



CARING FOR INFANTS IN OUT-OF-HOME
CARE IN NEW SOUTH WALES

CARERS' PERSPECTIVES

WESTERN SYDNEY
UNIVERSITY



TRéSI
CENTRE FOR TRANSLATIONAL
RESEARCH AND SOCIAL INNOVATION

FOREWORD

Babies are one of the most vulnerable populations in society, yet sadly in Australia they represent the highest rate of admissions to government care. We know the long-term impacts of trauma, and with such a challenging start to life, it is imperative infants are nurtured and supported in stable home-based care so they can begin to heal and thrive.

Whilst foster carers in Australia undergo relevant rigorous government authorisation processes and are required to undertake ongoing training to maintain their skills, the level of training provided to carers when it comes to infant-based care, particularly around caring for babies and toddlers with complex needs such as prenatal drug and alcohol exposure could be greatly improved.

With the numbers of children and young people entering out-of-home care increasing year-on-year, supporting foster and kinship carers through access to timely and relevant resources, training and supportive networks is crucial for them to be able to continue providing safe home-based care.

This research explores the experiences of carers in NSW relating to training and support received in their role in caring for our most vulnerable. Whilst foster and kinship carers carry significant responsibility in providing safe and nurturing homes for children, there are gaps in the support provided or available.


There is an opportunity for governments around the country to expand their support of foster and kinship carers of infants who are unable to live safely at home, and to upskill carers to empower them to provide the best level of care available.

Thank you to the Western Sydney University and TReSI researchers for providing the research for this report for My Forever Family NSW (the program operated by Adopt Changes and Founded by NSW Government). The findings highlight a need to provide increased training, support, and resources for new carers of infants in out-of-home care.

When it comes to protecting Australian infants, it's more than just removing them from harm. It's also about wrapping them in appropriate supports so they can thrive in their childhoods and into their futures.



Renée Carter
CEO
Adopt Change

A close-up photograph of a woman with dark hair, wearing a light blue button-down shirt, holding a newborn baby. The baby is wearing a white long-sleeved shirt and is looking up towards the woman. The woman's face is partially visible on the right side of the frame, showing her nose and a slight smile. The background is blurred, suggesting an indoor setting with natural light. A vertical blue bar is on the left side of the image, and a horizontal green and blue bar is at the bottom.

Infants under 4 years of age represent the highest proportion of admissions into out-of-home care. Carers of these children face limited supports and resources in providing effective care.

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EXECUTIVE SUMMARY

Adopt Change believes that every child has the right to grow up in a safe, nurturing and permanent family home, and that all families need the appropriate support for children to thrive.

This includes children and families in the out-of-home care (OOHC) context. With this goal in mind, Adopt Change operate My Forever Family NSW, a government funded program of training and support for foster and kinship carers, guardians and adoptive parents of children and young people in OOHC.

In 2021 Adopt Change partnered with researchers from the Translational Research and Social Innovation (TReSI) group in the School of Nursing and Midwifery at Western Sydney University to conduct research to better understand the support needs of foster and kinship carers of infants in OOHC. Over the past several years the members of the TReSI group have established themselves as leading international children and young people researchers. TReSI's mission is to conduct translational research that develops and supports implementation of social and system innovations for 'ensuring that new treatments and research knowledge actually reach the patients or populations for whom they are intended and are implemented correctly'.¹

This report presents the findings of an online survey and individual interviews which explored the experiences of carers providing out-of-home care to infants in New South Wales. While there is increasing research related to the care of children and young people requiring OOHC, there is comparatively less specifically related to the care of infants.


Survey data was collected from 142 carers in NSW providing OOHC to infants, and 13 individual interviews were conducted to gain insight to their experiences.




Infancy is a critical period of physical, cognitive, social and emotional development. What occurs during this period of time has been shown to significantly impact upon long-term outcomes in terms of health and well-being.

Infants represent the highest proportion of admissions to OOHC in Australia. However, recent studies have suggested that carers may be lacking skills and are not receiving training related to infant care.

1. Woolfe SH (2008) The meaning of translational research and why it matters. *JAMA*; 299(2): 211-213.

71%  of infants did not receive home visits from a community nurse or midwife

86%  of carers indicated infant specific training should be provided prior to receiving care of an infant

Key findings:

Overall, findings indicate that carers are not well supported to provide infant specific care, with 65–88% of respondents never receiving information or training related to infant nutrition, feeding, bathing, sleeping, immunisations or developmental milestones. Many who did receive information regarding infant care reported sourcing the information themselves.

The majority of infants (71%) did not receive home visits from a community nurse or midwife while in the respondents home. However, a large majority of respondents (82%) reported taking infants in their care for visits with a local community health nurse. Interview data indicates these visits with nurses provided comfort and reassurance to carers.

A minority of respondents reported receiving training related to attachment (25%) and developmental trauma (35%). Interview data also indicated that this training may be high-level and lacking infant specific application.

Despite the lack of training available, a large majority (88%) of survey respondents reported feeling confident or extremely confident they were able to provide infants with the care required. Conversely, interviewees described feeling unprepared, overwhelmed and poorly supported when receiving care of an infant.

The large majority (86%) of survey respondents indicated infant specific training should be provided prior to receiving care of an infant. Respondents were also in strong support of receiving nurse/midwife home-visiting services (89%) and support from community health nurses (94%) to assist them to provide appropriate infant care. This was also evident in the interviews.

Recommendations summary:

This study has revealed carers are poorly supported to provide infant specific care and desire training, information, in-home and community support from qualified health care professionals. To that end, the following recommendations are made:

- 1. Development and provision of training related to basic infant care, including topics such as infant feeding and nutrition, bathing and sleeping, immunisation and developmental milestones.**
- 2. Provision of details to access reliable/credible sources of information related to infant care-giving prior to or at the point of assuming physical care of an infant.**
- 3. Improved access to in-home and community nursing/midwifery services to support carers in their infant care-giving.**

BACKGROUND

Infants are an inherently vulnerable population due to their complete reliance on adults. Infants and young children (<4 years) represent the highest proportion of admissions into out-of-home care (OOHC) in many western countries, including Australia.^{2,3,4} In the Australian context, infants under one year of age are more likely, than other aged children, to be the subject of allegations and substantiations of child abuse and/or neglect and thus more likely to require placement into OOHC.

The majority of infants receiving OOHC services are placed into home-based care with foster and/or kinship carers who have been vetted and authorized by relevant governing bodies in each state/territory to provide day-to-day care. These carers are to be provided ongoing training as part of their care-giver role. However, there is emergent evidence that carers may not have had the same opportunities as parents to develop skills related to infant care. For example, in a recent study investigating infant feeding in the OOHC context, one quarter of the carer respondents indicated they had not had (biological) children of their own and therefore had no antenatal/postnatal training with qualified health care staff to attend to basic infant needs (e.g., bathing, feeding, settling).^{6,7} This is of particular concern given the majority of infants (and young children) placed into OOHC are known to have increased incidence of physical, mental and developmental health issues compared to the general population.^{8,9} For many this includes specific issues related to prenatal substance exposure and developmental trauma.

Foster/kinship carers have a significant responsibility to ensure the health and well-being of infants in OOHC. However, whether or not these carers are receiving specific training and/or support to care for infants (many of whom have increased health care needs) is largely unknown. This exploratory study sought to provide insight into carers needs related to caring for infants in OOHC and identify resources to support carers in this context.

Infants and
young children



represent the highest proportion
of admissions into out-of-home
care

2. Australian Institute of Health and Welfare. (2020). *Child Protection Australia 2018–19*. Retrieved from Canberra: www.aihw.gov.au/getmedia/3a25c195-e30a-4f10-a052-adbfd56d6d45/aihw-cws-74.pdf.aspx?inline=true
3. Boyd, R. (2019). *Foster care outcomes and experiences of infants removed due to substance abuse*. *Journal of Public Child Welfare*, 13(5), 529–555.
4. Bunting, L., McCartan, C., McGhee, J., Bywaters, P., Daniel, B., Featherstone, B., & Slater, T. (2018). *Trends in child protection across the UK: A comparative analysis*. *British Journal of Social Work*, 48(5), 1154–1175.
5. See www.facs.nsw.gov.au/families/carers/about-foster-care/chapters/legal-rights-and-responsibilities
6. Blythe, S., Peters, K., Elcombe, E., Burns, E., & Gribble, K. (2021). *Australian Foster Carers' Views and Concerns Regarding Maternal Drug Use and the Safety of Breastmilk*. *Children*, 8(4), 284. Retrieved from <https://www.mdpi.com/2227-9067/8/4/284>
7. Blythe, S., Elcombe, E., Peters, K., Burns, E., & Gribble, K. (2021). *Australian foster carers' views of supporting maternal breastfeeding and attachment in out-of-home care*. *Child Abuse & Neglect*, 105360.
8. Goemans, A., van Geel, M., van Beem, M., & Vedder, P. (2016). *Developmental outcomes of foster children: A meta-analytic comparison with children from the general population and children at risk who remained at home*. *Child maltreatment*, 21(3), 198–217.
9. Turney, K., & Wildeman, C. (2016). *Mental and Physical Health of Children in Foster Care*. *Pediatrics*, 138(5), 1–11. doi:10.1542/peds.2016-1118

SIGNIFICANCE

This project is significant as it aligns with several key global, national, and regional priorities. It is in line with the United Nations (UN) Sustainable Development Goal #3 *Ensuring Healthy Lives and Well-being for people of all ages*.¹⁰ It further aligns with the UN resolution recognising home-based care as preferable to institutional care for children who are unable to safely live with their families. This resolution calls for governments to ensure such care is of high quality.¹¹ It also aligns with the NSW Premiers Priorities¹² which is committed to breaking the cycles of disadvantage, and the NSW Health First 2000 Days Framework¹³ which emphasizes the importance of infancy and early childhood to an individual's long-term health outcomes. Importantly, listening to the voices of key stakeholders is part of the research strategy recently released by NSW Department of Communities and Justice (DCJ).¹⁴ Foster/kinship carers are an essential part of this system, and their voices are often not heard.

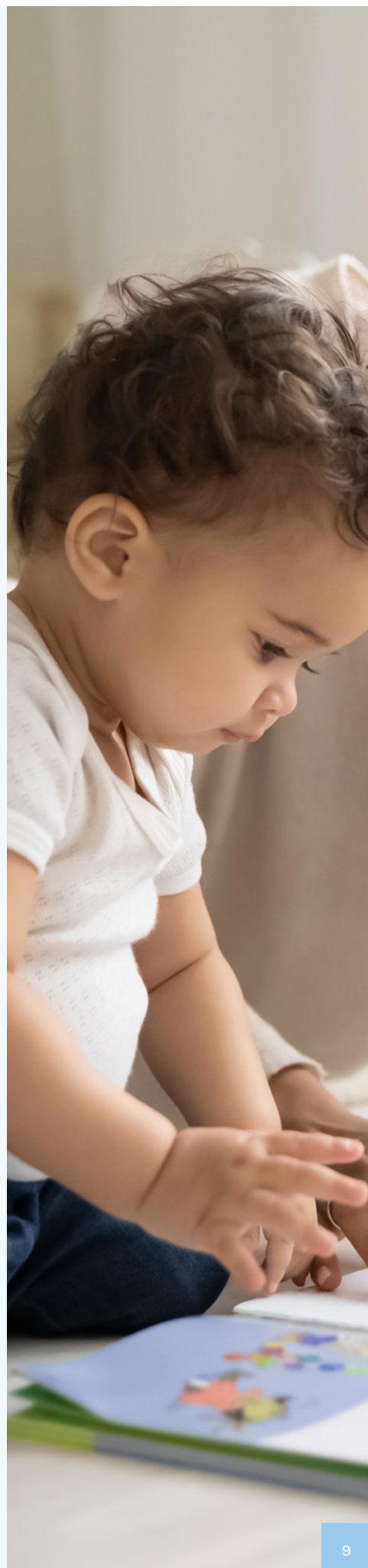
10. www.un.org/sustainabledevelopment/health/

11. *United Nations General Assembly, Promotion and protection of the rights of children, R.o.t.T. Committee, Editor. 2019, United Nations: New York. p. 32.*

12. www.nsw.gov.au/premiers-priorities

13. www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf

14. www.dcj.nsw.gov.au/about-us/research-strategy



METHODS

This study used a mixed methods design, employing an online survey and individual interviews with foster/kinship carers who had received an infant in NSW via the OOH system in the past five years. Participant recruitment was primarily via social media, electronic newsletters and email via which the aim of study and the survey link were shared. While the survey aimed to capture experiences of carers in NSW, it allowed for carers residing in other Australian states and territories to participate and share the link to the survey in the hope of recruiting a larger sample.

In mid-2021 the survey was designed to gather information from foster/kinship carers who had received infant/s (0-12 months) into their care within the last 5 years. This survey covered various topics including: the arrival of the infant, where the infant had come from, why the infant was entering care, what belongings the infant brought, as well as what training and support was provided to the carer prior to or upon arrival of the infant into their care. Information regarding the purpose of the study, and the voluntary nature of research was placed at the beginning of the survey. Participants were asked to acknowledge their understanding and consent to participation prior to commencing the survey.

In addition to basic demographic information, the survey asked questions about the carers experience of care related to the very first infant who entered their care and the most recent infant to enter their care. Questions focused on the carer's confidence to provide care, age of the infant, how the infant arrived at the carer's home (e.g., Did a case worker bring the infant to the carer), the carer's understanding of why the infant was in care, what (if any) physical belongings came with the infant, where the infant had resided prior to entering the carer's care (e.g., with another carer or in hospital), whether the infant received visits from a community nurse or midwife, whether the carer was provided information regarding infant care (e.g., Feeding, sleeping, bathing, etc.), whether the carer was given information related to infant

developmental milestones, and whether the carer received information related to attachment or developmental trauma.

At the end of the survey, participants were invited to share their contact information should they choose to provide a more comprehensive picture of their experience via interview. Once interest was expressed, potential participants were emailed an information sheet and a consent form, and invited to contact the researchers, via telephone or email, should they require any further information about the interview process or aims of the study. Potential participants were instructed to sign and return the consent form via email (or send an email stating they had read the consent form and agreed to the interview). Once received, the participant was contacted by researchers to set a date/time for the interview. Verbal consent was also obtained at the time of the interview. Due to ongoing public health restrictions, interviews occurred online via video call (Zoom).

In the interview, carers were asked to provide greater detail of their experiences, what support they received and whether that support was helpful, how and why. They were asked to expand on their expressed support needs, including questions about how that support should be provided and by whom, and what the barriers and facilitators there are for carers accessing supports within the community and service systems. Interviews were transcribed, checked for accuracy and subjected to content analysis.

To be eligible to participate in this study, carers needed to be formally authorised and have received care of an infant in the past five years (from 2015 onwards). This was to enable to capture of contemporary practice.

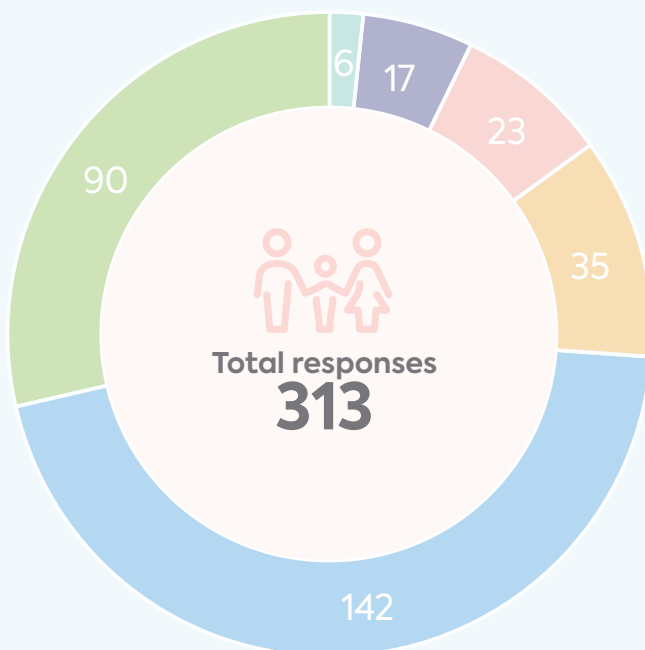
SURVEY RESULTS

A total of 313 responses were recorded, of these six were duplicate survey launches, 17 responders had not been a foster carer in the last 5 years (e.g., adoptive parents), 23 had not received an infant in the last 5 years and 35 responses were of a duration of under 2 minutes. This left 232 valid responses for analysis.

New South Wales

The majority of carers (n = 142, 61%) were from NSW with smaller representations being made by all other states and territories.

This document reports ONLY on carers registered and providing care in NSW.



- Duplicate IP addresses
- Not a foster care in the prev 5 years
- Did not receive an infant under 1 year in prev 5 years
- Duration under 2 minutes
- Valid responses (NSW)
- Valid responses (Other states)

Demographics

The most common age group for carers in NSW was 45-54 years (see Figure 1). The vast majority (99%) were women and in an ongoing relationship (75% married/de-facto) (see Figure 2). The majority had post-secondary education or training (see Figure 3). Almost one third of responders (31%) reported they did not have biological children of their own (see Figure 4).

FIGURE 1 – Age of carer

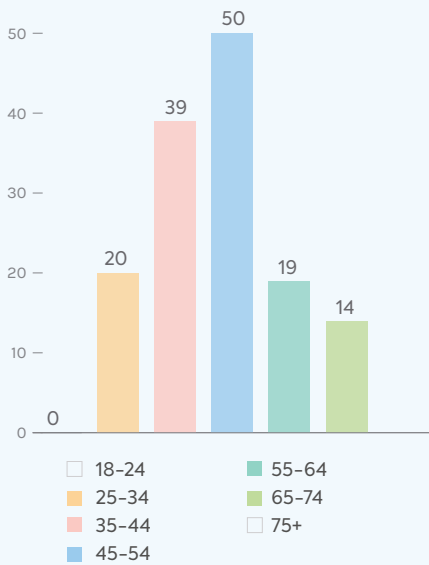


FIGURE 2 – Carer relationship status

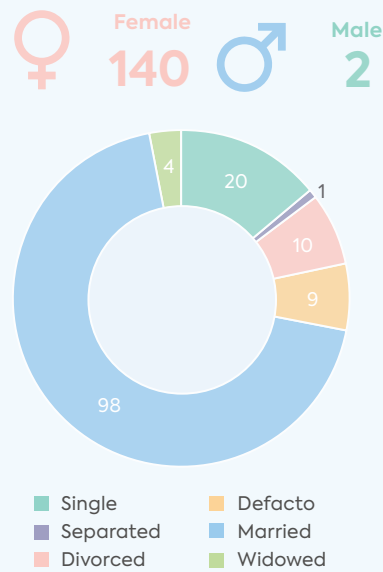


FIGURE 3 – Carer level of education

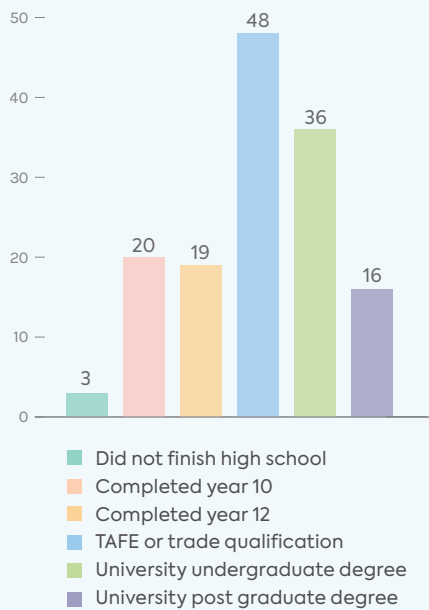
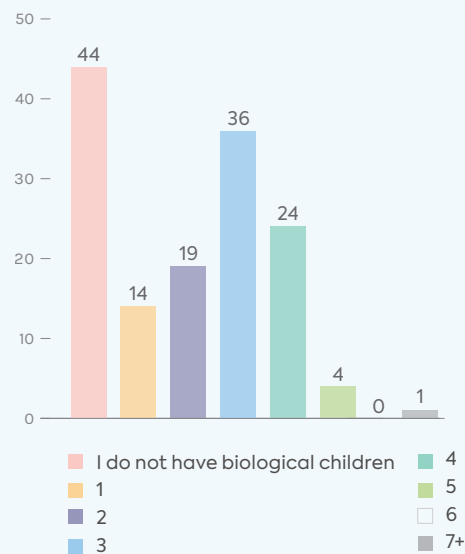


FIGURE 4 – Carer's number of biological children

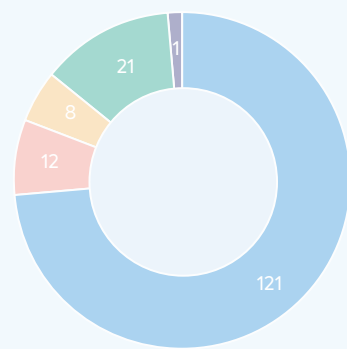


Carer's care-giving history

Carers were asked to provide a little information about their fostering experience. When asked what type of care they were authorised to provide at the time of the survey, 85% indicated foster care, 15% identified as an adoptive parent, 9% specified they provided kinship care and 6% were providing care via guardianship orders (see Figure 5). Carers were asked to select all types of care that applied to them.

When asked about their years of experience, the majority reported that they had been providing care for 1-5, or 6-10 years (see Figure 6). During their time as a carer, 28% reported that they had received one infant, while 25% reported receiving six or more infants (see Figure 7).

FIGURE 5 – Type/s of care provided



- Foster Carer
- Adoptive Parent
- Kinship Carer
- Guardian
- Other

FIGURE 6 – Years as a carer

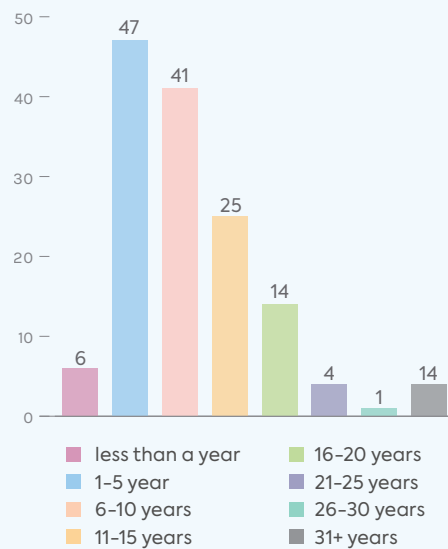
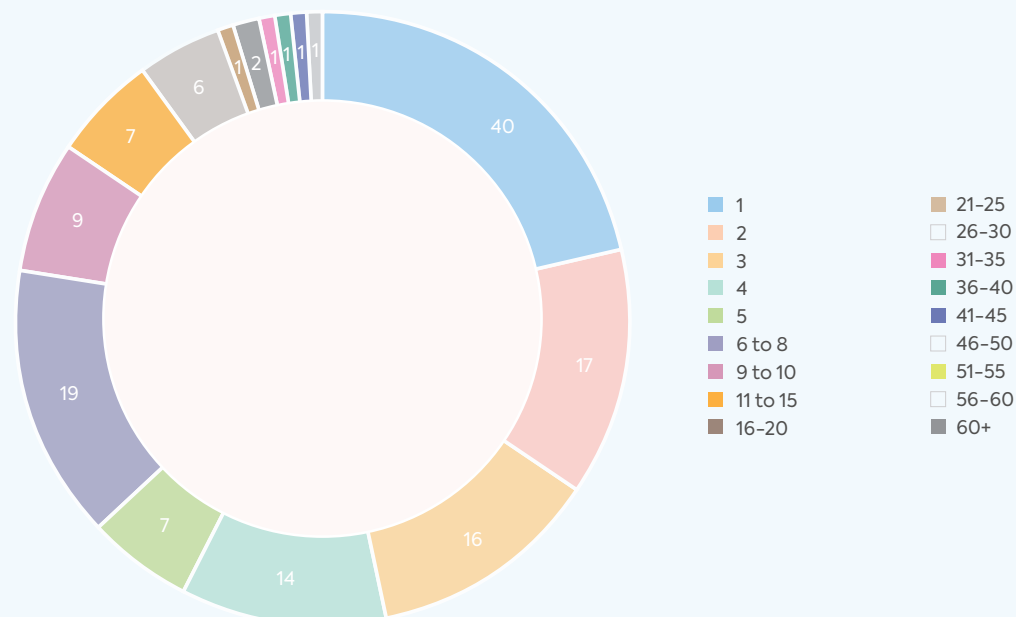


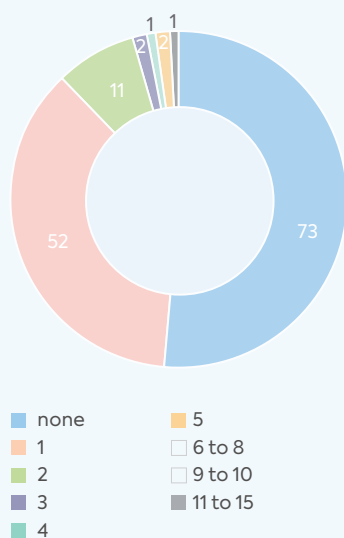
FIGURE 7 – Total of number of infants cared for



There is a strong relationship between the years spent caring and the number of infants the carer received (Kruskal-Wallis's stat = 78.6, df = 7, $p < 0.001$). Simply stated, carers with more years of experience were more likely to have cared for more infants.

When considering the previous 12 months, 51% of carers indicated they had not received an infant during this time, 37% had reported receiving one infant and 12% reported receiving more than one (see Figure 8).

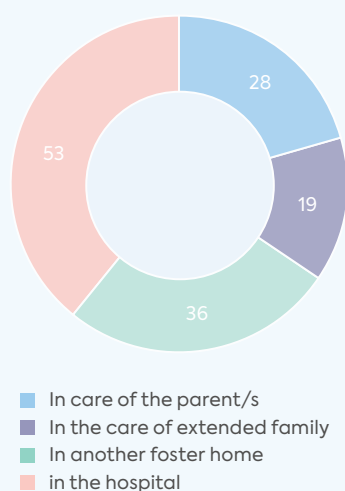
FIGURE 8 – Years of experience vs number of children



Details about the most recent infant arriving into care

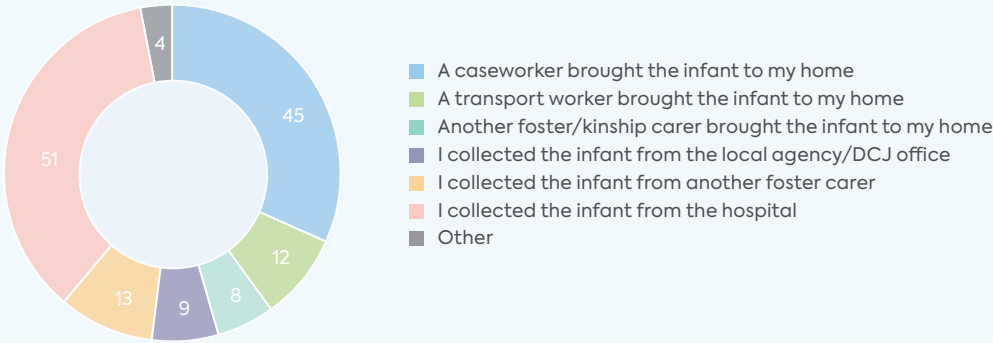
Prior to entering into the respondents care, infants were reported to have been living with their (biological) parents (21%), extended family (14%), another carer (26%), or in the hospital (39%) (see Figure 9). Infants coming from the hospital were more likely to be very young (< one month old).

FIGURE 9 – Location of infant prior to care



The most common way carers physically received infants, was for the carer to collect the infant from the hospital (36%). The next most common way was for a caseworker to transport the infant to the carers home (32%) (see Figure 10).

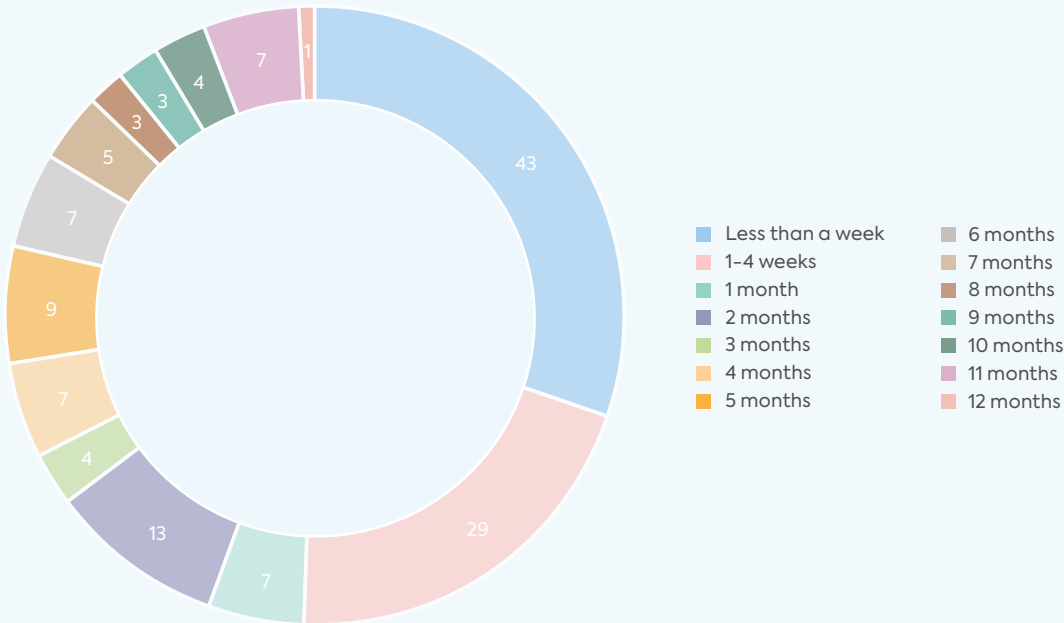
FIGURE 10 – Infant arrival



Child age

Half of the infants (50%) arriving into care were under four weeks of age, 14% were 1-2 months of age (see Figure 11). Infants under one month were more likely to come directly from hospital than older infants.

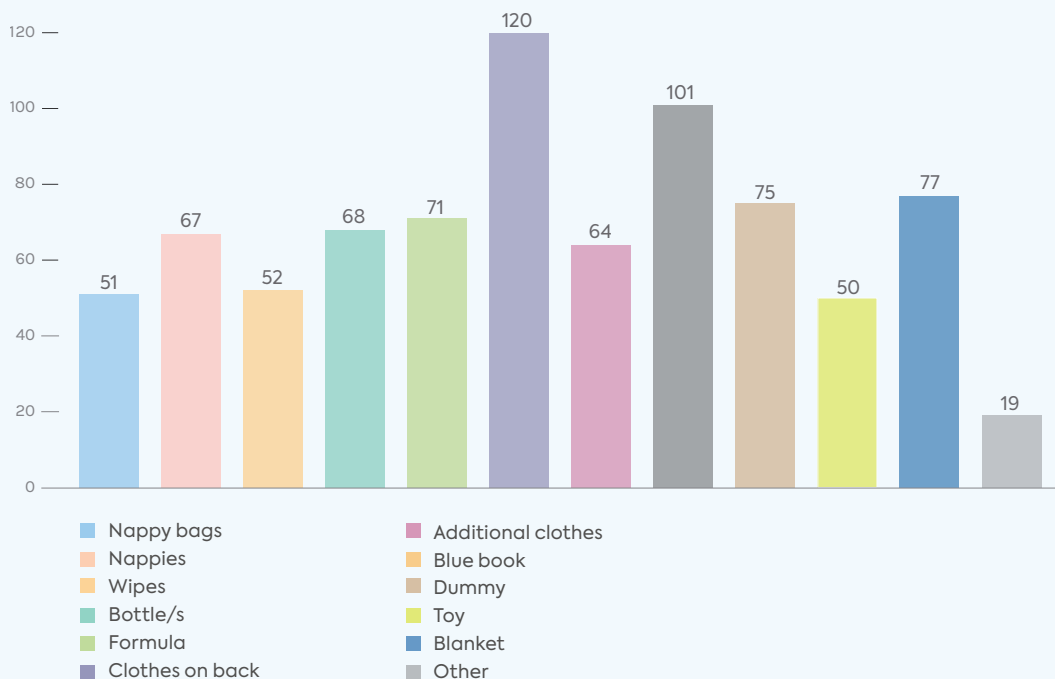
FIGURE 11 – Age of infant entering care



Infants' possessions

When arriving into care, a significant proportion of the infants did so with a selection of possessions, including nappies, bottles formula and clothes (see Figure 12). However, 14 infants (10%), arrived with nothing, or nothing other than the clothes they were wearing.

FIGURE 12 – Infant physical possessions



There was no association seen between where the infant was coming from, and the number of possessions they had with them, but there was an association with their method of arrival ($KW = 13.6$, $df = 6$, $p = 0.035$). Those infants arriving via another foster carer or caseworker were likely to have more possessions, while those arriving by transport worker, collected from the local DCJ/agency office or hospital were likely to have fewer possessions.

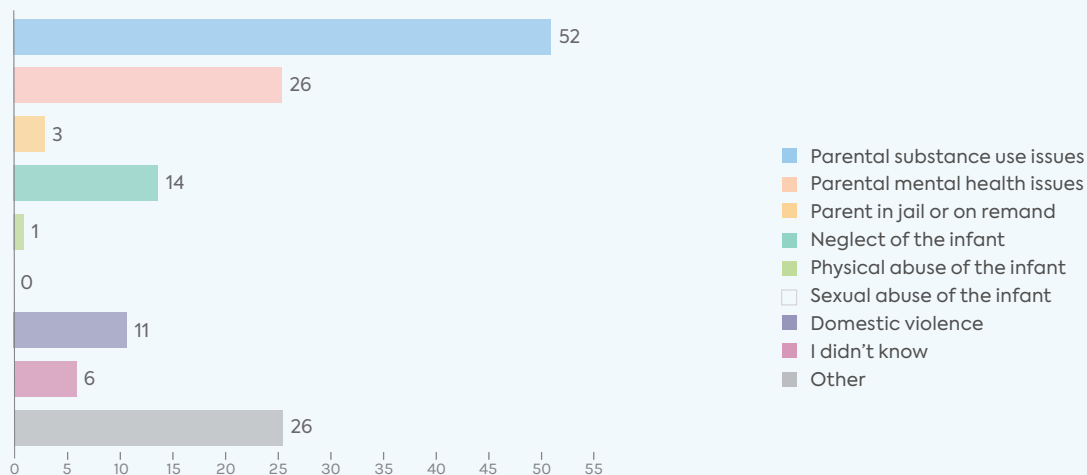
Confidence

A large majority (88%) of carers reported that they were confident or extremely confident that they would be able to provide the infant with the care they needed. However, a minority of carers (12%) reported a low level of confidence.

Reasons for infant entering foster care

Carers were asked about their understanding of the reason for the infant’s placement into care. The most common response was parental substance misuse (n=52), 26 carers reported parental mental health issues and 14 carers reported neglect of the infant (Figure 13).

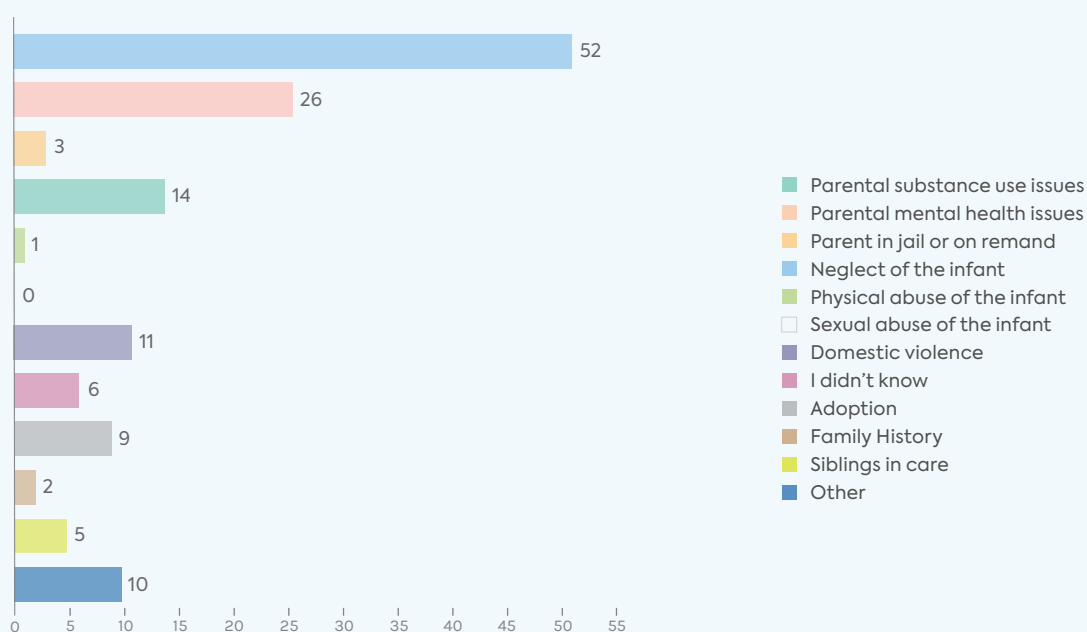
FIGURE 13 – Assumed reason for entering care



A follow up question was asked to those carers who reported that ‘parental substance misuse’ was their understanding as the reason for placement. They were asked if they felt it was possible that the mother was using substances during her pregnancy. All respondents answered ‘yes’ to this question. However, only 14 of these 52 carers (28%) reported receiving information about the care of an infant who had been exposed to substances during pregnancy.

After preliminary analysis of respondents answers to ‘Other’, three additional categories were identified and have been added to the chart, ‘child is up for adoption’, ‘siblings already in OOHC’, ‘family history’ (see Figure 14).

FIGURE 14 – Assumed reason for entering care (expanded)



Training and Support for carers

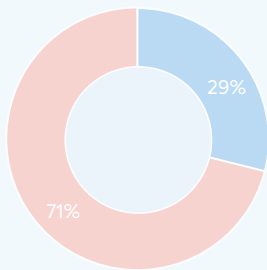
Carers were asked about the training and support they received

Support

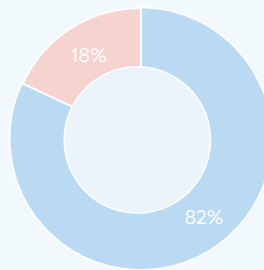
Around one third reported that infants were visited in the carer's home by a community nurse or midwife.

In contrast around three quarters of carers took their OOHC infants to see a local community health nurse.

Did the infant receive visits from a community nurse or midwife in your home?



Did you take the infant for visits with the local community health nurse?



■ Yes ■ No

General Infant Training

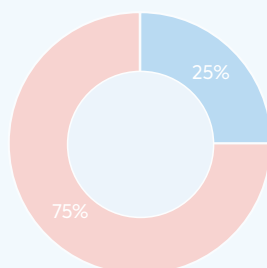
Overall the proportion of carers to receive training related to infant care was low, with only 12% to 35% of carers receiving training or provision of information.

Feeding and nutrition

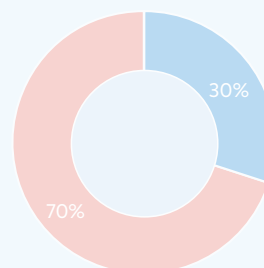
Around one quarter of carers reported receiving information on infant nutrition, and a third were given information on infant feeding.

At or prior to the arrival of the infant, were you provided with information or training about:

1. Infant nutrition?



2. Infant feeding (e.g., correct bottle technique)?

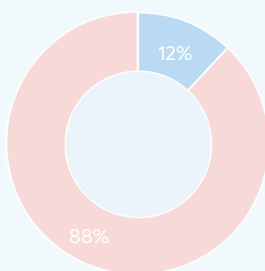


■ Yes ■ No

Bathing and Sleeping

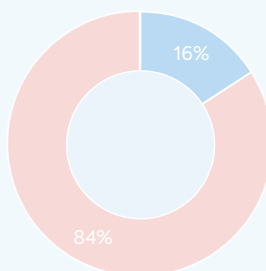
Under a sixth of carers were provided with information on infant bathing, infant sleeping or settling at or prior to the infants arrival.

3. Infant bathing?



■ Yes ■ No

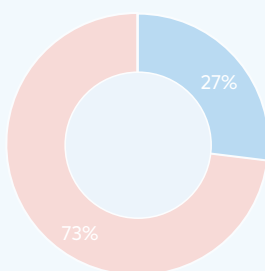
4. Infant sleeping?



Immunisation

One quarter of carers reported receiving information regarding immunisation

5. Childhood immunisation?

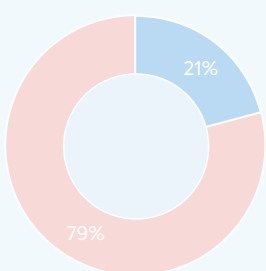


■ Yes ■ No

Child development

20% of carers were provided with information regarding typical childhood development

6. Typical infant developmental milestones?

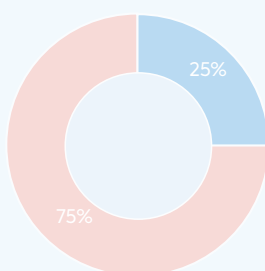


Specialised Infant Training

Infants arriving into out of home care have often experienced disrupted attachment and/or trauma of some kind. It is therefore important to have an understanding of how these issues can affect infants and children.

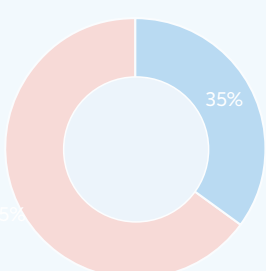
Only a quarter of carers reported receiving information or training on infant attachment, while just over one third were provided with information regarding developmental trauma.

7. Infant attachment?



■ Yes ■ No

8. Developmental trauma?



Sources of training material

Following on from each of the eight training questions, those participants who responded that they were provided with training were asked if the information was 'offered to them', or if they 'found it themselves'. Many of these carers reported to have sourced training and/or information regarding infant care themselves. (See Table below)

TABLE 1: Source of training material

	Found it myself	Offered to me
Infant nutrition	10 (31.3%)	22 (68.8%)
Infant feeding	7 (17.9%)	32 (82.1%)
Infant bathing	5 (31.3%)	11 (68.8%)
Sleeping and settling	8 (38.1%)	13 (61.9%)
Immunisation	9 (27.3%)	24 (72.7%)
Developmental milestones	12 (44.4%)	15 (55.6%)
Attachment	13 (41.9%)	18 (58.1%)
Trauma	12 (26.7%)	33 (73.3%)

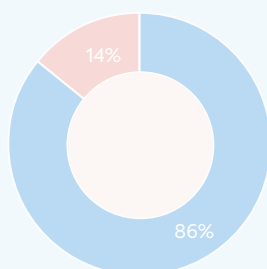
Total training and Support

When the eight types of training included above are considered together. It was found that 40% of carers did not receive any training, 16% received training in one area, 12% received training in two areas and 32% received training in three or more areas.

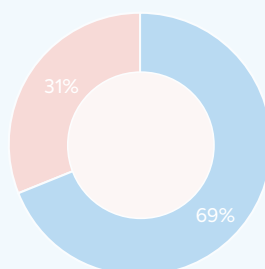
No relationship was seen between the amount of training provided and either number of infants fostered or the number of years they had been fostering. If training was being provided on the basis of carer need, then a strong relationship would have been seen here.

What training would carers like?

Do you think foster/kinship carers should be given information or training specific to the care of infants prior to receiving care of an infant?



Do you think you would have benefitted from receiving information or training specific to the care of infants prior to receiving the first infant?



■ Yes ■ No

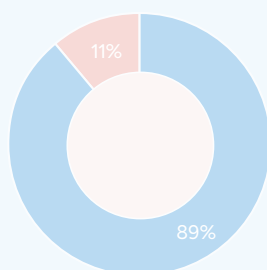
Overwhelmingly carers thought that they should be given training specific to infants prior to infants entering their care.

Carers also indicated they would have benefited from specific infant training if had been offered.

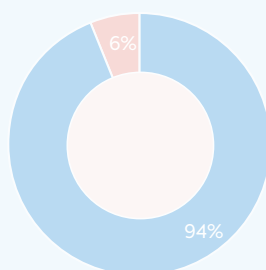
Carers were strongly in support of the infant receiving nurse home-visiting services and care from local community health nurses. These responses did not differ by the carer’s years of experience or number of children fostered.

How should training be delivered?

Do you think infants in foster/kinship care should receive in-home visits from the community nurse/midwife?



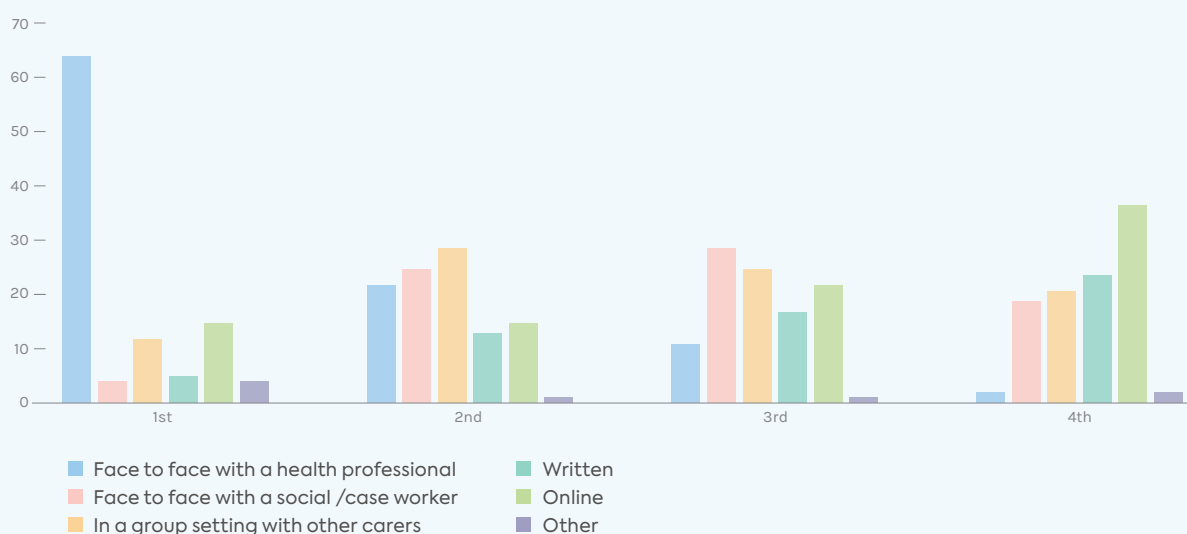
Do you think infants in foster/kinship care should receive care from local community health nurses?



■ Yes ■ No

Carers were asked to indicate their training delivery preferences. By far the most popular response to this was ‘face-to-face with a health professional’, followed by ‘in a group setting with other foster/kinship carers’ and ‘face-to-face with a social/case worker’ (see Figure 15).

FIGURE 15 – Preference of training methods



Differences in the experiences of carers with and without their own biological children

Demographics

A good proportion of responders (31%) did not have biological children at the time of answering the survey. Compared with carers who did have biological children, these carers were younger (most commonly 35–44yrs vs 45–54yrs, MW-U = 4.61, $p < 0.001$), had approximately 3.3 years less fostering experience (MW-U = 2.46, $p = 0.014$) and were more educated with 84% having a TAFE or University qualification compared to 68% of the older carers (45–54yrs) who had biological children (MW-U = -3.13, $p = 0.002$).

Carers without biological children reported good confidence levels with 50% reporting that they were extremely confident that they could meet the infant's needs. However, they were not as confident as their older peers where 74% reported being extremely confident (WM-U = 2.87, $p = 0.004$).

Use of community health services

There was little to no differences in behaviour between the number of carers who received home visits for their infants (Chi sq = 0.42, $p > 0.2$), or the number of carers who took their child to the community health nurse (Chi. Sq = 1.17, $p > 0.2$) and whether carers had biological children.

Training and support

Significant differences were present in the training given around basic infant care, with carers who had no biological children being more likely to receive training on infant nutrition, infant feeding, and infant bathing ([see Table 2](#)).

TABLE 2: training and support for carers with and without biological children

Community health service use	Has biological children		Chi Sq	p	
	Yes	No			
Did infant receive a visit from the Community nurse/midwife?	Yes	25 (26.9%)	14 (35%)	0.89	0.346
	No	68 (73.1%)	26 (65%)		
Did you take Infant for visits with the local Community health nurse?	Yes	77 (82.8%)	32 (80%)	0.15	0.701
	No	16 (17.2%)	8 (20%)		
Were you provided with information or training about					
Infant Nutrition	Yes	18 (19.4%)	15 (37.5%)	4.94	0.026*
	No	75 (80.6%)	25 (62.5%)		
Infant feeding	Yes	22 (23.7%)	18 (46.2%)	6.56	0.010*
	No	71 (76.3%)	21 (53.8%)		
Infant bathing	Yes	7 (7.5%)	9 (23.7%)	6.57	0.010*
	No	86 (92.5%)	29 (76.3%)		
Infant Sleeping	Yes	12 (13%)	9 (23.7%)	2.25	0.134
	No	80 (87%)	29 (76.3%)		
Infant attachment	Yes	19 (20.7%)	13 (35.1%)	2.97	0.085
	No	73 (79.3%)	24 (64.9%)		
Developmental trauma	Yes	30 (33%)	15 (40.5%)	0.66	0.416
	No	61 (67%)	22 (59.5%)		
Immunisation	Yes	20 (22%)	14 (37.8%)	3.39	0.066
	No	71 (78%)	23 (62.2%)		
Typical infant development	Yes	15 (16.5%)	12 (32.4%)	4.02	0.045*
	No	76 (83.5%)	25 (67.6%)		

* Statistically significant at alpha = 0.05 level

There were slight differences in the rates of training given for infant attachment, immunisation and typical infant development with carers who had no biological children marginally more likely to have received training.

There was no difference in training rates seen regarding infant sleeping and developmental trauma.

Note: that while carers without biological children were more likely to receive training, they were still unlikely to be trained. On average these carers had a 25–40% chance of being trained in any one topic, and on average only received training in 2–3 of these important areas. Fifteen of these carers (34%) received no training at all.

INTERVIEW FINDINGS

A total of 13 interviews were conducted online via Zoom. Interview questions focussed on carers' experiences of receiving care of an infant with particular interest in the support they received and the support they would like to receive. Questions related to what support was provided and by whom, and explored the barriers and facilitators to carers accessing supports within the community and service systems. Pseudonyms have been used to present these findings.

Unprepared

Interview data revealed carers were often unprepared to provide care to infants. Many carers did not have the equipment and supplies necessary to provide infant care, some did not have the knowledge or experience to manage particular infant care-giving tasks, and several were not prepared for the emotional impact of providing care to an infant in the out-of-home care system.

Several interviewees described receiving infants with very little notice and minimal time to prepare their homes. This left carers "scrambling" to organise the equipment and supplies needed to care for an infant. One carer explained she was given an hour's notice to prepare for a sibling group of two (five months and 18 months). She stated:

"I didn't have a pram, I didn't have a high chair, I didn't have anything" [Annie].

When carers did not have the appropriate equipment this sometimes led to unsafe practices. For example, Annie went on to explain not having a cot when the children were placed into her care led to unsafe sleeping practices until one could be sourced;

"that night they just had to sleep on my bed, you know, I had to kind of sleep next to my bed and sort of build a little cottage on my bed for the five-month-old".

All interviewees agreed that infant specific training should be provided to carers to ensure best practices were used when providing care. When this information isn't provided, there is potential for infant neglect and discomfort;

"I just see so many carers who, [pause] they really have no idea I've seen, like, carers who had babies who had severe constipation and they're not even aware they have been constipated! And that it's weird that, you know, Bobby hasn't done a number two for eight days and maybe that's why Bub's is very distressed and not very happy and not eating!" [Christy].

Interestingly, interviewees with childminding/ childcare experience and training described feeling surprisingly unprepared to provide care to younger infants. When reflecting on her journey, Donna, a professional in early childhood education with no parenting experience, giggled and stated; *"I did not expect to get a newborn baby"*.

Barbara, a professional day care provider, explained her professional knowledge and experience mostly related to older infants;

"I don't think I'd really done pretty much anything, actually, for looking after a newborn. So when it comes to day-care there are very few kids that go to day-care before six months of age, and even then it's probably more like 12-18 months."

Interviewees who were seasoned mothers with infant and child-raising experience also felt unprepared and needing a "refresher" as it had been a considerable time since they'd cared for an infant. Others recognised limitations to their own experiences, such as not knowing how to bottle feed given their biological children had been solely breastfed.

Interviews also revealed many infants requiring care had increased physical and mental health care needs. Many had experienced prenatal exposure to harmful and addictive substances, but none of the interviewees had received information or training related to this. Similarly, despite infants being removed from parental care, often due to neglect or abuse, carers did not receive training related to caring for an infant with a history of trauma. Rather, interviewees explained most trauma training focussed on older children.

Analysis revealed many carers were not prepared for the emotional toll of providing care to an infant in out-of-home care. As Evelyn described the physical appearance of the first infant who entered her care;

"It was a phone call from [agency].... just to say that they had a little, I think about four weeks old, between four and six weeks old I think he was. Yeah, and they just brought this little baby to us that was quite.... [pause] he had a very mouldy bond suit on... [pause]. It was a very big eye opener for us. I've never seen anything like it. Like, sort of, his neck was stuck too because they've been traveling, they'd been hitchhiking, they'd been on buses and trains and they'd come, all the way down from [somewhere in Queensland] and, yeah, when he was brought to us, he was... [pause] yeah, very grubby and um, it was very raw and yeah, very emotional."

It was clear from Evelyn's interview, that although she was keen to provide care to infants, she was not prepared to witness firsthand the effects of the circumstance which necessitated infant's placement into care.

Carers' interviews painted a picture of ambiguity as infants' case plans and timelines were not always clearly communicated. This caused frustration and impacted upon carers emotionally as they considered their future and that of the infants' in their care.

"I don't know how long she'll be with me. A lot of those conversations that people might have, sort of, down the track... your hopes and dreams and might have for their babies. That's hard, because I kind of find myself kind of going there too, and thinking about our first day of school and blah blah blah, but I don't know there'll be that person" [Donna]

Seeking support

Despite being underprepared, carers proved themselves to be resourceful and capable of providing the care the infants' required. This, however, at times required significant advocacy for the infants and sacrifice from the carers. The responsiveness and support, or not, provided by foster care agencies as well as health and social services, were key facilitators and barriers to accessing support.

The physical needs of infants seemed to take priority. Annie described racing out with children in tow to gather the equipment she needed to provide physical aspects of care;

"I went to [mother's group], which is about an hour from me, and they provided a pram and highchairs and a porta cot, and I think on Facebook marketplace I bought a bassinette. And then, yeah, did a Kmart run and got some clothes and nappies..."

Conversely, Barbara had been given advanced warning and time to prepare for the infant's arrival, and physical needs. This provided her the time and space to address the infant's mental health and focus on attachment. She explained;

"I just wanted to be alone with this baby. I wanted to bond, to figure out a routine, to just try to enjoy some of the life with a little one."

For those carers lacking knowledge or information, the internet became a common source of information for many carers;

"We had to Google a lot of information because we hadn't had a baby for so long! ... I've been to a lot of training and I've never had training to do with an infant" [Evelyn].

Carers were not afraid to seek support from health and social services, but many found it difficult to get the assistance they required. When reflecting on seeking assistance for an infant that was struggling to sleep, Evelyn stated;

"...but it took a hell of a lot of fighting and, you know, I never got any support at all from the organisation [foster care agency]."

Support from the health care system was also often lacking. For example, when Annie was concerned the infant in her care was not gaining weight, she was dissatisfied with the doctor's response and took matters in to her own hands;

"I thought she [infant] was lactose intolerant. The paediatrician was like, 'meh, whatever'... I got in trouble because I didn't go back to the paediatrician to get approval to change the formula. I did it myself, which was actually amazing. It was a huge change. She [infant] started putting on weight, stopped throwing up, the nappy changes became easier, all that sort of stuff. I did it slowly and then just jumped in. I did my research and figured out what to do."

Prioritising infants' needs often came at a great sacrifice. Some carers quit their jobs or reduced their hours in order to provide the care the infant's required, this had financial implications for their entire household. Infants' health care needs and regular visitations with their biological families placed significant demands on carers times with little regard for the carers other commitments or infants sleeping/feeding schedules. Donna explains;

"So roughly about eight or nine hours a week, all together, so she would go for an hour and a half or two hours stints. I'd take her to the Agency and drop her off at the specified time, I do the physical hand over with mum and dad in the reception when the supervisor comes out and then at the end I go back and pick her up because mum hands her back to me and so that has been onerous but I knew that that would be the situation, but the trickiest thing I think about that has been that the times change often just to fit in with the birth parents schedule. So, there's no regard at all for any part of my routine or any part of her routine at all it's all about fitting in with her birth parents' schedule. It's the same with... her birth parents are invited to come along to medical appointments with the caseworker, either the child protection or the Agency caseworker will come as well and it's mostly about making sure that I fit in with the birth parents' schedules to book those appointments."

Despite their importance in the lives of the infants in their care, many carers described feeling marginalised, rather than supported, by health and social service professionals, and even the wider community. One Carer reflected on the difference between becoming a carer to an infant, and becoming a mother (via birth), she stated;

"Unlike a newborn mum, you know, I didn't have people drop around meals or offer to take the baby."

She went on to explain that her own mother had stepped in to help;

"She [carer's mother] realised very quickly that, actually, what I needed was someone to do the washing up for me or to hang the washing on the line. I didn't realise how much of that stuff I did need, like, how much my mental health kind of picked up when there was one less stress over that"

One major challenge experienced by many carers was the lack of documentation needed to get support and services for the infants in their care. Donna explained that even after several months, the infant in her care did not have what was needed;

"She still doesn't have a birth certificate because they're waiting for her birth father to sign the form. So she still doesn't have a Medicare care, health care card or birth certificate."

In addition to practical help, carers needed affirmation that they were doing a good job. Heidi summarised it like this;

"I mean I could have just done with the reassurance, if nothing else, that I was doing Okay."

Similarly, when carers received acknowledgement and encouragement in their care giving role, it gave them confidence and endurance to continue;

"I've got a new case worker now and she is actually really pleasing. She compliments me and I didn't realise how much.... I don't think I need that, but... I didn't realise how much that means to me until she started doing it."

When carers felt poorly supported, they doubted their ability to adequately meet the infants' needs and would question themselves;

"Am I qualified to look after this very small child?" [Barbara].

For some, this caused them to think twice about providing care to another infant. First time, single carer, Christy stated;

"I'm still in two minds myself about whether I would do this again. It's hard for me too."

Need for training and information

Overwhelmingly, when reflecting on their experiences, carers indicated they would have benefited from more training and information related to the care of infants in out-of-home care. Experienced mothers, early childhood professionals and even seasoned carers articulated a desire for infant specific training. In their eyes, this training and information could be provided in a number of ways.

Barbara suggested reading material may be helpful;

"[at] the very least, kind of given a book about, you know, introducing solids and things like that."

Others felt early instruction from health care professionals was needed;

"I think there needs to be the practical stuff. Probably done at the hospital, done at home, during the first week. Like it pretty much needs to be done straight away. Like what are we feeding? How we bathing? What sleep... I mean there's no, I don't believe there's normal sleep for a baby, because every baby is different. But what... what, should we expect and what would flag a concern."

When asked what sort of training or support would be helpful, Christy stated;

"Wouldn't it be lovely if we could have a trained person, who worked with the organisation, who would go out and see these babies' young children? Young infants, you know, and help mums and dads and babies? And told us what to expect? What we're going to have you know."

Two of the interviewees who had newborn infants had received the support described by Christy. The infants in their care were referred to a community nurse, who visited them in their home. Reflecting on this one stated;

"She [home visiting nurse] was just so lovely like just so lovely, and that was really good. I've spoken to a lot of carers in the same area here who had bubs who've come to them from the hospital, and they were never even offered, I think I might have just been lucky."

Nurse home-visiting services gave carers the "opportunity to ask questions" and raise concerns without feeling "judged". Carers felt the weight of the responsibility they carried and wanted assurance they were doing things correctly;

"I also think the expectation of you as a foster carer, that you are perfect. You are a public parent and, an assessor actually told this to a foster carer of the other day, that... foster carers are to be perfect and exemplary at all times."

In addition to training regarding basic infant care giving, interviewees also indicated training related to attachment and trauma, as it relates to infants, was needed. One carer was concerned there may be a perception among carers that infants did not experience trauma. She stated;

"I think every single carer should do complex trauma training before they're allowed to have a child. And a lot of carers I have met say, 'but if you get a baby it's got no trauma.' And I'm like 'Oh my God!' It just makes my head explode!"

One carer who assisted with carer recruitment felt it important that even potential carers be given a more realistic idea fostering. She reflected;

"I find, sometimes, when I do recruitment sessions with my agency, there's a lot of carers [that say]: 'Like, well, I've had my own children and they turned out Okay. So therefore I know everything and I'll just do the same thing, and that will work.' ...And that might work for physical things like making a bottle and that but it's so much more than that."

Finally, when talking about the need for training and information regarding infant care, interviewees expressed the importance of ensuring they provided optimal care. Heidi stated;

"If we're removing these children from their family, we have to be removing them and putting them into a better situation than what they've left."

DISCUSSION AND CONCLUSION

This study sought to explore the experience of providing OOHC to infants in NSW in order to understand how best to support carers in their care-giving role.

Results indicate that, overall, carers are not well supported. Significant differences were present in the training given around basic infant care, with carers who had no biological children being more likely to receive training on infant nutrition, feeding, bathing, settling and sleeping. Although more likely to receive info/training, this still equated to only 1 in 3 carers.

Information and training related to infant attachment and developmental trauma were two of the most commonly offered supports to carers. This reflects a growing understanding and acknowledgement of the importance of a primary attachment relationship for healthy infant development. It also demonstrates an understanding that infants can and do experience trauma. Trauma can significantly interfere with early child development; it can disrupt attachment, delay language acquisition, impede social skills, and inhibit emotion regulation. Infants who experience trauma often fail to meet developmental milestones in a timely fashion. However, one must be aware of those milestones in order to recognise when an infant is not meeting them. The results of this study indicate not all carers have access to this information, and thus, the infants in their care may be at risk of inadvertently falling behind developmentally.

A positive attachment relationship with a primary caregiver is fundamental to healthy infant development. This attachment is especially important for infants who have experienced trauma, but may also be more difficult to develop as some infants may withdraw, avoid eye contact, fail to give off cues and regularly self-soothe, rather than seek out nurturing from their primary care-giver. Carers who have an understanding of this, are more likely to proactively engage with infants in order to foster that attachment. However, if carers are not aware of this, infants can become increasingly disengaged and fail to develop along a typical trajectory.

This study demonstrates some carers are receiving this information, however, the vast majority of carers are not. The first days, weeks and months of life are a critical period for healthy development. If infants in OOHC are to achieve their best possible outcomes, carers need education in how best to promote the infant's health during this critical time.

It is concerning that so few carers were provided with information/training on basic infant care-giving. This is particularly troubling for those carers who have not had biological children. The majority of these carers would not have attended antenatal classes, or had a period of time in the hospital under the guidance of a nurse or midwife who could provide instruction about basic care-giving skills. This lack of training can greatly impact on a carer's well-being, causing anxiety and a sense of self-doubt. Interview data provided more insight to these experiences and is demonstrating these experiences relate to carers both with and without biological children and may also lead to carer attrition.

Perhaps there is an assumption that carers who have had biological children already know what they are doing as they have had infants before. However, the survey data indicates that those carers with biological children are older, averaging 45–54 years. The average age of a birthing mother in Australia has been rising over the past several years, but is currently 30–34 years of age. Thus, the biological children of carers are likely older (10+ years) leaving a lengthy time between infant care-giving periods. Moreover, guidelines related to infant care continue to change. For example, sleeping guidelines related to Sudden Infant Death Syndrome (SIDS) have changed repeatedly over the past two decades.¹⁵ Carers without young children may use outdated infant sleeping practices. Further, carers who breast fed their own children may not have the knowledge to appropriately select, sterilise and bottle feed infants in a manner that ensures optimal nutrition.¹⁶ Such knowledge deficits may potentially (and certainly inadvertently) put infants at risk and cause anxiety in the carer. For example, one 59 year old carer, whose youngest biological child was 21, described feeling “extremely anxious” when receiving care of an infant due to the length of time it had been since had her own children. This is likely why interviewees who were experienced mothers indicated a “refresher” course in infant care would have been welcomed.

It is clear that basic infant care-giving is not routine training delivered by the OOH system, and one may ask why. It may, perhaps, be that this is viewed as an issue which should be addressed by the health care system. This perspective is not illogical. Nurse home visiting programs are designed to support both the infant and the parent, ensuring early identification and intervention for troublesome issues, enhancing attachment and bonding, increasing safety in the home and improving parental self-efficacy.¹⁷ Unfortunately, this study found only 1/3 of infants (and their carers) received in home visits from a

nurse/midwife. Indeed, one carer stated in her interview that the infant in her care had “fallen through the cracks” – aptly identifying a gap between the health care and social service systems. It is likely these infants are not routinely being seen by home-visiting services due to poor referral pathways. Generally mothers are referred to home-visiting services during pregnancy or at birth, when the infant is separated from the mother, there is currently no alternate referral pathway. Those interviewees who did receive nurse home-visiting service described the nurses as listening to concerns, providing helpful advice and offering encouragement.

The majority of carers in the study reported feeling confident in their ability to meet the infant’s needs. However, interview data demonstrated some questioned their capacity when support wasn’t available. This is likely why they also indicated infant specific training and support should be available to carers and that they themselves would have benefited from such training.

The self-selecting nature of respondents and over representation of female carers is a limitation of the research. As respondents were able to select multiple roles related to their care-giving experience, it was not possible to differentiate between the experiences foster and kinship carers. The experiences of respite carers was also not considered. Finally, the survey was lengthy and may have presented challenges to carers with lower literacy levels and may also explain the non-completion of some surveys.

This study is the first in Australia to explore the experiences of those providing care to infants in out-of-home care. Based on this research, there is a clear need to better prepare and support carers of infants in out-of-home care. That carers reported feeling confident to meet the needs of infants, yet also strongly supported the need for specific training and in home support related to the care of infants is notable.

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SUGGESTED RECOMMENDATIONS

Recommendation 1: Development of training related to basic infant care

This study demonstrated that carers of infants in out-of-home care are not routinely provided with training in relation to basic infant care-giving. Training related to infant feeding and nutrition, bathing and sleeping, immunisation, and developmental milestones should be offered to all carers of infants. This research has demonstrated that carers with and without parental experience would benefit from such training. This training would be best provided from a health care professional (ideally a child and family health nurse), who has particular expertise in infant health.

Recommendation 2: Provision of details to access reliable sources of information

Many carers in this study indicated they had sourced information regarding infant care on their own. While this demonstrates a willingness to provide optimal care, it is not known whether the information came from a reliable/credible source. It would be beneficial to collate and provide a list of credible resources and services available to assist carers of infants in NSW. This could be provided prior to or at the point of assuming physical care of an infant.

Recommendation 3: Improved access to nurse/midwifery services

This study found a small proportion of infants and carers to have access to nurse home visiting and community health services. Typically referral to these services are via the mother, during pregnancy or at the time of birth. Expansion of these services to include foster/kinship carers of infants is warranted.

APPENDIX A

SURVEY QUESTIONS

Project Title:

Exploring the needs of foster/kinship carers of infants

Survey Questions

Eligibility Questions

1. Have you been an authorised foster/kinship carer in the past five years? Yes/no
2. Do you live in NSW?
3. Have you received care of an infant (less than one-year-old) in the past five years?

Demographic information or training

4. Which of the following currently apply to you? (tick all that apply: foster carer, kinship carer, guardian, adoptive parent, other)
5. Please explain the 'other' from the previous question.
6. What is your current age? (select from drop down menu; 18-25, 25-34, 35-44, 45-54, 55-64, 65-74, 75+)
7. What is your sex? (select from drop down menu: male, female, prefer not to say)
8. How long have you been a carer? (select from drop down menu; less than a year, 1-5 years, 6-10 years, 11-15 years, 16-20 years, 21-25 years, 26-30 years, 31+ years)
9. What best describes your highest level of education? (Select from drop down menu: did not finish high school, completed year 10, completed year 12, TAFE or trade qualification, university undergraduate degree, university post graduate degree)
10. What is your current marital status? (select from drop down menu; single, separated, divorced, de facto, married, widowed)
11. How many biological children do you have? (select from drop down menu; I do not have biological children, one, two, three, four, five, six, seven or more)
12. How many infants (under one year of age) have you cared for during your time as a carer? (select from drop down menu; 1, 2, 3, 4, 5, 6-8, 9-10, 11-15, 16-20, 21-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 60+)
13. In the last year, how many infants (under one year of age) entered into your care? (select from drop down menu; 1, 2, 3, 4, 5, 6-8, 9-10, 11-15, 16-20, 21-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 60+)

The following questions relate to the very first infant (under one year of age) who entered your care.

14. Thinking about the very first infant (under one year of age) who entered your care, how confident were you that you were able to provide the infant with the care they needed? (likert scale)
15. Thinking about the very first infant (under one year of age) who entered your care, what year did this occur? (select from drop down menu; needs to start at least 30 years ago to now)
16. Thinking about the very first infant (under one year of age) who entered your care, how old was the infant when you received care? (select from drop down menu; less than a week, 1-4 weeks, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 7 months, 8 months, 9 months, 10 months, 11 months, 12 months)
17. Thinking about the very first infant (under one year of age) who entered your care, how did the infant arrive at your home? (select from drop down menu; caseworker brought the infant to my home, a transport worker brought the infant to my home, another foster/kinship Barbara brought the infant to my home, I collected the infant from the local agency/DCJ office, I collected the infant from another foster carer, I collected the infant from the hospital, other)
18. Please explain the 'other' from the previous question.
19. Thinking about the very first infant (under one year of age) who entered your care, what was your understanding, at the time, of why the infant was placed into care? (select from the dropdown menu; parental substance use issues, parental mental health issues, parental incarceration, neglect of the infant, physical abuse of the infant, sexual abuse of the infant, domestic violence, I didn't know, other)
20. Please explain the 'other' from the previous question.
21. IF the answer is parental substance use issues two additional questions will be asked (Q 22 & 23)
22. Is it possible the mother was using substances during her pregnancy with the infant? Yes/no

23. Were you given information or training regarding the care of an infant who had been exposed to substances during pregnancy prior to or at the time of the infant's arrival?
 24. Thinking about the very first infant (under one year of age) who entered your care, what (if any) physical belongings came with the infant? (select from drop down menu, you can choose all that apply: nappy bag, nappies, wipes, bottle/s, formula, clothes on the infant, additional clothing, blue book, other)
 25. Please explain the 'other' from the previous question.
 26. Thinking about the very first infant (under one year of age) who entered your care, where had the infant been immediately prior to entering your care? (select from the drop down menu; in the care of the parents, in the care of the extended family, in another foster home, in the hospital, other)
 27. Please explain the 'other' from the previous question.
 28. Thinking about the very first infant (under one year of age) who entered your care, did the infant receive visits from a community nurse or midwife in your home? Yes/no
 29. Thinking about the very first infant (under one year of age) who entered your care, did you take the infant for visits with the local community health nurse? Yes/no
 30. Thinking about the very first infant (under one year of age) who entered your care, were you provided information or training about infant nutrition prior to or at the time of the infants arrival? Yes/no
 31. Thinking about the very first infant (under one year of age) who entered your care, were you given information or training regarding infant feeding prior to or at the time of the infants arrival? Yes/no
 32. Thinking about the very first infant (under one year of age) who entered your care, were you given information or training regarding infant bathing prior to or at the time of the infants arrival? Yes/no
 33. Thinking about the very first infant (under one year of age) who entered your care, were you given information or training regarding infant sleeping or settling prior to or at the time of the infants arrival? Yes/no
 34. Thinking about the very first infant (under one year of age) who entered your care, were you provided information or training regarding infant attachment prior to or at the time of the infants arrival? Yes/no
 35. Thinking about the very first infant (under one year of age) who entered your care, were you provided information or training regarding developmental trauma prior to or at the time of the infants arrival? Yes/no
 36. Thinking about the very first infant (under one year of age) who entered your care, were you provided information or training regarding immunization prior to or at the time of the infants arrival? Yes/no
 37. Thinking about the very first infant (under one year of age) who entered your care, were you provided information or training regarding typical infant developmental milestones prior to or at the time of the infants arrival? Yes/no
 38. If 'yes' to any Q30-37 how did you get this information or training? (select from drop down menu: found it myself, offered to me)
 39. If 'yes' to any Q30-37, what was the source of the information or training (eg. foster care agency, community nurse)? (free text box)
- The following questions relate to the LAST infant (under one year of age) who entered your care. That is the infant who was most recently placed into your care.**
40. Thinking about the LAST infant (under one year of age) who entered your care, how confident were you that you were equipped to provide optimal care? (likert scale)
 41. Thinking about the LAST infant (under one year of age) who entered your care, what year did this occur? (select from drop down menu; needs to start 5 years ago to now)
 42. Thinking about the LAST infant (under one year of age) who entered your care, how old was the infant when you received care? (select from drop down menu; less than a week, 1-4 weeks, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 7 months, 8 months, 9 months, 10 months, 11 months, 12 months)
 43. Thinking about the LAST infant (under one year of age) who entered your care, how did the infant arrive at your home? (select from drop down menu; caseworker brought the infant to my home, a transport worker brought the infant to my home, another foster/kinship Barbararought the infant to my home, I collected the infant from the local agency/DCJ office, I collected the infant from another foster carer, I collected the infant from the hospital, other)
 44. Please explain the 'other' from the previous question.
 45. Thinking about the LAST infant (under one year of age) who entered your care, what was your understanding of why the infant was placed into care? (select from the dropdown menu; parental substance use issues, parental mental health issues, parental incarceration, neglect of the infant, physical abuse of the infant, sexual abuse of the infant, domestic violence, I don't know, other)

46. Please explain the 'other' from the previous question.
 47. IF the answer is parental substance use issues two additional questions will be asked (Q 48 & 49)
 48. Is it possible the mother was using substances during her pregnancy with the infant? Yes/no
 49. Were you given information or training regarding the care of an infant who had been exposed to substances during pregnancy prior to or at the time of the infant's arrival?
 50. Thinking about the LAST infant (under one year of age) who entered your care, what (if any) physical belongings came with the infant? (select from drop down menu, you can choose all that apply: nappy bag, nappies, wipes, bottle/s, formula, clothes on the infant, additional clothing, blue book, other
 51. Please explain the 'other' from the previous question.
 52. Thinking about the LAST infant (under one year of age) who entered your care, where had the infant been immediately prior to entering your care? (select from the drop down menu; in the care of the parents, in the care of the extended family, in another foster home, in the hospital, other)
 53. Please explain the 'other' from the previous question.
 54. Thinking about the LAST infant (under one year of age) who entered your care, did the infant receive visits from a community nurse or midwife in your home? Yes/no
 55. Thinking about the LAST infant (under one year of age) who entered your care, did you take the infant for visits with the local community health nurse? Yes/no
 56. Thinking about the LAST infant (under one year of age) who entered your care, were you provided information or training about infant nutrition prior to or at the time of the infants arrival? Yes/no
 57. Thinking about the LAST infant (under one year of age) who entered your care, were you given information or training regarding infant feeding prior to or at the time of the infants arrival? Yes/no
 58. Thinking about the LAST infant (under one year of age) who entered your care, were you given information or training regarding infant bathing prior to or at the time of the infants arrival? Yes/no
 59. Thinking about the LAST infant (under one year of age) who entered your care, were you given information or training regarding infant sleeping or settling prior to or at the time of the infants arrival? Yes/no
 60. Thinking about the LAST infant (under one year of age) who entered your care, were you provided information or training regarding infant attachment prior to or at the time of the infants arrival? Yes/no
 61. Thinking about the LAST infant (under one year of age) who entered your care, were you provided information or training regarding developmental trauma prior to or at the time of the infants arrival? Yes/no
 62. Thinking about the LAST infant (under one year of age) who entered your care, were you provided information or training regarding immunization prior to or at the time of the infants arrival? Yes/no
 63. Thinking about the LAST infant (under one year of age) who entered your care, were you provided information or training regarding typical infant developmental milestones prior to or at the time of the infants arrival? Yes/no
 64. If 'yes' to any Q56-63 how did you get this information or training? (select from drop down menu: found it myself, offered to me)
 65. If 'yes' to any Q56-63, what was the source of the information or training (eg. foster care agency, community nurse)? (free text box)
- These questions relate to foster carer support and training related to the care of infants.**
66. Do you think foster/kinship carers should be given information or training specific to the care of infants prior to receiving care of an infant? Yes/no
 67. Do you think you would have benefitted from receiving information or training specific to the care of infants prior to receiving the first infant? Yes/no
 68. Do you think infants in foster/kinship care should receive home visits from the community nurse/ midwife? Yes/no
 69. Do you think infants in foster/kinship care should receive care from local community health nurses? Yes/no
 70. How should information or training specific to the care of infants be provided to foster/kinship carers? (rate 1-6 in order of preference: online, face-to-face with a health professional, face-to-face with a social/case worker, in a group setting with other carers, written, other)
 71. Please explain the 'other' from the previous question.
 72. Reflecting on your experience, what support do you most value when receiving care of an infant in out-of-home care? (free text box)
 73. Reflecting on your experience, what support do you wish you had when receiving care of an infant in out-of-home care? (free text box)
 74. Thank you for your time. We will also be interviewing a number of carers to gain more in-depth information. If you are interested in being interviewed, please leave your name and email address below. Please click 'submit' to complete the survey.

Researchers

Associate Professor Dr Stacy Blythe

Dr Stacy Blythe, BN(Hons) Grad Cert(Dev Trauma) MBA PhD, is an Associate Professor in the School of Nursing and Midwifery at Western Sydney University and the Deputy Director of the Translational Research and Social Innovation group at the Ingham Institute for Applied Medical Research. Her research focuses on the health and well-being of children in out-of-home care and their families (biological, foster, adoptive).

Emma Elcombe

Emma Elcombe, MPhil(Research) MPhil(Brain and Mind Science) is a Senior Project Officer and Statistical Analyst in the School of Nursing and Midwifery at Western Sydney University. Currently working within the Translational Research and Social Innovation group, she is responsible for the management and analysis of all research data associated with the groups projects. Emma has nearly a decade of experience working in health and medical research as a data manager and analyst.

Contributors

Renée Carter

Renée Carter is the CEO of Adopt Change and a passionate advocate for the wellbeing of children and young people. She leads a team of Adopt Change Changemakers nationally, with major activities including the #THRIVE National Permanency Conference; My Forever Family NSW; Yesvember A Home for Every Child campaign; MyPacks first night back packs; Empower Change; along with engagement with community, government, child welfare sector; and regularly sought to speak with media about child welfare, permanency and adoption.

Renée is a member of the Institute Advisory Group for the independent research centre, Institute of Open Adoption Studies (The University of Sydney); a member of various government and cross-sector advisory groups and taskforces; and was previously Vice Chair of NSW Committee on Adoption and Permanent Care (COAPC).

She is a member of Australian Institute of Company Directors, with a background in communications and executive management, along with board level experience in corporate and not-for-profit sectors. Her experience includes three years as Chair of charity Child Abuse Prevention Service (CAPS), an organisation focused on early intervention, education and support of families and communities; and Managing Director of creative corporate and investor communications specialists Designate Group.

Renée is committed to influencing child welfare policy and practice to deliver timely and effective outcomes for children so they can have better childhood experiences and a brighter future.

Michelle Stacpoole

Michelle Stacpoole is the Head of Communications & Events for Adopt Change and the My Forever Family NSW program. For the past four and a half years at Adopt Change, Michelle has helped drive the increase in awareness for children to have safe and stable homes with supports to thrive. This has included increasing the number of potential carer homes across NSW through research-based communications and campaigns.

With a passion for creating systemic change for children and young people in out-of-home care, Michelle understands the impacts of impermanency and champions the need for greater trauma awareness.

A communications professional with extensive experience directing communications, campaigns, programs, projects and events at a senior level, Michelle is also a Dean's Merit List recipient at Western Sydney University.



Western Sydney University

Western Sydney University prides itself on challenging the traditional notion of what a university should be. We put students at the heart of everything we do.

We are embedded in the community and region we serve – Greater Western Sydney – which is Australia’s fastest growing economy and the focus of the nation’s largest infrastructure projects. We have a network of sites and teaching campuses across Greater Western Sydney and beyond. Western Sydney University has more than 49,000 students, 3,000 staff, and a strong cohort – both locally and globally – of more than 200,000 alumni.

The University has been named number one in the world for its social, ecological and economic impact in the latest Times Higher Education (THE) University Impact Rankings. We are globally focused, research led and committed to making a positive impact on the communities we engage with.



My Forever Family NSW

My Forever Family NSW is funded by the NSW Government and operated by Adopt Change Limited, to recruit, support, train and advocate for foster and kinship carers, guardians and adoptive parents from out-of-home care across the state. Since its inception in July 2018, we have referred over 2,461 potential carer households to agencies across NSW, have over 7,511 recorded attendances by carers at training sessions, and on average, the Carer Support Team assists over 157 carer households each month.



Translational Research and Social Innovation

Translational Research and Social Innovation (TReSI) is an Implementation Science hub of expertise that supports the translation of evidence into sustainable practice for relationship-based health and social services. TReSI is situated within the school of Nursing and Midwifery in Western Sydney University and is part of the Ingham Institute of Applied Medical Research. TReSI is comprised of a dedicated team of researchers, analysts, clinicians and field workers who generate evidence to promote child, youth and family health and wellbeing, supporting their partners to successfully apply this evidence to their programs of work.

TReSI’s underlying philosophy is that “A person’s potential should not be limited by the circumstance into which they are born.” As such, TReSI aims to generate knowledge of effective interventions to improve the health and wellbeing of children, youth and families and seeks to assist in the implementation of these evidence-based interventions.

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