highlights the frequency of positive social adjustment behaviours present in the previous six months. In a high percentage of cases, the children were infrequently ("never to rarely") displaying positive social functioning behaviours such as: "getting along well with people", "looking forward to mixing with others" and "willing to talk and express their feelings".

Table 3.10 Frequency and mean scores for positive social adjustment behaviours in previous six months compared with Barber & Delfabbro's (2000) normative data

Social adjustment	'Never'-'Rarely' (%)	'Sometimes' (%)	'Often' (%)	*N* = 354 - 360 *M* (*SD*)	*N* = 374 *M* (*SD*)*	*t***
Getting along well with people	79.4	16.8	2.5	3.05 (0.73)	1.30 (0.52)	35.71
Looked forward to mixing with others	77.5	15.7	4.9	3.12 (0.85)	1.20 (0.49)	36.23
Willing to talk and express his/her feelings	55.0	32.4	11.5	2.60 (0.91)	1.60 (0.70)	15.87

*based upon Parent ratings on a 1-4 scale where: 1= "Often", 2= "Sometimes", 3= "Rarely", 4= "Never", **all *t* scores significant at $p < 0.001$

Again, the scoring was reversed for these measures so that comparisons could be made with Barber and Delfabbro's (2000b) data. As can be observed in the table above (3.10), the current national sample had a significantly lower level of positive social functioning when compared to the Australian normative data.

An independent samples t-test revealed no significant gender or age differences for the social adjustment measure. A significant difference was observed between the Indigenous children (M =18.44, SD = 3.74) and the non-Indigenous children (M = 19.76, SD = 3.33) with the non-Indigenous scoring significantly poorer on this measure, t (df = 1, N = 331) = 2.74, $p < 0.05$.

Further analyses were conducted to determine whether there were any significant State differences in relation to the social adjustment measure. A one-way ANOVA revealed a significant between group difference (F (df= 3, N = 354) =2.78, p < 0.05). Fisher's LSD post-hoc comparisons revealed a significant difference between the Queensland sample (M = 20.25, SD = 2.88) and Victorian samples (M = 18.89, SD = 3.44). The Queensland sample was found to have a higher level of social functioning problems compared with the Victorian sample, but did not differ significantly from the South Australian (M = 19.27, SD = 3.67) and Western Australian (M = 19.94, SD = 3.48) samples.

3.1.8 Disrupted attachment-related problem behaviours

Attachment refers to the enduring affectional ties that children form with their primary caregivers (Bowlby, 1969). Bowlby argues that the strength or "security" of these early attachment experiences lays the foundation for later psychosocial and cognitive development. More recent research has identified the link between disrupted attachment and placement instability. Drury-Hudson (1994) states that the "loss of principal attachment figures in infancy and childhood is thought to be a major influence in the genesis of later behavioural difficulties" (p. 20). Newton (2000) also suggests that there is evidence to suggest that placement disruption and behaviour problems are associated, despite variations in the conditions responsible for placement disruption. For example, researchers have demonstrated that the problems of behaviourally troubled children have been repeatedly documented in association with histories of anxious-avoidant attachment (see Penzerro & Lein, 1995). Furthermore, Penzerro and Lain (1995) state that such children "are more likely to behave aggressively toward peers, to misread environmental and interpersonal cues, and to engage in bullying and other hostile behavior" (Sroufe & Rutter, 1984, cited by Penzerro & Lein, 1995, p. 352). Penzerro and Lein recently observed disordered attachments being directly responsible for placement disruption and describe a cohort of children who "display exceptionally clear patterns of alienation in relation to transitions from placement to placement" (p.351). For these reasons, the current study aimed to collect data on the current functioning of children in respect to their attachment related problems and behaviours.

The attachment disorder checklist comprised ten positive and negative items related to attachment-related behaviours on a four-point scale ranging from 1 = "Never", 2 = "Rarely", 3 = "Sometimes", 4 = "Often". The three positive items were recoded to give a total score range of 0 = "No problems" to 40 = "Severe problems". Table 3.11 summarises the mean scores on each of the ten items for the total sample (N = 336).

Table 3.11 Attachment-related behaviour scores for total sample

	M (*SD*)
Makes very little eye contact	2.36 (1.02)
Shows little guilt or remorse for actions	3.01 (1.00)
Has been indiscriminately affectionate towards strangers	2.09 (1.16)
Deliberately provokes anger in others	2.90 (0.94)
Produces theatrical displays of emotion	2.82 (1.12)
Has produced incessant nonsense speech	1.92 (1.11)
Has been excessively demanding or bossy	3.20 (0.89)
Has been able to give and receive affection	2.12 (0.85)
Has been willing to seek comfort from others when frightened or hurt	2.19 (0.90)
Is able to trust others	2.45 (0.82)
M (*SD*)	25.07 (5.01)

The overall mean score for the attachment disorder checklist indicates a relatively high level of attachment-related problem behaviours in the total sample. The highest score was noted on the items "has been excessively demanding or bossy" and "shows little guilt or remorse for actions" which indicates that on average these behaviours are occurring frequently. Further analyses were conducted to establish whether any gender, ethnicity or State differences existed on this particular measure and no significant gender differences were found nor were within or between group differences found.

Table 3.12 Attachment-related problem behaviour scores compared to normal, borderline and abnormal SDQ Total difficulties score (higher scores indicate poorer attachment)

	Normal	Borderline	Abnormal	χ^2 ($df = 2$)
Attachment (0-24)	38	24	77	
Attachment (25-40)	5	15	147	47.11***

***p < 0.001

Further analysis was conducted to determine whether any relationships existed between clinical scores on behavioural and emotional problems (SDQ) and scores on the attachment disorder checklist (see Table 3.12). Chi-square tests revealed that those children who scored higher than 25 (out of a possible score of 40) were significantly more likely to fall into the abnormal range for SDQ Total difficulties score. This finding indicates that those children who display behaviours that are symptomatic of attachment disorder also display poor emotional and behavioural functioning. Previous research has indicated that poor attachment to their primary caregivers often occurs because of early abuse or neglect and that this early trauma then contributes to poorer emotional and behavioural functioning in later years. Furthermore, Newton (2000) states that maltreated children who are removed from dangerous or neglectful environments, who then are confronted by further disruption through numerous placement failures are likely to be particularly at risk of experiencing difficulties trusting adults and forming attachments with adults and children (Rutter, 1981).

The findings are therefore consistent with previous research showing that children with attachment-related problem behaviours also have co-morbid emotional and behavioural problems. For example, Pardeck (1983) noted that emotionally disturbed adolescents in care are most likely to have histories of placement disruption, especially those adolescents with externalising disorders (Proch & Taber, 1987). Such externalising disorders include attention deficit hyperactivity disorder, oppositional-defiant disorder, and conduct disorder (American Psychiatric Association, 1994).

3.1.9 Education

Numerous studies have confirmed that children in care perform significantly worse in school than do children in the general population (see Cashmore & Paxman, 1996). Such studies have shown that the education deficits of foster children often result in higher rates of unemployment, criminality, substance abuse and homelessness (Buehler et al., 2000). The main reason attributed to such deficits is the many placement changes and subsequent school changes experienced so commonly by foster children. Children also often have severe cognitive, emotional and behavioural problems that ultimately affect their academic functioning (Pelnick, 2000). Therefore, considering that the children selected for this study had high levels of placement instability it was important to ascertain the percentage of children in this sub-group who were attending school and to determine what sort of education-based supports or services they were receiving, if any.

A high percentage of children were attending school (69.8%) at the time of first placement into care system. At the time of review, a slightly higher percentage of children and young people were attending school or some form of TAFE/apprentice program (73.1%). The distribution of children and young people in different grade levels was reasonably consistent. Approximately a third (37.3%) of the sample were in Primary school (Reception – Grade 7) and 31.7% of the sample were in High/Secondary school (Year 8 -12) at the time of review and 4.1% of the sample were in TAFE or an apprentice program. The highest proportions of children in the study were in Grade 9 at the time of the review (14.3%). No significant differences were found between the States in respect to school attendance at time of first placements or current school attendance.

A proportion of the sample were receiving a number of school service supports including: periodic meetings between teachers and carers (54.4%); individually tailored curricula (41.4%); general education support worker at location (24.7%); a range of other services such as special day programs or specially designed educational interventions (28.0%); a private tutor at home (14.6%); and a private tutor at school (6.9%).

Table 3.13 State differences in utilisation of school support services

	SA	QLD	WA	VIC	χ^2
	N (%)	*N* (%)	*N* (%)	*N* (%)	
Periodic meetings	58 (52.7)	37 (48.7)	41 (57.7)	62 (62.6)	7.36
Tailored curricula	38 (34.5)	23 (30.3)	44 (62.0)	46 (46.5)	19.17*
Tutor (school)	9 (8.2)	4 (5.3)	5 (7.0)	7 (7.1)	4.61
Tutor (home)	11 (10.0)	11 (14.5)	10 (14.1)	21 (21.2)	5.25
Support worker	29 (26.4)	11 (14.5)	8 (11.3)	42 (42.9)	28.12*
Other services	8 (7.4)	1 (1.3)	46 (64.8)	47 (47.5)	113.75*

* $p < 0.001$

Pearson's chi-square analyses were conducted to determine whether State differences existed in the proportion of children receiving school support services. Significant State differences were observed for three school service supports namely: individually tailored curricula, general education support worker, and other general support services. As can be observed in Table 3.13, individually tailored curricula were more frequently observed in Western Australian samples than the Queensland and South Australian samples. In addition, individually tailored curricula were observed more frequently in the Victorian sample than the Queensland sample. General education support workers were more commonly noted in Victorian sample than the South Australian and Queensland samples. Furthermore, general education workers were more commonly noted in the South Australian sample than the Western Australian sample but higher in Western Australian than the Victorian sample. Other general education support services were also more frequently observed in the Western Australian and Victorian samples than the South Australian and Queensland samples.

At the time of the interview, 34% of the total sample had been suspended from school in the previous six months with a mean number of 1.13 times (*SD* = 2.80) and a range of 0 to 25 suspensions during the time period. No significant differences in the frequency of suspensions or the mean number of suspensions in the previous six months were found between the four States (see Table 3.14).

Table 3.14 Frequency of school suspensions and exclusions

	SA *N* (%)	QLD *N* (%)	WA *N* (%)	VIC *N* (%)	χ^2 (*df* = 3 *N* = 357)
Suspensions	43 (38.4)	26 (33.3)	26 (36.1)	27 (28.4)	7.11
Exclusions	11 (9.8)	6 (7.7)	7 (9.7)	21 (22.1)	12.96*

*$p < 0.05$

A smaller percentage of the sample (12.7%) had been excluded from school with a mean number of 0.49 (*SD* = 2.45) exclusions in the previous six months (range 0 to 25). A significant difference was found between the State samples in respect to the frequency of exclusions from school. An independent samples t-test revealed that the Victorian sample had a significantly higher frequency of exclusions from school in the previous six months in comparison to the Queensland sample, t (df = 1, N = 171) = 2.64, $p < 0.05$. A one-way ANOVA also revealed a significant between groups not within groups difference between the four States (F (df = 3, N = 353) = 4.23, $p <$ 0.05). Fisher's LSD post-hoc comparisons revealed that the Victorian (M = 1.23, SD = 3.81) sample had a significantly higher mean number of exclusions than the South Australian (M = 0.34, SD = 2.39), Western Australian (M = 0.21, SD = 0.84) and Queensland (M = 0.08, SD = 0.27) samples.

The results suggest that this sample of children have low levels of school attendance and high levels of suspensions and exclusions, and these features appear to be similar across the four States. As previously indicated, education is essential for good outcomes later in life including employment and as a protective measure against risk factors such as; substance abuse, homelessness and criminality. Therefore, it is essential that education is given priority within the care system so that children and young people are not placed in a position that is likely to lead to negative life outcomes.

4.1 Psychological outcomes in relationship to placement background

This section builds on the previous two sections (2 & 3) and examines the relationship between current psychological functioning and children's placement

histories. Extensive information was collected on the placement histories (including the nature, type, frequency and reasons for breakdown) of the children from both case-files, interviews with case-workers and from system data from the central databases. This section provides details on the relationship between psychological outcomes and social and placement background, including the frequency of family contact. The section aims to determine whether children who have experienced a higher level of placement instability are exhibiting poorer levels of psychological functioning.

4.1.1 Placement history

As mentioned previously, the children had experienced on average just under 11 previous placements (M = 10.53, SD = 7.80) prior to them entering their current placement or program. Analysis of placement changes revealed that 64 (17.6%) children had experienced between 2 to 4 placements since entering care, 86 (23.6%) children had experienced 5 to 7 placements, 71 (19.5%) children had experienced between 8 and 10 placements, and 110 children (30.2%) had experienced 10 to 15 placements since entering care. A smaller proportion of children had experienced very high number of placement changes: 30 children (8.2%) had experienced between 16 and 20 placements, another 19 (5.1%) children had experienced 21 to 30 placements and 10 (6.9%) children had experienced 31 to 55 placements since entering the care system. A selection of children in the total sample had also experienced placements in both residential/group care (56.6%) and relative care (47.3%) and a number of previous reunification attempts (M = 0.85, SD = 1.46).

Table 4.1 Range and frequency of placement breakdowns in previous two years (N = 359)

Number of placement breakdowns	N (%)
2 –5	252 (69.3)
6-10	80 (22.0)
11-14	17 (4.7)
15-30	8 (2.2)

Information was also collected on the number, type and reasons for placement breakdown. On average, the number of placement breakdowns experienced by the children in the previous two years was 4.95 (*SD* = 3.99) with a range 2 to 30 breakdowns during that time period. As can be seen in Table 4.1, a large proportion of children had experienced a high number of placement breakdowns or unplanned placement terminations during that time period. The majority of children (69.3%) had experienced between 2 and 5 placement breakdowns and a further 22.0% had experienced between 6 and 10 breakdowns during the previous two years. A smaller number of children had experienced between 11 and 14 breakdowns and eight children had experienced between 15 and 30 breakdowns during the same time period. The mean number of placements breakdowns identified by case-workers as being requested by carers because of the child's behaviour was 3.01 (*SD* = 3.05) with a range of 0 to 20 changes requested specifically by carers due to the child's behaviour.

Table 4.2 Age differences in frequency of placement breakdowns in the previous two years

	N	*M* (*SD*)
Younger (4- 12 years)	139	4.32 (3.05)
Older (13-18 years)	220	5.35 (4.45)

No significant gender differences or differences between the Indigenous sample and non-Indigenous sample were noted for the number of placement breakdowns in the previous two years, but a significant age difference was observed. As might be expected the older children (13 -18 years) were found to have a significantly greater number of placement breakdowns in the previous two years than the younger children (4-12 years), t (df = 1, N = 357) = 2.49, $p < 0.05$ (see Table 4.2).

Psychological outcomes in relation to placement background

Analyses were undertaken to determine whether children with more severe levels of behavioural and emotional problems (as based on SDQ scales) had higher levels of placement instability in the previous two years (see Table 4.3). Firstly one-way ANOVAs were conducted on each of the four SDQ sub-scales (Conduct disorder, Hyperactivity, Emotionality and Peer problems) and then the Total difficulties score

(sum of the four sub-scales). Significant between groups differences were found for the conduct disorder (F (df = 2, N = 342) = 3.41, $p < 0.05$) and peer problems (F (df = 2, N = 315) = 3.42, $p < 0.05$) sub-scales but not for the hyperactivity and emotionality sub-scales. Fisher's LSD post-hoc comparisons revealed that those children who fell into the abnormal range for conduct disorder sub-scale had a significantly higher number of placement breakdowns than those children that fell into the borderline clinical range (d = 0.80). Children who fell into the normal range for conduct disorder also had a higher mean number of placement breakdowns in the last two years than the borderline group of children (d = 0.52), but did not differ significantly from those in the abnormal range (d = 0.11). This finding indicates that there was not a linear relationship evident between conduct disorder and the number of placement breakdowns.

Table 4.3 Placement breakdowns according to clinical score on Conduct disorder, Peer problems and Total Difficulties Scale (SDQ), *M* (*SD*)

	Conduct disorder	Peer problems	Total difficulties score
Normal	4.69 (5.13)	3.90 (2.47)	3.74 (2.48)
Borderline	2.96 (1.55)	6.00 (4.96)	3.95 (4.68)
Abnormal	5.18 (3.99)	5.02 (4.08)	5.31 (4.10)

In relation to peer problems sub-scale, post hoc comparisons (Fisher's LSD) revealed that those children who fell into the borderline range for the scale had a significantly higher number of placement breakdowns in the last two years than those children who fell into the normal range (d = 0.56). Those children who fell into the abnormal range also had a significantly higher number of placement breakdowns than those children that fell into the normal range (d = 0.35). There was no significant differences observed between the children who fell into the borderline and abnormal group (d = 0.21).

A one-way ANOVA revealed a significant difference between the groups of children in the normal and abnormal ranges for SDQ Total difficulties score (F (df = 2, N = 302) = 4.05, $p < 0.05$), showing that children in the abnormal range had

significantly higher number of placement breakdowns than those children that fell into the normal (d = 0.48) and borderline range (d = 0.31) for this scale.

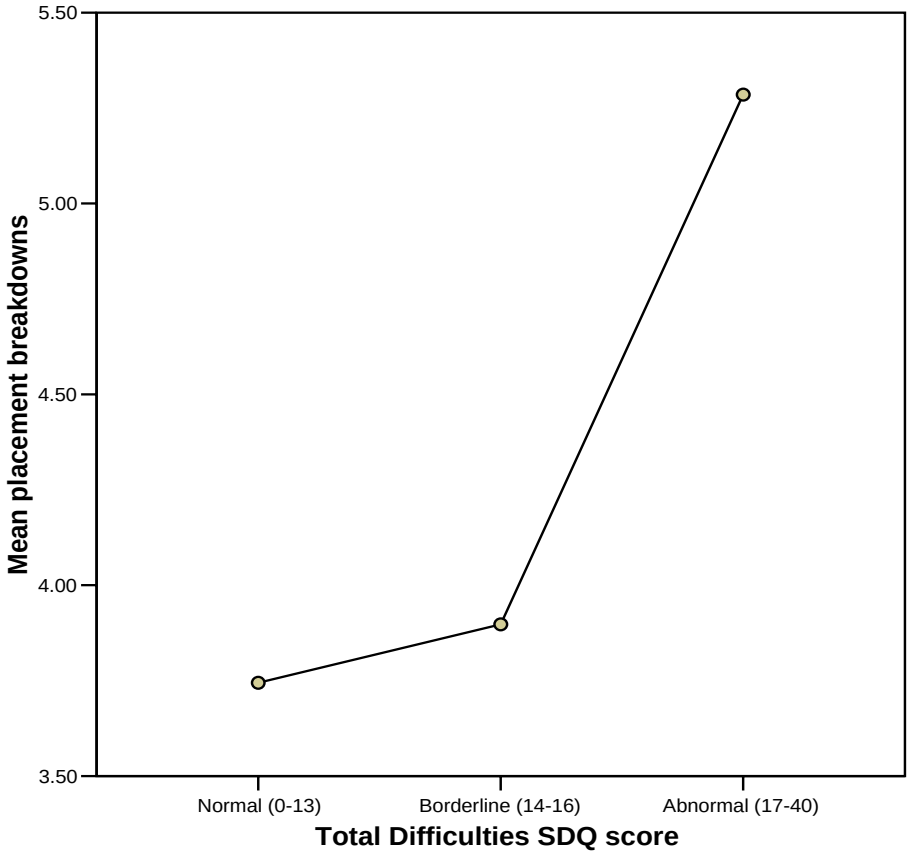

Figure 4.1 Relationship between SDQ Total difficulties score and placement breakdowns in previous two years

As can be observed in Figure 4.1, a positive curvilinear relationship is evident with respect to the Total difficulties score; those children with the poorest levels of functioning experienced the greatest number of placement breakdowns.

4.1.2 State comparisons

Analyses were conducted to determine whether State differences existed in the number of placement breakdowns. A one-way ANOVA revealed a significant difference between the four States (F (df = 3, N = 355) = 4.71, $p < 0.01$).

Table 4.4 State comparisons of placement breakdowns in previous two years

	M (*SD*)
SA	5.20 (4.68)
QLD	5.42 (3.87)
WA	5.72 (4.32)
VIC	3.70 (2.48)

Fisher's LSD post-hoc comparisons revealed that Victorian sample had a significantly lower number of placement breakdowns that the other three State samples in the last two years (see Table 4.4). The table highlights the similarity in the other three State samples in respect to the number of placement breakdowns.

The results above suggest that those children with the most severe levels of behavioural and emotional problems do indeed suffer the highest numbers of placement breakdowns. Although some inconsistencies were observed in the sense that higher rates of placement breakdown were not always associated with children in the abnormal range of scores on the SDQ, it is important to remember that this sample does not represent the full range of children in out-of-home care. Instead, the children were purposively sampled to identify those who had more disrupted placement histories. For this reason, it is likely that a clearer relationship between psychosocial dysfunction and placement disruption (of the nature observed by Barber & Delfabbro, 2004) would have been observed if the same analyses had been undertaken using a sample drawn from the general population of children in care.

5.1 Correlations between measures

Analyses were conducted to ascertain whether any correlations existed between the psychosocial adjustment measures namely; Boyle's CBC, Goodman's SDQ, Social Adjustment measure and the Attachment disorder checklist, and the number of placements and placement breakdowns the children had experienced.

No significant correlations ($r \geq 0.30$) were found between the age, gender and ethnicity of the children and any of the other variables. This finding very likely highlights the homogeneity of the sample in relation to the level and complexity of

problems in that limited range of scores may have attenuated the correlations.

As one would expect a small significant correlation was found between the number of placements the children had previously had and the number of placement breakdowns in the previous two years ($r = 0.30$, $p < 0.01$). Higher scores on the social adjustment (Socadj) measure was significantly correlated with a higher scores on a number of variables including; the attachment disorder (Att) measure, the CBC conduct (CBCC) sub-scale, the SDQ conduct (SDQC) and hyperactivity (SDQH) sub-scales. Higher scores on the attachment disorder measure was also significantly correlated with higher scores on a number of variables including the CBC conduct sub-scale, and the SDQ conduct and hyperactivity sub-scales. Higher scores on a number of CBC and SDQ sub-scales were significantly correlated with higher scores on several other variables (see Table 5.1 below).

Table 5.1 Correlation matrix for SDQ sub-scales, CBC scales, attachment checklist and social functioning scale

	Att	Socadj	SDQC	SDQH	SDQE	SDQP	CBCC	CBCH
Attachment								
Social adjustment	0.63							
SDQ Conduct	0.58	0.60						
SDQ Hyperactivity	0.36	0.34	0.36					
SDQ Emotionality	0.23	0.20	0.15	0.26				
SDQ Peer problems	0.45	0.45	0.27	0.41	0.27			
CBC Conduct	0.51	0.48	0.78	0.39	0.12	0.32		
CBC Hyperactivity	0.25	0.21	0.28	0.75	0.18	0.30	0.37	
CBC Emotionality	0.29	0.27	0.19	0.30	0.75	0.29	0.19	0.24

All correlations (two-tailed) are significant at $p < 0.01$

6.1 Family contact

Several researchers have attempted to investigate the effects of family contact in the lives of foster children. Some of the main reasons or arguments for family contact include maintaining relationships, and improving the chances of reunification.

For example, Poulin (1992) argues that family contact is essential to maintain long-term attachments between children and their families especially when they leave care and require a support network. Fanshel (1975) also argues that family contact is essential as it increases the chance of reunification. Cantos, Gries and Slis (1997) further emphasised that family contact enhances the psychological well-being of foster children by mitigating the negative psychological consequences of removal and maintaining the child's sense of continuity and identity. One of the reasons for collecting data on frequency of family contact was to determine whether any age, gender or State differences exited within or between the samples, and whether high support needs children maintain adequate connections with their families. Furthermore, family contact was considered as a social variable (i.e. as a positive sign of social functioning) and therefore it was important to examine whether those children with high levels of placement instability had low levels of contact, and whether family contact was related to general difficulties in psychosocial functioning.

In the current study, case-workers were asked to rate how often the children had been in contact with their birth parents and/or other relatives during the previous six months. Three types of contact were considered: (1) Indirect (i.e.) Telephone, (2) Direct face-to-face supervised or unsupervised contact and (3) Overnight stays. The frequency of each form of contact was measured on six-point scales: 0 = "Never", 1 = "Monthly or less often", 2 = "2-3 times per month", 3 = "Once per week", 4 = "2-6 times per week", and 5 = "Daily or more often". As can be seen in Table 6.1, the majority of children were never having telephone contact or direct (supervised, unsupervised face-to-face contact and overnight stays) contact with their mother, father or relatives. Only a quarter of the sample (24.4%) were having weekly telephone contact with their mother, whereas only 9.3% of the sample were having weekly telephone contact with their father. Approximately a fifth of the sample (18.7%) were having monthly telephone contact with their mother and 9.3% having telephone contact with their father. Approximately a fifth of the sample were having direct supervised (24.4%) and unsupervised (19.0%) contact with their mother on a monthly basis and only 9.6% of the sample were having monthly overnight stays. A smaller percentage of children were having direct supervised (9.9%) and unsupervised (13.5%) monthly contact with their fathers and only 6.9% were having monthly overnight stays. A higher percentage of children were having unsupervised direct

monthly contact (30.5%) with relatives and 11.3% of the children were having monthly (11.2%) overnight stays with relatives (such as grandparents, aunties, uncles and other siblings). A percentage of children were also having weekly telephone (11.0%) and direct unsupervised contact (11.3%) with relatives.

Table 6.1 Frequency of telephone and direct (supervised, unsupervised and overnight stays) contact with mother, father and relatives in previous six months

Contact type (%)	Never	Monthly	Weekly	Daily
Mother				
Telephone	48.9	18.7	24.4	6.6
Direct – supervised	65.1	24.4	7.9	1.4
Direct – unsupervised	60.7	19.0	13.7	5.2
Overnight stays	78.3	9.6	4.4	6.6
Father				
Telephone	77.7	9.3	9.3	2.5
Direct – supervised	86.3	9.9	2.1	0.5
Direct – unsupervised	80.2	13.5	2.7	2.5
Overnight stays	88.7	6.9	0.8	2.5
Relatives				
Telephone	64.3	18.1	11.0	5.5
Direct – supervised	76.9	6.3	2.5	0.0
Direct – unsupervised	50.5	30.5	11.3	6.6
Overnight stays	78.0	11.2	3.3	6.3

Family contact with biological mother and father and other relatives was then broken down into six variables (never, monthly or weekly telephone or direct contact, see Table 6.2) so that age, gender and State comparisons could be conducted.

Table 6.2 Telephone and direct family contact in previous six months, *N* (%)

	Never	Monthly	Weekly
Mother – telephone	178 (48.9)	68 (18.7)	113 (31.0)
Mother - direct	237 (65.1)	89 (24.5)	34 (9.3)
Father- telephone	283 (77.7)	34 (9.3)	43 (11.8)
Father - direct	314 (86.3)	36 (9.9)	10 (2.7)
Relatives-telephone	234 (64.3)	66 (18.1)	60 (16.5)
Relatives - direct	280 (76.9)	65 (17.9)	14 (3.8)

These analyses revealed no significant gender differences in the frequency of children's contact with their mothers, fathers or other relatives, but a significant age difference between younger (4-12 years) and older (13-18 years) children was observed. As can be seen in Table 6.3, older children had significantly less frequent telephone contact with their fathers and relatives than younger children ($\chi 2$ ($df = 2$, $N = 359$) = 11.17, $p < 0.01$), and they also had significantly less frequent direct contact with their mothers ($\chi 2$ ($df = 2$, $N = 360$) = 39.70, $p < 0.001$), and fathers ($\chi 2$ ($df = 2$, $N = 359$) = 11.03, $p < 0.01$),. On the other hand, older children had significantly more frequent phone ($\chi 2$ ($df = 2$, $N = 360$) = 15.69, $p < 0.001$), and direct contact ($\chi 2$ ($df = 2$, $N = 359$) = 10.41, $p < 0.05$), with their relatives (siblings, grandparents, aunts and uncles) than younger children.

Table 6.3 Age differences in family contact in previous six months, *N* (%)

	Younger			Older		
	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)
Mother phone	71 (51.1)	26 (18.7)	42 (30.2)	107 (48.6)	42 (19.1)	71 (30.2)
Mother direct	64 (46.0)	53 (38.1)	22 (15.8)	173 (78.3)	36 (16.3)	12 (5.4)
Father phone	112 (80.6)	5 (3.6)	22 (15.8)	171 (77.4)	29 (13.1)	21 (9.5)
Father direct	111 (79.9)	22 (15.8)	6 (4.3)	203 (91.9)	14 (6.3)	4 (1.8)
Relative phone	107 (77.0)	20 (14.4)	48 (21.7)	127 (57.5)	46 (20.8)	12 (8.6)
Relative direct	102 (73.4)	35 (25.2)	2 (1.4)	178 (80.9)	30 (13.6)	12 (5.5)

6.1.1 State comparisons

Analyses were conducted to determine whether State differences existed in the frequency of family contact in the previous six month period. Pearson chi-square analyses revealed significant State differences in the frequency of telephone contact with biological father ($\chi 2$ (df= 6, N = 360) = 23.91, $p < 0.01$) and with relatives ($\chi 2$ (df= 6, N = 360) = 40.15, $p < 0.001$). The results showed that children in South Australia had significantly lower levels of telephone contact with biological fathers and relatives than the other three States. However, no other significant differences were observed suggesting that the low levels of family contact described above for the sample as a whole was generally consistent across all the States.

6.1.2 Family contact and social background history

Analyses were conducted to examine the relationship between frequency of contact and family and social background variables (i.e. abuse, neglect, parental mental health problems, imprisonment etc.). Several significant relationships were

observed between frequency of contact with both mothers and fathers and certain social background variables (see Table 6.4). Specifically, a relationship was observed between children's telephone contact with mothers and parental mental health problems. A greater proportion of children were having weekly telephone contact if their mothers did have mental health problems. A greater proportion of children were having weekly direct supervised contact with their mother if she did have a physical disability or intellectual disability.

Table 6.4 Significant variations in direct supervised contact with mother in relation to social background

	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)	χ^2 *df* = 2
Telephone				
Mental health problems	76 (42.0)	37 (20.4)	68 (37.6)	8.94*
No mental health problems	102 (57.3)	31 (17.4)	45 (25.3)	
Direct supervised				
Physical disability	19 (59.4)	6 (18.8)	7 (21.9)	6.48*
No physical disability	218 (66.5)	83 (25.3)	27 (8.2)	
Intellectual disability	27 (56.3)	11 (22.9)	10 (20.8)	8.33*
No intellectual disability	208 (67.1)	78 (25.2)	24 (7.7)	

*$p < 0.05$, N =358-359

There were also relationships observed between the likelihood of contact with fathers and several social background variables. As indicated in Table 6.5, a greater proportion of children were having monthly telephone contact with their fathers if their fathers had not been imprisoned or who had no history of sexual abuse of child. A greater proportion of children were having weekly direct unsupervised contact or overnight stays with their father if they did not have a parent who had been or was currently imprisoned. A greater proportion of children were observed to be having

weekly direct contact with their father if they had a parent with mental health problems.

Table 6.5 Significant variations in telephone and direct unsupervised contact with fathers in relation to social background

	Never *N* (%)	Monthly *N* (%)	Weekly *N* (%)	χ^2 *df* = 2
Telephone				
Past or present imprisonment	108 (85.7)	5 (4.0)	13 (10.3)	7.83*
No imprisonment	175 (74.8)	29 (12.4)	30 (12.8)	
Sexual abuse history of child in care	146 (83.4)	10 (5.7)	19 (10.9)	6.36*
No history of sexual abuse	137 (74.1)	24 (13.0)	24 (13.0)	
Unsupervised/ overnight stays				
Past or present imprisonment	113 (89.7)	10 (7.9)	3 (2.4)	13.60**
No imprisonment	171 (73.1)	45 (19.2)	18 (7.7)	
Parental mental health problems	136 (74.7)	30 (16.5)	16 (8.8)	6.68*
No mental health problems	148 (83.1)	25 (14.0)	5 (2.8)	

*$p < 0.05$, **$p < 0.01$, N =360.

These findings highlight possibly the contextual and pragmatic reasons that may affect the frequency of certain kinds of contact. For example parental imprisonment may make it more difficult to organise ongoing contact between the children and their parents. However it appears for those children whose parents suffer from a mental illness or a physical or intellectual disability, a greater proportion of the children were having more frequent telephone and direct contact than those children who parents did not have a mental illness or disability. This finding is similar to that reported by Barber & Delfabbro (2004) who identified that children who enter care for reasons related to parental incapacity are more likely to have ongoing contact than those who enter due to protective reasons such as abuse.

6.1.2 Family contact and placement instability

An analysis was undertaken to determine whether children with greater placement disruption were more likely to have lost contact with their parents. The results revealed no significant differences between the frequency and type of family contact and mean number of previous placements during their time in care or the mean number of placement breakdowns in the previous two years.

6.1.3 Family contact and psychosocial functioning

Following the findings of Barber and Delfabbro (2004), it was also hypothesised that children with the highest level of emotional and behavioural problems, as based on clinical scores from SDQ, would also have the lowest level of contact with family members (see Table 6.6).

Table 6.6 Frequency of contact with biological mother and SDQ scores, *M* (*SD*)

	Telephone			Direct supervised			Direct and overnight stays		
	Never	Monthly	Weekly	Never	Monthly	Weekly	Never	Monthly	Weekly
SDQ cond.	5.38 (2.46)	5.29 (2.37)	5.40 (2.33)	5.45 (2.47)	5.26 (2.44)	5.12 (1.76)	5.33 (2.38)	5.35 (2.38)	5.58 (2.43)
SDQ hyper.	6.02 (2.59)	6.66 (2.55)	6.27 (2.62)	6.15 (2.62)	6.35 (2.72)	6.41 (2.09)	6.08 (2.68)	6. 79 (2.14)	6.11 (2.68)
SDQ emot.	4.18 (2.79)	4.78 (2.86)	4.20 (2.68)	4.11 (2.71)	4.13 (2.92)	5.53 (2.49)	4.38 (2.76)	4.00 (2.67)	4.12 (2.89)
SDQ peer	4.93 (2.48)	4.86 (2.40)	5.39 (2.56)	4.83 (2.37)	5.23 (2.68)	6.36 (2.53)	5.15 (2.57)	4.82 (2.56)	5.06 (2.27)
Total diff. score	20.61 (7.38)	21.15 (6.43)	21.79 (6.31)	20.73 (6.95)	20.87 (6.96)	24.38 (5.47)	20.98 (7.20)	21.12 (6.18)	21.47 (6.65)

One-way ANOVAs were conducted to examine whether SDQ scores and the Total Difficulties SDQ score differed according to the frequency of contact (telephone, direct supervised, unsupervised direct and overnight stays) with their biological mothers. A significant difference was observed for emotional problems sub-scale and direct supervised contact with the mother, F (df = 2, N = 346) = 3.86, p < 0.05. Fisher's LSD post-hoc comparisons revealed that those children that were having weekly direct supervised contact with their mothers had a significantly higher score on the emotional problems sub-scale than those children who were having monthly direct supervised (d = 0.52) or no direct supervised contact (d = 0.55). A significant between groups difference was also observed for the peer problems sub-scale and direct supervised contact with the mother, F (df = 2, N = 315) = 5.02, p < 0.05. Fisher's LSD post-hoc comparisons revealed that those children who were having the most frequent level of direct supervised contact with their mothers also had a significantly higher score on the SDQ peer problems than those children who were only having less frequent (d = 0.43) or no direct supervised contact (d = 0.62). No significant differences were noted for the SDQ sub-scales and the other types of contact with the mother. However a significant difference was noted for the Total difficulties score and direct supervised contact with mothers, F (df = 2, N = 302) = 3.34, p < 0.05. Fisher's LSD post-hoc comparisons revealed that those children with the most frequent levels of contact (weekly) also had the highest score on the SDQ in comparison to those children having monthly direct supervised contact (d = 0.56) or no direct supervised contact (d = 0.59). As can be observed in Figure 6.1, a positive relationship was evident between the frequency of direct supervised contact with biological mother and the SDQ Total difficulties score. No significant differences in the children's behavioural and emotional functioning and the frequency of contact with biological fathers were observed.

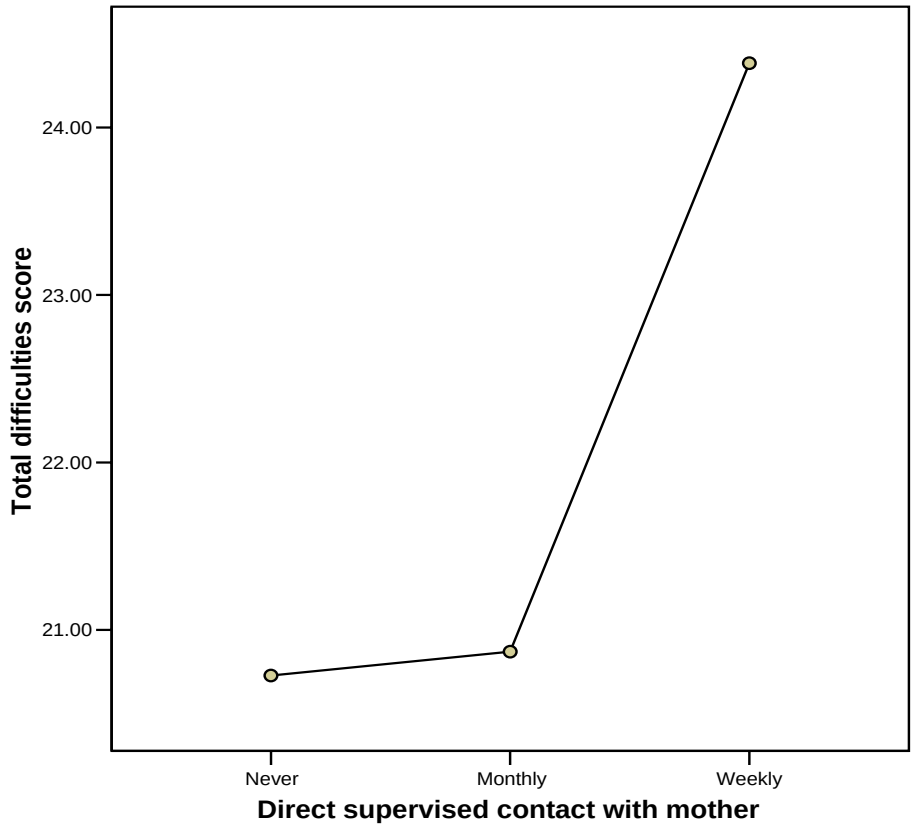

Figure 6.1 Relationship between direct supervised contact with mother and SDQ Total difficulties score

The findings differ from those reported by Barber and Delfabbro (2004). It appears that those children with the highest level of direct supervised contact with their mothers also have the highest emotional symptoms and peer problems scores and the overall Total difficulties score for the SDQ. It is hard to determine whether this is a causal relationship in that the high frequency of contact is affecting their behavioural and emotional functioning. The fact that the only relationship that was evident for direct supervised contact with mothers is also interesting as no other relationships were found between the frequency of other types of contact (telephone or direct unsupervised contact and/or overnight stays) and the SDQ sub-scales. This may be related to the fact that those children who need to have supervised contact with their mothers are systematically different from those children who do not need to have supervised contact (i.e the reasons for entry to care) or it may be that supervised contact is a very stressful event in the lives of the children and this may impact on their behavioural and emotional functioning. This finding therefore warrants further investigation.

Nevertheless, the main findings from these analyses demonstrate that this majority of this sub-population of children in care have very low levels of family contact. These results are concerning in that previous research (Cashmore & Paxman, 1996; Delfabbro et al., 2002; Fanshel, 1975) has demonstrated the importance of family contact for children, especially in their adult lives. The current findings differ substantially from the results observed in Barber and Delfabbro's (2004) study in South Australian foster care which found that the vast majority of children in general in out-of-home care in their study were having relatively frequent contact with their families. However, these findings contrast with previous research that showed that better adjusted children and families are more likely to remain in contact (Cantos et al., 1997; Delfabbro et al., 2002). They show that this relationship may vary according to the type of contact: supervised versus unsupervised.

6.1.4 Conclusion

Several researchers have attempted to identify the factors that increase a child's risk of experiencing placement instability. The current study findings are in line with previous research (Pardeck, 1984; Pardeck et al., 1985) that demonstrated increased age and the presence and severity of behavioural and emotional problems are significantly related to higher rates of placement instability. Palmer's (1996) research identified some evidence that boys may be at greater risk for instability than girls, although she suggests that this may only be because boys are typically more likely to experience the sorts of behavioural problems that are the cause of placement instability.

Delfabbro, Barber and Cooper (2000) argued that child factors may play a role in placement disruption. They found that gender, location and placement history were important predictors of disruption. In respect to placement history, they found that if children had a history of previous multiple placement changes (6 or more), they were 3.38 times at greater risk of experiencing disruption. Considering that on average the children had been in care for just under five years and had experienced close to 11 placement changes during their time it is not surprising that placement disruption is so extreme in this sample of children. The results of the current study support their previous findings that suggest that problems increase as children grow older and the longer they remain in care.

Research has also been conducted on the social-interaction factors that may influence placements and result in disruption. For example Stone and Stone (1983), found several factors that were related to placement disruption and these included; poor parent-child relationship, child's inability to form positive attachments to caregivers, or prior experience of living in chronically abusive or neglectful homes. The vast majority of the sample were noted to have attachment difficulties and had experienced living in chronically abusive and neglectful homes prior to entering care. Therefore, it is highly likely these factors may have contributed to ongoing behavioural and emotional problems and made it more difficult for children to form stable attachments with new caregivers.

7.1 Case studies

The following four case studies provide an overview of the multiple problems of each child and family involved with community service departments across Australia. The purpose of providing the case studies is to give the reader an opportunity to understand the individual histories of the child and families and to comprehend the level of difficulties and multiple problems that the departments are faced with on a daily basis.

Case study 1: Male 14 years

This particular boy entered care at age 11 years after a history of allegations of physical, sexual emotional abuse and ongoing neglect concerns. The reason for entry was the child's self-harming behaviours and the parents requesting the child be removed from their home. Since his time in care he has experienced 16 foster placements including several residential care placements. His parents have a history of mental health issues and substance abuse and intellectual disability. The child's father was previously his primary caregiver until four years ago when he passed away. The boy subsequently lived with his mother and step-father where he suffered physical and emotional abuse and severe neglect. The boy suffers from mental health issues, a physical disability (hydrocephalus), a moderate intellectual disability, difficult behaviours and poor peer functioning, poor social functioning and poor attachment to others. He is very underweight and has poor physical coordination. The boy also has a history of severe school problems and he is currently attending a specialist school. In the last two years he has experienced eight placement breakdowns.

Case study 2: female 16 years

This teenage girl entered care at the age of 11 years after first notifications to the department of allegations of physical and severe sexual abuse were substantiated. During her time in care she has had four foster placements including an unsuccessful relative placement. Her family has a history of domestic violence, intellectual disability, imprisonment, and sexual and physical abuse. The girl has been diagnosed with conduct disorder and also exhibits sexualised behaviours. She is aggressive to others, frequently runs away and is involved in self-harming behaviours. She also displays poor social functioning and poor attachment to others. She is currently attending a specialist school. In the previous two years she has experienced two placement breakdowns.

Case study 3: Male 11 years

This young boy entered care just over twelve months ago. The first notification to the department was related to his mother's inability to cope or deal with the child's difficult behaviours. The family has a history of domestic violence and mental health issues, physical illness and intellectual disability. There is also a family history of substance abuse, financial problems, and imprisonment. The child eventually entered care due to emotional abuse, medical neglect and the child being at risk of physical harm in the home. The boy has experienced four foster placements, including a residential placement since entering care. The boy displays disruptive and aggressive behaviour and sexualised behaviours. He also has poor social functioning and very poor attachment to others. He has been diagnosed with ADHD and is having great difficulties at school. In the last twelve months he had experienced three placement breakdowns.

Case study 4: Female 7 years

This young girl entered care at age one. The first notifications to the department included concerns about domestic violence, mental health problems of the parents, severe neglect and emotional, physical abuse of the child. The mother has an acquired brain injury as a result of domestic violence and was having difficulty managing seven children at home. During her time in care the young girl has experienced 11 foster placements including two reunifications, five residential placements and one relative placement. The young girl suffers from an intellectual

disability and developmental delay and displays aggressive and sexualised behaviours in her current placement. She is having difficulty at school and exhibits poor social functioning and poor ability to attach to others. In the previous two years she has experienced four placement breakdowns.

8.1 Service history

An important feature of the current study that extended previous Australian research in the area of child welfare, was the collection of data on the early and ongoing service response for children and their families. The main purpose for collecting this information was to help identify when and what type of services that were provided to families and children and to help identify service responses that may have been important. This information may help inform the appropriate use of early intervention services for families and children with multiple needs and possibly prevent the traumatic journeys experienced by this sub-population of children and their families.

8.1.1 Early and ongoing service responses for children and their families

Extensive information was collected on the specific therapies or interventions the children and/or the biological families had received before or since they came into contact with the department. As illustrated in Table 8.1 a higher proportion of children were receiving or had previously received services than the biological parents. However, it should be noted that children's case-files did not always contain complete information about the services for biological parents, so that these findings need to be treated with caution.

Table 8.1 Frequency of services accessed by children and/or biological parents before or after entering care system

Services	Children *N* (%)	Biological parent(s) *N* (%)
Assertion training	10 (2.7)	6 (1.6)
Self-esteem building	104 (28.6)	23 (6.3)
Psychiatrist	128 (35.2)	76 (20.9)
Psychologist	279 (76.6)	107 (29.4)
Treatment for specific mental health issues	67 (18.4)	53 (14.6)
Anger management	125 (34.3)	57 (15.7)
Social skills training	116 (31.9)	24 (6.6)
Dealing with grief and loss	135 (37.1)	29 (8.0)
Behaviour management	203 (55.8)	89 (24.5)
Employment training/apprenticeship	61 (16.8)	6 (1.6)
Independent living/Short periods away from home	70 (19.2)	8 (2.2)
Substance abuse treatment	35 (9.6)	78 (21.4)
Safe sex practices	69 (19.0)	n/a
Family mediation	80 (22.0)	71 (19.5)
Family support worker visits	n/a	150 (41.2)
Mentor	141 (38.7)	n/a
Other services	247 (67.9)	265 (72.8)

Table 8.1 above highlights the range and diversity of services and interventions offered to the children and families prior to entering care and during their time in care. Services from a psychologist were the most frequently accessed intervention by both children and their families, but this may not indicate treatment but rather just assessment of the individuals. This finding is also not surprising as psychological assessment is mandated as part of a child's case plan in some Australian States such as South Australia.

The services and interventions listed above were collapsed into six general services for children and families.

The six services for children and the frequency of provision were:

1) Child psychological services (*N* = 317, 87.1% = psychologist, psychiatrist, treatment for mental health issues, and/or grief and loss counselling);

2) Child personal and social services (*N* = 231, 63.5% = assertion training, self-esteem building, social skills training, anger management, substance abuse treatment and/or safe sex practices training);

3) Child behaviour management (*N* = 203, 55.8% = any type of behavioural management intervention);

4) child vocational support and guidance (*N* = 185, 50.8% = employment training/apprenticeships, independent living services, and/or mentor services);

5) Child and family services (*N* = 80, 22.0% = family mediation services); and

6) any other services or interventions (*N* = 158, 43.4%).

The six general services for families and the frequency of provision were:

1) family psychological services (*N* = 182, 50.0% = psychologist, psychiatrist, treatment for mental health issues, and/or grief and loss counselling);

2) Family personal and social services (*N* = 89, 24.5% = assertion training, self-esteem building, social skills training, anger management and/or substance abuse treatment);

3) family behavioural management (*N* = 89, 24.5% = any type of behavioural management training for parents);

4) family vocational support and guidance (*N* = 13, 3.6% = employment training/apprenticeships and/or independent living services);

5) Child and family services (*N* = 179, 49.2% = family mediation services and/or family support workers visits); and

6) any other services or interventions (*N* = 176, 48.4%).

Analyses were conducted to determine which children and families were most likely to receive services according to age, gender, level of psychological adjustment and which State the child resided. Several significant differences were found between the age of the children and the services they received. The children were divided into 2 groups; younger children (4 -12 years, *N* = 223, 61.3%) and older children (13-18 years, *N* = 141, 38.7%). A significantly higher proportion of the older children had

received services and interventions than the younger children including: child psychological services, child personal and social services, child vocational support and guidance, and child and family services. Interestingly, no significant differences were noted between the younger and older children on the provision of behavioural management intervention services (see Table 8.2).

Two significant gender differences were noted. First, boys were found to have received more behaviour management intervention services than girls and boys were also noted as receiving more child vocational support and guidance services than girls. This finding may highlight the gender difference in presentation of problems as males generally present with more externalising behavioural problems whereas females problems often tend to be more internalised (Barber & Delfabbro, 2004). The provision of more child vocational support and guidance to the males may indicate that the services (i.e. independent living services and employment training/ apprenticeships) were either more available for the male children or possibly considered more suitable for males because of behavioural problems that had made them less suitable for conventional schooling.

Table 8.2 Age and gender differences in service provision for children

	Age			Gender		
	Younger *N* (%)	Older *N* (%)	$\chi 2$ (*df* = 1)	Male *N* (%)	Female *N* (%)	$\chi 2$ (*df* = 1)
Child psychological services	117 (83.0)	200 (89.7)	3.46*	186 (87.7)	131 (86.2)	< 1
Child personal and social services	69 (48.9)	162 (72.6)	20.94***	135 (63.7)	96 (63.2)	< 1
Child behaviour management services	78 (55.3)	125 (56.1)	< 1	136 (64.2)	67 (44.1)	14.46***
Child vocational guidance and support services	33 (23.4)	152 (68.2)	69.24***	117 (55.2)	68 (44.7)	3.87*
Child and family services	22 (15.6)	58 (26.0)	5.46*	47 (22.2)	33 (21.7)	< 1
Child 'other' services	55 (39.0)	103 (46.2)	1.81	93 (43.9)	65 (42.8)	< 1

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$, *N* range = 306-364.

Several State differences were noted in the provision of certain services and interventions to the children. Child psychological services were found to be provided more frequently to South Australian children than those in Queensland, whereas child behavioural management services were more frequently provided to children in Victoria than in Queensland. A similar trend was observed for child and family services. The provision of a variety of 'other' services was more likely to be observed in the Victorian sample than the Western Australian sample. Child personal and social services was noted to be less frequently provided to the Western Australian sample than all the other States and child vocational guidance and support services were noted to be less commonly provided to the Queensland sample in comparison to children in the other States (see Table 8.3).

Table 8.3 State differences in service provision for families and children

	SA	VIC	WA	QLD	$\chi 2$
	N (%)	*N* (%)	*N* (%)	*N* (%)	(*df* = 3)
Child psychological services	103 (91.2)	94 (94.9)	58 (80.6)	62 (77.5)	16.37**
Child personal and social services	75 (66.4)	73 (73.7)	4 (47.2)	49 (61.3)	13.28**
Child behaviour management services	58 (51.3)	79 (79.8)	26 (36.1)	40 (50.0)	36.44***
Child vocational guidance and support services	57 (50.4)	54 (54.5)	49 (68.1)	25 (31.3)	21.37***
Child and family services	17 (15.0)	44 (44.4)	2 (2.8)	17 (21.3)	47.81***
Child 'other' services	31 (27.4)	90 (90.9)	16 (22.2)	21 (26.3)	125.41***
Family psychological services	56 (49.6)	74 (74.7)	30 (41.7)	22 (27.5)	42.46***
Family personal and social services	17 (15.0)	37 (37.4)	16 (22.2)	19 (23.8)	14.58**
Family behaviour management services	14 (12.4)	47 (47.5)	3 (4.2)	25 (31.3)	55.35***
Family vocational guidance and support services	1 (0.9)	9 (9.1)	2 (2.8)	1 (1.3)	12.51*
Family and child services	54 (47.8)	80 (80.8)	11 (15.3)	34 (42.5)	74.25***
Family 'other' services	55 (48.7)	80 (80.8)	29 (40.3)	12 (15.0)	79.28***

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$, *N* range = 306 – 364.

Several States differences were also noted in the provision of certain services and interventions to the families (see Table 8.4). The Victorian sample was found to have received the highest proportion of services than all of the other three States; however this finding may be reflective of the more detailed data available that was collected in Victoria. Family psychological services were more commonly provided to the Victorian than the Queensland sample. Family personal and social services, family behaviour management training, family vocational support and guidance, family and child services and other services were more frequently noted as having been provided to the Victorian sample than those in the other three States. These State differences in child and family service provision may reflect differences in demand and availability of services in the different States or differences in the quality of source records monitored by the different Departments.

Table 8.4 Differences in service provision for children based on clinical scores for Conduct disorder sub-scale for SDQ

	Normal	Borderline	Abnormal	$\chi 2$ ($df = 2$)
Child psychological services	35 (83.3)	23 (95.8)	246 (87.9)	2.24
Child personal and social services	19 (45.2)	11 (45.8)	191 (68.2)	11.99*
Child behaviour management services	16 (38.1)	13 (54.2)	165 (58.9)	6.47*
Child vocational guidance and support services	13 (31.0)	7 (29.2)	157 (56.1)	14.21**
Child and family services	6 (14.3)	4 (16.7)	66 (23.6)	2.26
Child 'other' services	14 (33.3)	11 (45.8)	124 (44.3)	1.87

*$p < 0.05$, **$p < 0.01$, $N = 346$

Analyses were conducted to determine if any differences existed in the provision of services to children depending on their level of functioning on the SDQ. The six child services and interventions were compared to the level of child functioning on the four sub-scales of SDQ (Conduct problems, Hyperactivity/ Inattention, Emotionality and Peer problems) and the Total Difficulties score. The three levels of functioning were based on the clinical levels of functioning on the SDQ (i.e. normal, borderline and abnormal ranges of functioning, see Table 8.5). A significant difference was found in the service provision for children who fell into the

abnormal range for Conduct problems for child personal and social services, child behaviour management intervention services and child vocational support and guidance. Surprisingly, no significant differences were observed in relation to the provision of psychological services based on the child's level of conduct problems. However, there was some evidence for appropriate matching of services. Children who fell into the abnormal range for conduct problems were more likely to receive behaviour management intervention services, whereas children with emotionality problems (depression and anxiety) in the abnormal range had received significantly more child psychological services ($\chi 2$ ($df = 2$, $N = 351$) = 9.81, $p < 0.05$).

Table 8.5 Differences in service provision for children based on clinical scores for Peer Functioning sub-scale for SDQ, *N* (%)

	Normal	Borderline	Abnormal	$\chi 2$ ($df = 2$)
Child psychological services	54 (90.0)	26 (74.3)	205 (91.5)	9.47*
Child personal and social services	39 (65.0)	22 (62.9)	147 (65.5)	< 1
Child behaviour management services	31 (51.7)	14 (14.0)	140 (62.5)	7.51*
Child vocational guidance and support services	36 (60.0)	21 (60.0)	109 (48.7)	3.44
Child and family services	18 (30.0)	2 (5.7)	57 (25.4)	7.82*
Child 'other' services	26 (43.3)	12 (34.3)	99 (44.2)	1.22

*$p < 0.05$, $N = 319$

No significant differences in service provision were noted for those children that fell into the different ranges on the hyperactivity/inattention sub-scale of the SDQ. However, significant differences were noted in the provision of child psychological services for children who fell into the abnormal range for peer problems ($\chi 2$ ($df = 2$, $N = 319$) = 9.47, $p < 0.05$), child behaviour management intervention services ($\chi 2$ ($df = 2$, $N = 319$) = 7.51, $p < 0.05$) and child and family services ($\chi 2$ ($df = 2$, $N = 319$) = 7.82, $p < 0.05$).

There were two significant differences in service provision for those children that fell into the abnormal range for Total Difficulties Score. These children were

significantly more likely to receive psychological services ($\chi 2$ ($df = 2$, $N = 306$) = 6.67, $p < 0.05$) and also more likely to receive personal and social services ($\chi 2$ ($df = 2$, $N = 306$) = 6.06, $p < 0.05$) than those children that fell into the normal and borderline range for the SDQ. These findings are encouraging as it appears that those children that fell into the abnormal clinical range for psychological functioning as measured by the SDQ were the most likely to receive services and interventions.

8.1.1 Summary and conclusions

The results of this national study show that children within this population are usually around 12 to 13 years of age and have typically experienced ten or more previous placements in their lifetime, with many having experienced over 20 and 30. Most first came into contact with the Departments at around the age of three, but usually did not finally enter care until four years later. On average, these children had been in the care system for five years, but there had been few attempts to reunify them with their families. Compared with the Australian out-of-home population in general (AIHW, 2005), this group contained an over-representation of boys (60% vs. 50%), and an under-representation of Indigenous children (17% vs. 24% in the general out-of-home care population), suggesting that non-Indigenous boys are the group in Australia most likely to be at risk of significant ongoing placement disruption. Almost all of the children had been subjected to traumatic, abusive, and highly unstable family backgrounds. In every State, domestic violence, physical abuse and substance abuse were the three most prevalent problems, with parental mental health problems and neglect also observed in at least half of the sample. Over half of the sample had experienced four or more family background problems and this included 15% of the sample who had experienced very close to all of the problems identified. Specific analysis of children who had been subjected to abuse showed that one third of children had been exposed to every type of abuse: physical, sexual and neglect.

Further comparative State analyses showed that there were some subtle differences in the profiles of children in each of the different States.

- South Australian children with high levels of placement instability were more likely to be female than in other States; had the highest levels of placement instability; tended to enter care somewhat earlier; were more likely to be

subject to neglect; and had low rates of reunification success.

- Victorian children were less likely to be Indigenous; were generally more likely to be male; came into care somewhat later; had greater reunification success; were more likely to have parents with mental health issues; and had been subjected to particularly high levels of domestic violence and physical abuse.

- Western Australian children were more likely to be Indigenous. Compared with South Australian and Victorian children, they were less likely to be neglected, to have experienced physical abuse or to have parents with mental health problems; however, their parents were more likely to be imprisoned.

- In Queensland, there was a greater likelihood of attempts to reunify children with their birth families and children tended to come into care older than in South Australia or Victoria. Compared with the other States, Queensland children were generally less likely to have experienced domestic violence, physical or sexual abuse; to have parents who were imprisoned, or to have parents with mental health problems.

Without further more extensive investigation, it is difficult to determine whether these differences reflect broader social and economic differences between the States, differences in the implementation of child protection policy, the availability of placement opportunities, diversity in practice, or in the nature of the records maintained by the respective Departments. For example, the particularly high level of placement instability in South Australia may only reflect a greater use of short-term emergency placements to assist in the planning for longer term placements. Barber and Delfabbro (2004), for example, found using longitudinal tracking that most placement changes in South Australia were intended, rather than due to genuine breakdowns in the placement. Alternatively, this finding may reflect the relatively low availability of non-family-based forms of care in South Australia, and the greater reliance on family foster care, a placement option that may be particularly unsuitable for this population of children and young people. Similarly, the greater proportion of

parents imprisoned in Western Australia may reflect the greater proportion of Indigenous children, whose parents may have a greater likelihood of being highly represented in the correctional system (Aboriginal Affairs Department, 1995).

Nevertheless, despite these differences between the States, the results show that the young people in the sample were generally very similar in their characteristics, suggesting that it is possible to adopt a national perspective when discussing policies and services suitable to meet the needs of this population. Another important finding in this research is the fact that this population of children do not appear to fall into neat sub-groups or clusters as might be expected based on the range of different background variables. Instead, children within this population appear to form one single cluster based upon very common family experiences; namely, the combined effects of domestic violence, substance abuse and physical violence and neglect. Such findings suggest very strongly that out-of-home care policy cannot, and should not, be considered in isolation from other important areas of social policy and public health. Any policies which are successful in reducing levels of substance abuse, domestic violence and the problems of adult mental health are likely to have significant impacts upon the out-of-home care system. Although much of the research in this field, including this report, has emphasised the ongoing psychological harm resulting from unsuccessful placement experiences, it is also almost certainly true that many of the children displaying significant emotional and behavioural difficulties when they are older had already suffered significant, possibly irreparable physical and psychological harm during their early years and before they were born (e.g., via the effects of substance abuse, poor parental nutrition and stress on foetal development).

As emphasised previously in this report, there are a great many studies (Chu & Dill, 1990; Femina, Yaeger, & Lewis, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1996) that have shown that early exposure to abuse and trauma is associated with significantly poorer psychological and social functioning, a greater likelihood of substance abuse, inter-generational abuse, and poor employment and relationship outcomes. The young people in this current study were generally too young for many of these longer term issues to be investigated. However, there was clear evidence that bears out many of these previous findings within this population of children. As shown particularly in relation to the scores obtained on the SDQ, the vast

majority of the young people had abnormally high levels of conduct disorder, difficulty with peers, and other social behaviours often associated with disruptions to early attachment experiences. Almost half suffered from clinical depression and anxiety and many also appeared to have considerable difficulty in regulating and expressing their emotions in a way that would be conducive to healthy peer relationships and the formation of bonds with adults who might act as parents towards them.

In other words, one of the most important implications of these results is that any attempt to assist this population of young people needs to be undertaken with a clear understanding of the links between the child's current behavioural and emotional functioning and their previous family and placement history. Therapeutic interventions involving the treatment of trauma, the establishment of better attachments and social functioning, must therefore be emphasised in addition to interventions that seek to stabilise and control the behaviours contributing to placement breakdowns (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Hughes, 2004).

Methodological considerations and future reporting

Although data collection methodology used in this study was thorough and was successful in obtaining detailed information about children's social history, it is important to recognise several limitations. The findings here can only be generalised to four Australian States and the findings relate solely to children in metropolitan areas, so the relevance of these findings for rural children needs to be treated with caution. In addition, it is important to acknowledge that there may have been omissions and inaccuracies in case-files and case-worker reports used as the basis for this study. Not all relevant psychiatric, medical or child protection paperwork may always be filed, so that it is possible that the figures reported here understate the true prevalence of problems within this sample. However, in support of this methodology, previous research by Femina et al. (1990) has suggested that using objective administrative records may be a more accurate method than child self-report in obtaining details of abuse because of the danger of distortions, omissions and repression of early traumatic experiences, many of which might have occurred before the age of three. Another potential strength of the data collection was that placement

data could, in most cases, be verified from one date to the next against computerised payment records for individual carers. Thus, it is highly likely that the data above provides a very accurate depiction of the level of placement instability affecting this sample.

The findings on the provision of services to children and families demonstrates that those children with the highest level of problems appear to be the most likely to receive services and interventions. Several State differences in service provision were observed; specifically the Victorian sample received a significantly higher number of family services and interventions. However, it is important to recognise that the observed State differences in the frequency of service provision may not be a true reflection because of the variations in the quality of records collected from different States. The State differences in service provision could also be attributed to differences in the children and families themselves. For example, the Victorian sample was observed to have a significantly higher proportion of males and to have had their first contact with the department at a significantly older age than the other three States. As a result the children may have entered care with more behavioural problems and hence received more behavioural intervention services. The families of the Victorian sample were also observed to have received a higher proportion of services and interventions and the South Australian sample was also observed to have received a significantly higher number of child psychological services, but this may only reflect differences in the demand for, and availability of services, in each of the four States. Nevertheless, the findings demonstrate that nationally the children and families are currently receiving or had previously received a wide variety of services and interventions, but that there was a need for a greater integration of services, and more focus on ensuring an ongoing commitment to addressing the entrenched psychological and social difficulties contributing to placement instability.

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