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OUT OF HOME CARE FOR CHILDREN IN AUSTRALIA

A REVIEW OF LITERATURE AND POLICY

FINAL REPORT

CIARA SMYTH AND TONY EARDLEY

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Out of Home Care for Children in Australia
A Review of Literature and Policy

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Report for the Department of Families, Community Services and Indigenous Affairs

Final Report

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Preface

This report was submitted in draft to the then Department of Families, Community Services and Indigenous Affairs in December 2005. It was then revised and submitted in final form in September 2006, following comments from the States and Territories on the evolution of policies for children in out of home care in the various jurisdictions. Publication of the report has been delayed since this date. As a result, some of the legislation, policies and programs referred to have changed further since the end of 2006, and readers should refer to the particular jurisdictions for updated information. The broad conclusions of the study remain valid, however, and will be of interest to those concerned with the development of care and protection for children at risk in Australia.

Dr Tony Eardley
February 2008

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Executive Summary

Background

Children at risk of abuse or neglect in their parental home often require placements in out-of-home care. These placements can include group homes or other small residential institutions, but in recent years they have more often taken the form of home-based care with unrelated foster carers, or alternatively with relatives – a form of placement known as kinship or relative care.

The provision of home-based care is under strain because State authorities are having difficulty recruiting and retaining carers. At the same time, the number of children coming into care has grown significantly in recent years. This has been ascribed to increases in family breakdown, reported child abuse, and drug and alcohol misuse amongst parents.

Much of the increase in demand has been met through kinship care rather than traditional foster care, partly because of the difficulties of recruiting foster carers but also because kinship care is seen as providing better opportunities for familial and cultural continuity for children. Kinship care is now more common than traditional fostering in some jurisdictions in Australia and is the main form of care placement for Indigenous children nationally.

The majority of kin carers are grandparents, so kinship care needs to be seen significantly as a question of grandparent care. Recognition of grandparents as key providers of relative care has also led to several studies of their legal and financial status, the pressures they experience and the levels of support available when they become primary carers.

In spite of the growing importance of kinship care, the level of knowledge about it in Australia is still limited. While there is a substantial body of research from overseas, Australian research is relatively scarce. There have been some concerns about the quality of outcomes for children cared for in kinship settings and about the best ways of providing support for these carers. This has led some States to undertake reviews of policy and practices towards relative carers and to pilot specialist programs of support.

In July 2004, the inter-State Community and Disability Services Ministers' Conference endorsed a National Plan for Foster Children, Young People and Foster Carers. This recommended a number of priorities for action, including investigation and development of emerging models of out-of-home care.

In 2005, the Senate Community Affairs Committee issued a report *Protecting Vulnerable Children: a National Challenge*, which outlined the role of the Commonwealth in the policy area of child protection and care. The Committee endorsed foster care as a priority area for research.

As a department with a portfolio concerned with the wellbeing of children and with children's services, the Department of Families, Community Services and Indigenous Affairs has a policy interest in this area. As a contribution to this agenda, FaCSIA commissioned the Social Policy Research Centre to carry out a review of literature and policy on out-of-home care.

Research aims and methods

The aims of the study were to review trends in out-of-home care, both in the numbers of children being placed in different types of care in Australia and in the ways of organising and supporting such care that are emerging in different national and State contexts. The study also involved identifying emerging models of care and the drivers of change, and reviewing evidence on the outcomes of different models.

The research involved a review of recent literature from Australia and the main English-speaking countries overseas; analysis of policy documents relating to fostering and kinship care in the States and Territories of Australia; and informal discussions with policy informants and practitioners in Australia and overseas.

Trends in policy for out of home care of children

Child protection has been characterised historically by pendulum swings in policy between emphasis on family maintenance and on child removal. Nevertheless, the underlying priority in most jurisdictions is now to keep children with their original family wherever possible. If children are placed in care, the goal is ultimately to reunite them with their families where appropriate. To this end a range of family support programs exist that seek to prevent separation. Where removal from the original family is seen as necessary, placement within the wider family or community is the preferred option, particularly for Indigenous children.

The out-of-home care systems in Australian States and Territories are facing challenges in line with those of many other OECD countries. All have experienced an increase in the number of children entering out-of-home care, and many of these children are presenting with increasingly complex and challenging behaviours. There has been a decline in residential placements without a parallel increase in alternative placement options. Most States and Territories are having difficulties attracting and retaining foster carers.

Many ‘easier to care for’ children today benefit from Commonwealth- or State-funded early intervention programs and do not enter the foster care system. Consequently it is children who are beyond the scope of early intervention programs, or for whom early intervention has failed, who are the most likely to enter care. Provision for high needs children is limited and in most cases the only placement option is with foster or kinship carers. However, many carers struggle to meet the demands of caring for these children, leading to an increase in placement breakdowns and carers leaving the system. Such problems are not restricted to Australia, but have been identified in research in both the US and the UK.

The reduction in placement options is partly linked to a decline in the provision of residential care for children in Australia over the last four decades. Although this decline is consistent with international trends, Australia has experienced a steeper decline than in either the UK or the US.

A number of factors have contributed to this decline. Australia-specific factors include recognition of problems caused by institutionalisation and mistreatment of Indigenous children taken from their families (the Stolen Generation), and revelations of forced migration of children from Britain and Ireland in the earlier years of the last century. However, residential care for children has also declined internationally as a

result of research on child development. Particularly important have been theories of 'attachment', which have highlighted the detrimental effects of institutionalisation.

The decline has also been hastened by the major social policy ideologies of the last two decades. The focus on de-institutionalisation, normalisation and 'least restrictive environment' has been compatible with government efforts to reduce welfare spending, leading to the closure of relatively costly residential placements.

Another effect of the reduction in residential placements is that many young people leaving care end up in homeless youth programs, particularly the Supported Accommodation Assistance Program (SAAP). Young care leavers are also at high risk of contact with the juvenile justice system.

The negative consequences of the closure of residential facilities have prompted a reappraisal of their role. There is increasing recognition that residential provision must continue to be an integral, albeit small, component of the OOHC system, particularly for children with challenging behaviours, and for sibling groups who cannot be accommodated together in foster families.

Residential placements are still provided for children with severe emotional and behavioural problems. Over the last few years, there has been some growth in privately run, for-profit residential provision for children in OOHC. These services tend to be costly and only loosely regulated, often employing untrained staff.

One result of fewer residential placements has been the growth of kinship care as a leading model of out-of-home care. Although this type of care is by no means a new phenomenon, with many cultures seeing it as a normal element of childrearing and family life, its formalisation within the OOHC system is relatively recent.

Kinship care placements occur on both a formal and informal basis. Only formalised arrangements between the kinship carer and the child welfare department fall within statutory responsibilities. It is not known how many children are in kinship care in Australia on an informal basis. US research has indicated a possible ratio of about five to one in informal versus formal care, whereas Australian research suggests it may be in the region of three to one.

There are several other explanations put forward for the growth in kinship care. One is that child welfare agencies have become more sensitive to cultural factors and the importance of family continuity in child development. Another is that it is simply a response to the difficulty of attracting and retaining foster carers. The growth in kinship care is also compatible with traditional family values. Moreover it is cheaper not only than residential care but also than foster care, partly because kinship carers tend to receive lower levels of service support than non-kin foster carers.

Research studies have also highlighted the characteristics of kinship carers and the differences between them and non-related foster carers. Kinship carers tend to be predominantly single women, usually grandmothers or aunts, with the majority related to the mother of the children, whereas foster carers are mainly couples. Half are aged 50 years or over, while foster carers tend to be somewhat younger. Only one-third are in paid employment and almost half are reliant on a pension or benefit.

Grandparent-headed households also have the second lowest gross household incomes after lone mother households, have proportionately higher rates of poor dwelling conditions than other household types and generally high levels of socioeconomic disadvantage.

The recognition that kinship care is significantly an issue of *grandparents* has led to examination in Australia of the experience of being a grandparent carer. Grandparents who take on primary care of their grandchildren tend to express feeling high levels of stress. This can be exacerbated by what is perceived as insufficient financial and service support. In response several States have set up specific support services for grandparent carers.

Despite the growth in kinship care in recent years there is little conclusive evidence on whether it provides better outcomes for children than other forms of care. A recent audit of Australian child protection and out-of-home care research notes that only a handful of studies focus on kinship care. Hence there is a reliance on insights from overseas research, mostly from the US.

It is commonly believed that kinship care is in the best interests of the child because it is more likely to help maintain shared biological, emotional and cultural connections, and to offer greater placement stability. It is often preferred by family members because their children are not placed with 'strangers'. However, many kin carers accept their caring role because there is no alternative placement option and some end up caring for longer than originally planned.

The question of whether children in this type of care experience better outcomes than those in other forms of care depends on how outcomes are defined and on how long-term a perspective is taken. Children placed with kin carers tend to have fewer multiple placements than those with non-kin carers, but they also tend to remain in placements longer and are less likely to be reunited with their birth parents.

Existing research has also had problems adequately differentiating the effects of kinship care from pre-existing difficulties and few studies compare the outcomes of kinship care directly with those of other forms of care.

Overall, review of outcome studies for children in kinship care presents a limited but conflicting picture of the benefits and disadvantages, making the task of drawing firm conclusions about it difficult. In the absence of clear evidence on kinship care outcomes, there is a need for continuing assessment and interventions to support both children in kinship care and their carers.

Another subject of ongoing debate has been whether kinship care properly belongs inside or outside the formal child welfare system and thus what levels of support and provision can and should be provided. Several Australian States are in the process of determining their policies on this question.

The increasing number of high needs children entering OOHC in recent years has led to the development of a range of 'treatment foster care' options that incorporate a therapeutic component. The rationale for these is the belief that many children in OOHC need the intensive structure of residential care but also benefit from the influence of a family environment. Many commentators argue that treatment foster

care is preferable to residential care because it is less expensive, produces comparable results and offers a less restrictive treatment environment.

Treatment foster care is most developed in the US, from where programs such as the Oregon Multidimensional Treatment Foster Care (MTFC) have been influential both in Australia and in the United Kingdom.

A review of published outcome studies of treatment foster care programs in the US found large positive effects on placement permanency and social skills. Medium positive effects were found in reducing behaviour problems and improving psychological adjustment. However, the review advises caution in interpreting the findings because of the methodological limitations of many of the studies.

No existing research has been identified as yet which provides a thorough overview of the current range of therapeutic/treatment foster care options in Australia. One ongoing review has identified 20 Australian OOHC programs that are specifically designed for children with significant emotional/behavioural disorders and have a therapeutic/treatment focus. However, it is unclear at this stage what proportion of these programs are home-based or residential-based, and how many of them have been subject to evaluation.

A further important aspect of out-of-home care systems is what happens to young people when they reach the age at which the Government no longer has statutory responsibility for them. Young people who have spent many of their childhood years in statutory care face significant challenges when making the transition to independent living. As well as being at greater risk of homelessness and other social disadvantage, they are also disproportionately likely to become involved in juvenile crime and drug abuse.

Several States have introduced or are introducing various schemes for transitional housing and living skills support. There is also increasing interest in the 'foyer' model of combined accommodation and employment support for disadvantaged young people, originally developed in France. This model has been widely adopted in the UK and several schemes now operate with some success in Australia, but foyers have also attracted some criticism in the UK for being coercive, focusing more on policing behaviour than providing effective support.

Traditionally, out-of-home care placement options have been viewed as falling along a 'continuum of care', with the least intrusive and restrictive options (family care) at one end and the most restrictive (institutional care) at the other. Recently this concept has been criticised as being based too much on 'arbitrary classifications' of care types. Critics argue that focus should be on the dimensions of care that may be most useful in differentiating between types of program.

It is argued that this 'dimensions of care' perspective provides a more flexible framework for designing programs based on combinations of different service elements that are not bound by debates on the relative advantages of residential versus foster care. It is also important to recognise that high needs children are themselves a heterogeneous group with a range of difficulties including intellectual, behavioural and trauma-based problems. Given this heterogeneity, programs should to be tailored to specific groups of young people with similar identified needs.

However, a key challenge facing both practitioners and researchers in the out-of-home care sector is how to identify 'effective' OOHC models and programs. This task is complicated by the profusion of programs, variations in evaluation methodologies and the difficulties inherent in identifying and replicating models, particularly those that have been developed in other countries.

Recent developments in out of home care for children in the States and Territories of Australia

Between June 1996 and June 2005 the number of children in formal out-of-home care in Australia increased by 70 per cent. The total number of children in care in June 2005 was just under 23,700 – a nine per cent increase on the previous year. There were wide variations by State and Territory that are only partly attributable to the relative populations of children. Only four per cent of children were in residential care, with 57 per cent in foster care and 42 per cent in relative or kinship care.

While home-based care accounts for 95 per cent of children in OOHC across Australia, several jurisdictions, particularly South Australia, Queensland and the Northern Territory, are much more reliant on foster care than NSW, which in turn has the highest rate of kinship care.

Indigenous children are heavily over-represented in OOHC relative to other Australian children. The placement rate of Indigenous children in out-of-home care between 1996 and 2005 was more than six times that for other Australian children. The underlying reasons include historical patterns of trauma, socio-economic disadvantage and family violence, but the immediate causes include a much higher rate of reporting of child neglect and abuse amongst Indigenous than non-Indigenous communities.

The Aboriginal Child Placement Principle enshrines a preferential hierarchy for placement of children with Indigenous carers. Preference starts with the child's extended family, followed by other members of the child's kinship group, then other Indigenous people. All jurisdictions have adopted the ACPP either in legislation or policy. Thus an increasingly high proportion of Indigenous children in care are placed with kin.

The States and Territories have all been experiencing similar overall pressures, including increasing numbers of children needing care, greater demand from children with high or complex needs, a consequent rise in the real costs of services, and a shortage of foster carers.

Because of their particular histories of policy and provision, the jurisdictions are differently placed to respond to these demands. A recent national comparison of child protection systems found that the statutory child protection services were providing very similar models of intervention, but that procedural and legislative frameworks guiding these interventions and defining the child protection population varied significantly.

There are certain broad trends common to all jurisdictions. First, there is the accepted principle of least intrusive intervention and the hierarchy of placements this implies. However, set against this is a growing move towards permanency planning, to avoid 'drift' and disruption in OOHC placements. Second, there is a greater reliance on

kinship care, especially for Indigenous children, but with some recognition that this is not in itself a panacea for the pressures on OOHC. Third, there is interest in the development both of more professional foster care and a variety of specialist or therapeutic models of care. Overall, there is greater emphasis on the development of a range of appropriate alternative forms of care suited to the needs of individual children.

Conclusions

The States and Territories are moving in similar policy directions in the provision of out-of-home care, even though the current mix of care options and provision differs significantly between jurisdictions. In particular, kinship care is likely to continue to expand as a key type of care option.

Given this, there is a need for a better understanding of trends in fostering generally and in kinship care in particular. More information is needed about the outcomes being achieved in different types of out-of-home care and for different types of children, in particular those achieved in kinship care, and about the models and structures of support that are required to meet the full range of future needs in out-of-home care placements.

While recent studies have highlighted the pressures experienced by grandparents taking on primary care of their grandchildren, further research is also needed on how they can be supported to provide a high quality of care without detrimental effects on their own health and wellbeing.

More work is also needed on evaluation of different forms of treatment foster care in the Australian context, so as to aid the development of a range of effective types of intervention for children with high and complex needs. This would include further research on the circumstances in which forms of residential care might be the preferred option.

1 Introduction

1.1 Background

Children and young people at risk of abuse or neglect in their parental home often require placements (short or extended) in out-of-home care. Placements include group homes or other small residential institutions, but in recent years they have more often taken the form of home-based care with unrelated foster carers, or alternatively with relatives – a form of placement generally described as 'kinship care' or 'relative care'.

A number of recent Australian studies have found that the provision of home-based care is under considerable strain because State authorities are having difficulty recruiting and retaining carers. The pool of potential foster carers appears to have been decreasing and it has been suggested that rising female labour force participation has been a factor. The increasingly complex needs of children requiring care seem also to have discouraged some potential foster care providers.

At the same time, the number of children coming into care has grown significantly in recent years. Between 1996 and 2005 the number of children in out-of-home care rose by 70 per cent (Australian Institute of Health and Welfare, 2006). This development has been variously ascribed to increases in family breakdown, reported child abuse, and drug and alcohol misuse amongst parents. Partly because of the difficulties of recruiting foster carers, much of this increase in demand has been met through kinship care rather than traditional foster care. The majority of kin carers are grandparents, so kinship care needs to be seen significantly as a question of grandparent care. Kinship care is now more common than traditional fostering in some jurisdictions in Australia and is the main form of placement for Indigenous children nationally.

In spite of the growing importance of kinship care, the level of knowledge about it in Australia is still limited. While there is a substantial body of research from overseas (particularly from the US and the UK), Australian research specifically on the topic is relatively scarce (Spence, 2004; Mason *et al.*, 2002; Cashmore *et al*., 2006). In the absence of such research, there have been some concerns about the quality of outcomes for children cared for in kinship settings and about the best ways of providing support for these carers. This has led some States to undertake reviews of policy and practices towards relative carers and to pilot specialist programs of support (eg., Department of Human Services Victoria, 2000a, 2002; Department of Community Development Western Australia, 2001). Some non-governmental family support organisations, such as the Mirabel Foundation for the children of parents who are drug users, have also been examining the topic as it applies to their particular client group and developing specialist programs aimed at relative carers (Patton, 2003).

Recognition of grandparents as key providers of relative care has also led to several recent studies or reviews looking at their legal and financial status, the many pressures they experience and the levels of support available when they become primary carers (COTA National Seniors, 2003; Fitzpatrick and Reeve, 2003; Goodnew and Laverty, 2003; Parliament of Tasmania, 2003; Goodman *et al.*, 2004; Grandparents Australia, 2004; Orb and Davey, 2004; Baldock and Petit, 2006). It should also be noted that much of kinship care takes place informally outside the child protection system, but little of the existing research has examined this area of care.

Given the importance of kinship care within the spectrum of out-of-home care, it is generally recognised that there is a need for a better understanding of trends in fostering generally and in kinship care in particular. More information is needed about the outcomes being achieved in kinship care as opposed to 'stranger' fostering, and about the models and structures of support that are required to meet future needs in out-of-home care placements.

In July 2004, the inter-State Community and Disability Services Ministers' Conference endorsed a National Plan for Foster Children, Young People and Foster Carers, which recommended a number of priorities for action, one of which was investigation and development of emerging models of foster care, including relative/kinship care (CDSMC, 2004). Following that, in 2005, the Senate Community Affairs Committee issued a report *Protecting Vulnerable Children: a National Challenge*, which outlined the role of the Commonwealth in the policy area of child protection and care – one which is primarily a State and Territory legislative responsibility (Senate Community Affairs Committee, 2005). The Committee noted variations across jurisdictions in definitions of when children would be regarded as at risk or needing care and protection, as well as a lack of uniformity in the collection of data. It recommended the development of a national approach to child protection legislation and programs. The Committee also endorsed foster care as a priority area for research, noting that greater numbers of children with complex needs are entering the out-of-home care system.

As a department with a portfolio concerned with the wellbeing of children and with children's services, the Department of Families, Community Services and Indigenous Affairs has a policy interest in this area. Thus as a contribution to this agenda for action, FaCSIA commissioned the Social Policy Research Centre to carry out a review of literature and policy on fostering and kinship care under the 2005 round of the Social Policy Research Services agreement.

1.2 Research aims and methods

The aims of the study were to identify and review trends in out-of-home care in Australia, both in the numbers of children being placed in different types of care and in the various ways of organising and supporting such care that are emerging in different national and State contexts. The study also involved identifying emerging models of care and the drivers of change, and reviewing evidence on the outcomes and strengths or weaknesses of different models.

The research was undertaken by reviewing recent literature from Australia and the main English-speaking countries overseas on trends and models of OOHC provision; analysis of policy documents relating to fostering and kinship care in the States and Territories of Australia; and informal discussions with key policy informants and practitioners in the field in Australia and overseas.

1.3 Report structure

The next Section presents the results of the review of literature on trends in out-of-home-care and the policy questions that arise from a reading of this literature both in Australia and overseas. Section 3 then provides a description of numerical trends in out-of-home care in the different jurisdictions of Australia and discusses the policy directions being pursued by the States and Territories. Section 4 presents conclusions and discusses areas for potential further research.

2 Trends in policy for out of home care of children

2.1 Introduction

Child protection is an area of public concern characterised historically by pendulum swings in policy between emphasis on family maintenance and on child removal (Scott and Swain, 2002). Shifts in policy have often been driven by media attention on high profile cases where social services have been portrayed either as indifferent and ineffective, or alternatively as over-zealous and interfering with family rights. Nevertheless, the current underlying priority in most jurisdictions is to keep children with their original family wherever possible. If children are placed in care, the goal is ultimately to reunite them with their families where appropriate. To this end a range of family support programs exist that seek to prevent separation. Where removal from the original family is seen as necessary, placement within the wider family or community is the preferred option, particularly and most explicitly for Indigenous children.

The out-of-home care systems in Australian States and Territories are all facing similar challenges, in line with those experienced in many other OECD countries. All have experienced an increase in the number of children entering the out-of-home care (OOHC) system in recent years, and many of these children are presenting with increasingly complex and challenging behaviours (Ainsworth and Hansen, 2005; Delfabbro, Osborn and Barber, 2005). There has been a decline in residential placements without a parallel increase in alternative placement options. Most States and Territories are having difficulties attracting and retaining foster carers and all are faced with a limited range of placement options for children in need of protection. The sections that follow review the current state of the main categories of out-of-home care and draw on both Australian and overseas research. This is followed by a discussion of the need to expand the range of OOHC options and concludes with a section on the difficulties inherent in identifying 'effective' OOHC models.

2.2 Foster care in crisis

Australia, like many OECD countries, is experiencing major difficulties attracting and retaining foster carers (Community Service Commission, 2000; Barber and Gilbertson, 2001; CAFWAA, 2002; Carter, 2002; Peakcare, 2002; DHS, 2003; Crime and Misconduct Commission, 2004; Fostering Network, 2004). It is difficult to quantify the shortage of foster carers in Australia as there is no central database indicating current or past numbers and evidence of shortage has been largely anecdotal. However, a study of foster caring in NSW by McHugh *et al.* (2004) found urgent needs for carers in all areas of fostering. Using projections based on ABS Census data, they estimated that between 2003 and 2013 the number of foster carers is likely to increase at a slower rate than that for all women aged over 15, but with no major change in the composition of foster carers by age or labour force status. Regional analysis suggested rates of change commensurate with those for the population as a whole.

In Victoria, an audit of foster care found that the number of carers has been declining since 1995-96, with more carers leaving the system than joining it (Department of Human Services Victoria, 2005).

The crisis in recruitment is placing the OOHC system under great stress. This has focused attention on the sustainability of foster care and whether it can continue to rely on voluntary carers (McHugh *et al.*, 2004). It also has major implications for policies that prioritise home-based care in the hierarchy of placement options.

As mentioned earlier, there is evidence that a key factor underlying the shortage of carers is that children entering OOHC are presenting with increasingly complex needs (Bath, 2002-03; Ainsworth and Hansen, 2005; Delfabbro, Osborn and Barber, 2005). Such needs are wide-ranging, including both physical and psychological disabilities and challenging behaviours. A review of home-based care in Victoria also found that the OOHC system was having to absorb the effects of a crisis in the wider welfare system, with an escalation of complex problems presented by the parents of children coming into care, including psychiatric disabilities, substance abuse and domestic violence (Department of Human Services Victoria, 2003).

Many 'easier to care for' children today benefit from a number of Commonwealth- or State-funded early intervention and family support programs (such as Families First in NSW, for example) and so do not enter the foster care system. Consequently it is children who are beyond the scope of early intervention and support programs, or for whom early intervention has failed to ameliorate the problem, who are the most likely to enter out-of-home care. Provision for high needs children is limited and in most cases the only placement option is with foster or kinship carers. However, many carers struggle to meet the demands of caring for these children (and are often poorly trained to manage difficult behaviours) leading to an increase in placement breakdowns, carer 'burnout' and carers leaving the system (Barber and Delfabbro, 2004). As Ainsworth and Hansen (2005) describe the situation, 'It is not that foster care has failed these children and young people. It is that it is unrealistic to expect foster carers to be able to manage extreme behaviours' (2005: 198).

Such problems are not restricted to Australia. In a large study of out-of-home caring in the US, Jarmon *et al.* (2000) identified a range of complex problems amongst children, including conduct disorders, depression, difficulties at school and impaired social relations. They found that the mental health needs of children were often 'routinely ignored' (2000: 7, 8) and that carers often lacked the skills and the resources to nurture highly deprived children. Similar findings have emerged from UK studies such as those by Sinclair, Gibbs and Wilson (2000) and Triseliotis, Borland and Hill (2000).

2.3 A profile of foster carers

Studies of foster carers in Australia and the UK indicate that they share a number of similar characteristics (Sinclair, Gibbs, and Wilson, 2000; Triseliotis, Borland and Hill, 2000; McHugh 2002; Collis and Butler, 2003; Kirkton, Beecham and Ogilvie, 2003; McHugh *et al.*, 2004).

The average age of carers in a national Australian study (n = 159) was 47 (McHugh 2002), similar to that found in a recent NSW survey (n = 450) (McHugh *et al.*, 2004). Another national survey (n = 812) reported that most carers were in the age band of 45-54 years, with 20 per cent over the age of 54 (AFCA, 2001: 76). It appears that the age profile of foster mothers in NSW and elsewhere has increased over the past two decades, which is consistent with the trend towards delayed family formation for the

general population of mothers. A 1986 study of NSW foster carers found most female carers in the age group 25-49 years (Gain, Ross and Fogg, 1987), whereas in 2004, 70 per cent of female carers in NSW were aged 35-54 years (McHugh *et al.*, 2004). The average age for female carers found in Australia is similar to that found in four UK studies (Sinclair, Gibbs, and Wilson, 2000; Triseliotis, Borland and Hill, 2000; Collis and Butler, 2003; Kirkton, Beecham and Ogilvie, 2003).

At a time when recruitment and retention of foster carers is problematic both in Australia and the UK (Triseliotis, Borland and Hill, 2000, McHugh *et al.*, 2004) the ageing of the carer population, particularly the older more experienced carers, raises the question of who will be found to replace these carers when they retire.

Most Australian foster carers are married or de facto couples (McHugh, 2002), but the proportion who are single parents has been increasing in line with the rise in single female-headed families in Australian society more generally. In 2004, in NSW, single mother foster carers represented around one-quarter of all foster families, compared to just 14 per cent in 1986 (Gain, Ross and Fogg, 1987; McHugh *et al.*, 2004).

The majority of female foster carers are not in paid work. In NSW less than two-fifths (39 per cent) were in paid employment in 2004 and those who were employed were mainly in part-time work (McHugh *et al*., 2004). The employment rate of female foster carers suggests that the nature and demands of providing a fostering service may limit the possibility of full-time involvement in paid work. Alternatively women who foster may choose to be at home because they believe this is best for foster children or they may have already left paid work (e.g. on age pension). A further reason for foster mothers' non-employment of is that some fostering agencies prefer one partner (of a married couple) or the sole carer not to be in paid employment. Intensive fostering, a type of foster care for children aged between 10-17 offered by NSW DoCS, is also generally a full-time caring role for specially recruited carers who receive a higher level of payment than general carers (NSW DoCS, 2006: 11). Some fostering schemes in the UK also operate with full-time carers (Sinclair, Gibbs and Wilson, 2000).

Although there are only limited data available on the incomes of foster carers in Australia, most appear to have only modest household incomes (Crime and Misconduct Commission, 2003: Brandon, 2006; Thorpe, 2006). An analysis of 2001 Census data for NSW suggested that amongst single parents those with weekly incomes of $650 or less were the most likely to foster, while amongst couple families the highest rates of fostering were amongst those with incomes of $850 or less per week (McHugh *et al*., 2004). Similar results were found in a Victorian survey of carers, where 40 per cent of carers surveyed had incomes of $863 or less per week (DHS Victoria, 2003: 126).

Most carers foster one or two children, but a significant minority foster more. McHugh (2002) found that six per cent of carers nationally had four or more foster children and seven per cent had 5-10. A NSW survey found that nearly one in ten carers had four or more children in their care (McHugh *et al.*, 2004). Two Queensland reports on foster carers also indicate carers fostering large numbers of foster children. A 2001 survey of carers (n=477) found 26 per cent of families fostering three or four children and nine per cent fostering between five and nine children (Department of Families Queensland, 2001: 127). A subsequent audit of foster carers (n=869) also

expressed alarm at the increasing numbers of families with six or more foster children, finding some carers at times fostering up to 12 children (Department of Families Queensland, 2003). The audit also reported that the number of families with six or more foster children had increased from 23 in 1997 to 74 at June 2003. The average number of children placed rose from 2.05 in 1997 to 2.96 in 2003.

Data for NSW also suggest that current carers are fostering more children per household than they were two decades ago. In 1986, almost two-thirds of carers had only one child in their care but by 2004 this had dropped to less than half of all carers (48 per cent) (McHugh *et al.*, 2004). Nine per cent of carer households in 2004 had four or more children in their care at the time of the study, compared with less than four per cent households in 1986.

The picture is similar in the UK, with most carers fostering 1-2 children, while at the other end of the scale around one-fifth (18 per cent) fostered three or more, often sibling groups (Trisiliotis, Borland and Hill, 2000: 94). There is also some evidence there of an increase over time in the number of families fostering large numbers of children.

The USA, a country similar to Australia and the UK in many aspects of fostering, has somewhat different carer characteristics. The number of African-American and Hispanic carers tends to reflect the population of children in care.[1] A large study of carers in the State of Illinois found that compared to Australia and the UK the proportion of foster carers who were single parents was also relatively high (46 per cent) and close to two-thirds of all carers (both partnered and single) were in full or part-time employment (Zinn *et al.*, 2006). The age profile of carers in Illinois was younger than that in Australia or the UK, with nearly three-fifths (58 per cent) aged between 30 and 49 years.

2.4 Decline in residential care

The reduction in placement options referred to above is partly linked to a decline in the provision of residential care for children in Australia over the last four decades (Ainsworth, 2001; Ainsworth and Hansen, 2005). Although the decline in residential placements is consistent with international trends, Australia has experienced a steeper decline than most comparable countries. The percentage of residential placements as a proportion of all OOHC placements is estimated at 18 per cent in the US and 13 per cent in England. This compares to about four per cent in Australia (Flynn *et al.*, 2005).[2]

A number of factors have contributed to the decline in residential placements. Australia-specific factors include recognition of problems caused by

[1] The population of fostered children in the US comprises African-American 38 per cent, White 37 per cent, Hispanic, 17 per cent and 'other' eight per cent (Wehrmann, Unrau and Martine, 2006: 92). In the UK, approximately 18 per cent of fostered children are 'black' (precise statistics on ethnicity do not yet exist) (Wilson, 2006: 173). In Australia, 26 per cent of foster children are Indigenous (NSW DoCS, 2006a)

[2] There is considerable variation in the level of residential care across the States and Territories. This is discussed below in Section 3.

institutionalisation and mistreatment of Indigenous children taken from their families (the Stolen Generation) up to the 1970s, and revelations of forced migration of children from Britain and Ireland in the earlier years of the last century (Murray and Rock, 2003). However, residential care for children has also declined internationally as a result of research on children's development. Particularly important have been theories of 'attachment', which gained prominence in the 1960s and 1970s and highlighted the potentially detrimental effect of institutionalisation on children's development (Ainsworth and Hansen, 2005). Alongside these theories were ideas of normalisation based on traditional social constructs of family life.

This decline has been hastened further by the major social policy ideologies of the last two decades. The focus on de-institutionalisation, normalisation and 'least restrictive environment' have all been compatible with government efforts to reduce welfare spending, leading to the closure of relatively costly residential placements (Ainsworth and Hansen, 2005).

One important consequence of the decline in residential placements has been to put additional pressure on an already overburdened foster care sector. Many foster carers receive little training and often lack the skills to manage challenging behaviours, leading in many cases to placement breakdown. The inquiry into child protection in Queensland by the Crime and Misconduct Commission, for example, found that the proportion of children experiencing four or more placements before leaving care rose from 14 per cent in 2001 to 37 per cent in 2003 (Crime and Misconduct Commission, 2004).

Another effect of the reduction in residential placements is that for want of other options many young people leaving care end up in homeless youth programs, particularly the Supported Accommodation Assistance Program (SAAP): 'Thus, SAAP facilities have become the *de facto* residential programmes of the child care and protection system' (Ainsworth and Hansen, 2005: 197). These programs tend to be staffed by workers with only limited training in child protection. Young people leaving care are also at high risk of contact with the juvenile justice system (Cashmore, 2003).

One of the other major drivers behind the closure of residential placement options for children has been their relative cost compared to family-based forms of OOHC. However, residential placements are still provided at considerable cost for children with severe emotional and behavioural problems who cannot be placed in a foster care environment. Over the last few years, there has been a growth in privately run, for-profit residential provision for children in OOHC. These services tend to be expensive and only loosely regulated, and often employ untrained staff (Ainsworth and Hansen, 2005: 197). A recent study by the Association of Children's Welfare Agencies (ACWA) (Flynn *et al.,* 2005) suggests that residential care is growing again, particularly in NSW, partly as a result of a market response by both private and non-governmental organisations offering fee for service placements for young people with high and complex. It was reported that in 2004 the NSW Department of Community Services paid private companies up to $800,000 a year to look after a single highly disturbed child requiring twenty-four hour monitoring and supervision (Horin, 2004). Other children were costing the Department $400,000 a year. They were amongst 169 children who were each costing the Department more than $104,000 in care and accommodation.

The negative consequences of the closure of residential facilities have prompted a reappraisal of the role of this type of care. There is increasing recognition that residential provision must continue to be an integral, albeit small, component of the OOHC system, particularly for children and young people with challenging behaviours, and for sibling groups who cannot be accommodated together in foster families (Ainsworth, 2001; Frensch and Cameron, 2002; Department of Child Safety Queensland, 2004; Department of Human Services Victoria, 2003; Department of Community Services NSW, 2004; Ainsworth and Hansen, 2005; Flynn et al, 2005).

The recent ACWA study gives a useful picture of the state of residential care in NSW (Flynn *et al.*, 2005). The research was based on interviews with Chief Executive Officers, program managers or coordinators of 42 of the 44 residential care providers identified in NSW. The vast majority said their target group was children and young people with high and complex needs. Most of the agencies had a stated approach of developing an individual plan for the resident to address their developmental, educational, physical and social needs. Some reported having a structured approach to developing the plan whereas others had an unstructured approach. All agencies reported having a behaviour management policy. While some agencies said they provided a 'therapeutic' program, the research highlighted the mixed interpretations of the term therapeutic. The researchers found that only very small number of programs could be described as being therapeutic '[if] therapeutic was defined as a program systematically applying a formal clinical therapy' (2005: 20). Very few of the agencies offered specialised programs (e.g. for Indigenous children; for children from a specific cultural background; or for sexually offending behaviour).

A number of agencies were providing individual residential placements. At the time of interview, 108 residents were placed alone with staff, 83 of them in premises designated for one resident only. The vast majority of individual residential placements were due to the child/youth's challenging or violent behaviour. The length of the individual placements across 27 agencies ranged from three nights to three and a half years. Many of the agencies identified a range of disadvantages for youth in individual placements including:

- Social isolation from peers;
- Intense scrutiny, leading to a unnatural 'hothouse' atmosphere;
- Problem of focusing all the attention on one individual;
- Setting of unrealistic expectations about continued individual attention;
- Potential to develop abusive relationships;
- Failure to address issues if a containment approach rather than a therapeutic approach was used;
- Difficulty of ending the placement and moving the resident on to live with others;
- Uncertainty about the duration of the placement and what happens after;
- Difficulty of forming attachments because of many staff working short shifts; and
- Potential stigma for the resident.

The agencies also identified a range of disadvantages for the service system, including the high cost of individual placements, stress on workers and the potential for workers to become over involved with the resident.

The research concluded that residential care remains an essential component of OOHC and that capacity needs to be increased. In particular, many of the participants in the research highlighted the need for specialised programs to deal with populations of children with particular needs. These included children making the transition to independent living; Indigenous children and young people for whom culturally appropriate models were needed; and children with high needs and challenging behaviours, for whom therapeutic residential programs were often appropriate.

Flynn *et al.* also explored agencies' views of how residential care should best be provided. There was a preference for models of care based on small numbers in each residence (two to four children), with a carefully selected mix of residents. Staffing was viewed as crucial in terms of the quality of care provided. Two staffing models suggested included the 'houseparent model' and 'rostered staffing'. The former involves employment of a primary paid carer with a partner or other staff available to provide support or respite. The latter model involves staff with a range of skills, rostered to allow them breaks from full-time caring.

2.5 Growth in kinship care

One of the consequences of fewer placements being provided for children in residential settings has been the growth of kinship care as a leading model of out-of-home care. Kinship care is the placement of a child who cannot be safely cared for by their parents, in the short or long term, with an extended family member.[3] It is the fastest growing form of out-of home care both in Australia and overseas. Although this type of care is by no means a new phenomenon, with many cultures seeing it as a normal element of childrearing and family life, its formalisation within the OOHC system is relatively recent (Ainsworth and Maluccio, 1998).

In Australia, it is the most common form of placement for Indigenous children, in line with the Aboriginal Child Placement Principle, which sets out a hierarchy of placement options. Kinship placement is also increasing for non-Indigenous children in Australia, although this is not as yet enshrined in legislation or policy.[4] Given the minimal guidelines for caseworkers in respect to kinship care for non-Indigenous children, Spence (2004) suggests that many are interpreting the 'least intrusive' principle outlined in OOHC legislation as placement with kin.

Kinship care placements occur on both a formal and informal basis. Formalised arrangements between the kinship carer and the child welfare department fall within statutory responsibility. Other kinship placements are arranged between family members on an informal basis or with the assistance of an agency (ACWA, 2005, personal communication).

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[3] It can also in some cases include placement with another person in the community connected to the child, such as a teacher, neighbour or friend.

[4] Kinship care will be directly legislated for in Victoria in March 2007 with the proclamation of the *Children, Youth and Families Act* 2005 *S10 3 (h)*).

It is unclear how many children are in kinship care in Australia on an informal basis although it is generally believed that there are far more children in the latter than in the former. US research has indicated a possible ratio of about five to one in informal versus formal OOHC in that country (Harden, Clark and Maguire, 1997), but Australian data do not indicate as high a ratio here. Research by the Australian Institute of Health and Welfare suggests that between 1997 and 2000 the proportion of children living with relatives/kin who received some formal financial reimbursement from government grew from 12 per cent to 22 per cent, compared with an increase from seven to 12 per cent in the proportion of children living with relatives who were reimbursed (Johnstone, 2001). More recently Brandon (2004) has analysed the living arrangements of Australian children using data from the HILDA survey. He estimates that, in 2001, 1.2 per cent of children aged under 15 years (around 46,700) did not live in a household containing either of their biological parents (0.71 with grandparent/s only, 0.3 per cent with foster parents only and 0.19 per cent with other relatives only). These data do not contain information about custodial status, but comparing this total with Australian Institute of health and Welfare estimates of the number of children (aged under 17 in this case) in formal, non-institutional out-of-home care in 2001 (around 18,200) (AIHW, 2003) suggests a possible ratio of around three to one in informal versus formal care.

Ainsworth and Maluccio (1998) have put forward a number of explanations for the growth in kinship care. It may, they suggested, be an indication that child welfare agencies have become 'more sensitive to family, racial, ethnic and cultural factors and the importance of family continuity in child development.' (1998: 4). On the other hand, it may simply be a response to the increasing difficulty of attracting and retaining foster carers. They also suggested that the growth in kinship care is compatible with 'the political rhetoric associated with conservative family values' (1998: 4). Another attractive feature of kinship care is that it tends to be cheaper not only than residential care but also than regular foster care. One reason for this may be that, as suggested by some studies, kinship carers tend to receive lower levels of service support than non-kin foster carers (McHugh *et al.*, 2004). This needs to be borne in mind when assessing the relative outcomes of the two types of care.

2.6 Characteristics of kinship carers

Research studies have also shed light on the characteristics of kin carers and have highlighted a number of differences between kin and non-related carers. A 2000 Victorian audit of kinship carers found that they were predominantly single women, usually grandmothers or aunts, with the majority related to the mother of the children. Half were aged 50 years or over. Only one-third were in paid employment and almost half were reliant on a pension or benefit (DHS Victoria, 2000). National data from the ABS also show that in 2003 47 per cent of families where a child was living with just grandparents were 'lone grandparent families' and that 93 per cent of these were lone grandmothers caring for children (ABS, 2005). Brandon's (2004) analysis of children's living arrangements using HILDA data shows that in 2001 43 per cent of children living with a grandparent only were of Aboriginal or Torres Strait Islander descent. This household type also had the second lowest gross household income after lone mother households, had proportionately much higher rates of poor dwelling conditions than other household types and had generally high levels of socioeconomic disadvantage.

UK studies of kin carers paint a similar picture, with most kin carers being maternal or paternal grandparents or aunts, and largely reliant on pensions. One-third of kin carers were found to be living in poverty compared to 19 per cent of all parent-headed families (Goodman *et al.*, 2004). US studies on kin carers show that they are more likely to be African-American and to be older, single females. Compared to non-related foster carers, they are generally less well educated, living in poorer financial circumstances, in poorer health and less likely to receive supports and services (US DHHS, 2000; Sykes *et al.*, 2001; Geen, 2004; Harden *et al.*, 2004; Iglehart, 2004). Compared to the homes of non-related foster families, those of kinship care families were also found to be more crowded, less safe and less clean.

The recognition that kinship care is significantly an issue of *grandparent care* has led to examination in Australia of the experience of being a grandparent carer and of the difficulties often experienced in that role (COTA National Seniors, 2003; Goodnew and Laverty, 2003; Parliament of Tasmania, 2003; Goodman *et al.*, 2004; Grandparents Australia, 2004; Orb and Davey, 2004; Baldock and Petit, 2006). The findings of these surveys and enquiries are all similar, in that grandparents who take on primary care of their grandchildren tend to express feeling isolated and overwhelmed by the (frequently sudden) responsibilities placed on them. Taking on primary care at an older age can also place a high level of stress on their other relationships and on their health.

This is exacerbated by what is generally perceived as insufficient financial and service support. Dealing with authorities, including Centrelink for income support payments, is often made more problematic by the legal and financial ambiguities of their circumstances, where formal care orders might not have been made and where access to legal aid is usually unavailable. Commonly the reason for their having to take on caring is drug abuse by the child's parent/s. This can create anxiety about other people's reactions to what has happened to their families, further adding to the stress. Many of the grandparents surveyed felt governments were letting them down: they were asked to take on responsibility for often traumatised grandchildren but then received insufficient recognition and support.

In spite of the difficulties, grandparents often emphasised the positive aspects of having their grandchildren living with them and their determination to protect the children's welfare. What was needed was greater support in doing this. As one step towards rectifying this situation several States have set up specific support services for grandparent carers.

2.7 Evidence on the outcomes of kinship care

Despite the growth in kinship care in recent years there is little conclusive evidence on whether it provides better outcomes for children than other forms of care. In an audit of recent Australian child protection and out-of-home care research, Cashmore *et al.* (2006) note that only a handful of studies focus on kinship care. Hence there is a reliance on insights from overseas research, mostly from the US (Spence, 2004; McHugh, 2005; Dunne and Kettler, 2006).

The literature identifies a number of perceived benefits of kinship care. It is seen as being in the best interests of the child because it is more likely to help maintain shared biological, emotional and cultural connections (Wilson and Chipunga, 1996; Beeman

and Boisen, 1998; Mason, 2002; Cuddeback, 2004). It appears to offer greater placement stability. It is generally preferred by family members because they know their children are not placed with 'strangers' (Greeff, 1999; US DHHS, 2000; Tregeagle, 2002). However, many kin carers accept their caring role because there is no alternative placement option and some end up caring for longer than originally planned (Mason at al., 2002; Testa and Slack, 2002; Goodnew and Laverty, 2004).

There are also a several studies suggesting that kinship care is less resource intensive for government providers. First, kin carers tend not be assessed as thoroughly by social services as non-related carers and most do not receive initial or ongoing training. Kin carers are less likely to be supervised or supported regularly. They are less likely to have a caseworker and although many receive financial support it is often less than that received by non-related foster carers (US DHHS, 2000; Tregeagle, 2002; Cuddeback, 2004; Geen, 2004; Lorkovich *et al.*, 2004; McHugh *et al.*, 2004). These findings tend to support those of the surveys of grandparent carers cited above.

The question of whether children in this type of care experience better outcomes than those in other forms of OOHC depends on how outcomes are defined (McHugh, 2005). It also depends on how long-term a perspective needs to be taken to judge the durability of a particular outcome. Research on outcomes for children in kinship care focuses on a wide range of different measures. These include placement location relative to birth home; the ability to keep sibling groups together; placement stability and security; reunification with birth parents or other permanent care arrangements; children's development, well-being and happiness; and health, behavioural and educational outcomes.

A number of studies that have reported that children placed with kin carers were less likely to have multiple placements than those with non-kin carers. However, they tended to remain in the placement longer and were less likely to be reunited with their birth parents (US DHHS, 2000; Cuddeback, 2004; Geen, 2004). Greater access to children and the reduced stigma associated with kinship care may also reduce parents' motivation to reunify formally with their children (Chipman, Wells and Johnson, 2002; Geen, 2004).

Research on the stability of kinship placements paints a conflicting picture. Some studies have found that that kinship care placements were more stable than non-related care placements and children in kin care had fewer prior placements (Cuddeback, 2004). Other studies, by contrast, have found that kinship care placements were just as likely to breakdown as non-kin placements (Geen, 2004).

McHugh (2005) notes that there is insufficient research on the long-term outcomes of children placed in kinship care to permit an assessment of the durability of outcomes. One longitudinal study in the US found little discernible difference in adult functioning between children placed in kin and non-kin care (Geen, 2004). Another found that women who had been in kinship care had poorer emotional wellbeing, but not poorer physical health, than women who had lived with a biological or adoptive parent (Carpenter and Clyman, 2004).

A recent review of Australian and overseas literature on social and emotional issues for children in kinship care found that children placed with kinship carers tended to display a range of problems that could impact on their lives as adults (Dunne and

Kettler, 2006). However, the authors concluded that existing research was unable adequately to differentiate the effects of kinship care from pre-existing difficulties and that few studies compared the outcomes of kinship care directly with those of other forms of care.

Overall, review of outcome studies for children in kinship care presents a conflicting picture of the benefits and disadvantages, making the task of drawing firm conclusions about it difficult. Many commentators argue that more research is needed, particularly Australian research, to allow for a more considered assessment of the outcomes (Ainsworth and Maluccio, 1998; Spence, 2004; McHugh, 2005; Cashmore *et al.*, 2006).

Another subject of ongoing debate has been whether kinship care properly belongs inside or outside the formal child welfare system and what levels of support and provision can and should be provided. Several Australian States are in the process of determining their policies on this question (Spence, 2004). A paper by Barnardos Australia (2001) has suggested that the inclusion of kinship care in the formal child welfare system would subject carers to unnecessary surveillance and monitoring, reduce the sense of normality for children in kinship placements, and make placements less stable. The paper also argued that the inclusion of kinship care within the system would have a major impact on child welfare resources. By spreading expertise too thinly through increased caseloads, children in foster and residential care might be deprived of proper monitoring.

Cashmore (2001), by contrast, has argued that while many children in kinship care do not require long-term monitoring and supervision, it is nevertheless wise to monitor all children at least in the early stages of the placement. She also contended that if kinship care is excluded from the child welfare system, many children will not benefit 'from some of the support that being in care provides' (2001: 7). She argued that '[n]either blanket exclusion nor blanket inclusion is the best policy' for children in kinship care, but that the exclusion of kinship care from the OOHC system would on balance be more harmful than inclusion. A more sensitive and differentiated approach is required to provide support and supervision to kin carers.

Dunne and Kettler (2006) similarly argue that in the absence of clear evidence on kinship care outcomes there is a need for continuing assessment and interventions to support both children in kinship care and their carers.

2.8 The development of 'treatment foster care' and other innovative models

The increasing number of high needs children entering OOHC in recent years has led to the development of a range of foster care options that incorporate a therapeutic component. Given the profusion of programs (see below for more discussion of this) it is not possible in the context of this review to document the full range of options available. It is also hard to draw firm conclusions about the programs, given the methodological difficulties that have been identified in a number of reviews and evaluations in this field (see section 2.11 below for a discussion of these problems). Rather, this section outlines a small number of key foster care programs identified in the literature that have a therapeutic component, mostly from the US, which have been influential in the pattern of program development in Australia and other countries.

No existing research has been identified which provides a thorough overview of the current range of therapeutic/treatment foster care options in Australia. A review being undertaken at present by Delfabbro and Osborn (2005) has identified 20 Australian OOHC programs that are specifically designed for children with significant emotional and behavioural disorders and have a therapeutic/treatment focus. In treatment foster care, carers are trained and supported to undertake individualised interventions within their own home. Sometimes these interventions are designed and supervised by mental health professionals. However, it is unclear at this stage what proportion of these programs are home-based or residential-based, and how many of them have been subject to evaluation.

The rationale for the development of treatment foster care programs is the belief that many children in OOHC 'require the intensive structure of residential care [but] benefit from the influence of a 'true' family environment' (Reddy and Pfeiffer, 1997: 581). Many commentators argue that treatment foster care is preferable to residential care because it is less expensive, produces comparable results and offers a less restrictive treatment environment (Reddy and Pfeiffer, 1997; Barth, 2005).

Reddy and Pfeiffer (1997) conducted a review of 40 published outcome studies of treatment foster care programs. They coded the studies against five dependent variables to assess the impact of treatment foster care: placement permanency, behaviour problems, discharge status, social skills and psychological adjustment. They found that treatment foster care produced large positive effects on placement permanency and social skills. Medium positive effects were found in reducing behaviour problems, improving psychological adjustment and reducing restrictiveness of post-discharge placement.

The authors concluded that the review offers a favourable outlook on the efficacy of treatment foster care. However, they advised caution in interpreting the findings because of the methodological limitations of many of the studies. Moreover, few had collected data at the time of program completion or conducted any follow-up assessment, thus 'precluding a test of the durability and generalisability of treatment foster care outcomes' (Reddy and Pfeiffer, 1997: 581).

One of the most clearly articulated treatment foster care models is Multidimensional Treatment Foster Care (MTFC). This has been influential both in Australia and in the United Kingdom. The MTFC program model was developed by the Oregon Social Learning Center. It originally targeted serious and chronic juvenile offenders, but has since been adapted for severely emotionally disturbed children and youth involved with juvenile justice, mental health and child welfare (Multidimensional Treatment Foster Care, <http://www.mtfc.com/index.html>, viewed 19/09/05).

The goals of MTFC are to decrease delinquent behaviour and increase participation in developmentally appropriate pro-social activities. This is described as being achieved through close supervision; fair and consistent limits; predictable consequences for rule breaking; a supportive relationship with at least one mentoring adult; and limited exposure and access to delinquent peers. MTFC foster parents are carefully recruited, trained, supported and matched with youth. They work closely with case managers, program staff and participate in weekly supervision/support meetings (Fisher and Chamberlain, 2000).

Fisher and Chamberlain (2000) also outline evaluation findings comparing the outcomes of youth in MTFC and group care. At one year after leaving care, boys in the MTFC program had significantly fewer arrests than boys in group care. In addition, boys in MTFC reported engaging in significantly fewer delinquent activities than the comparison group. Two years of post-discharge data showed that those in MTFC continued to demonstrate better outcomes than the comparison group.

Two other examples of innovative foster care models that do not specifically incorporate a therapeutic intervention are described below.

The aim of the Shared Parenting project in Ontario, Canada, was to develop a model of foster care in which the role of the foster family was to become one of an extended family rather than a substitute for it. Although the child was in the care of a foster family who received specialised training, there was ongoing contact between the foster family and the birth family. The role of the foster family was to offer support, advice and guidance to the birth parents to enhance their parenting skills. The objectives of the model were: to reduce the number of placement breakdowns; reduce the amount of time children spend in care; enhance natural parents' parenting skills; improve family functioning; and enhance the retention and recruitment of foster parents by recognising their expertise (Landy and Munro, 1998).

The findings from a small-scale evaluation showed that only one-third of the children in the program (13 in all) were successfully returned home. However, the authors point out that most of the families referred to the program had multiple risk factors, with at least one factor at extreme risk, and 'would require a range of intensive, sophisticated outreach and long-term services in order to significantly improve their level of functioning and to allow their children to return home safely' (Landy and Munro, 1998: 316). Therefore they conclude that the program may be better suited to higher functioning children and more stable families.

Another innovative model is the Hope Meadows program from Illinois, USA, which was launched in 1994 to facilitate the adoption of children who had spent a number of years 'trapped' in the foster care system. It is an intergenerational planned community composed of senior citizens, foster and adoptive families, children and program staff. The program provides child welfare services, on-site therapy and counselling, and weekly parent training. A key component is the group of senior citizens who live in the neighbourhood and receive below-market rate rent in return for six hours a week of volunteer work (tutoring, playing games, child care, guarding school crossings, playground supervisions etc.). While there are a number of articles describing this model and its operations (such as Eheart and Hopping, 2001), these mainly derive from those involved in the program and there do not appear to be any independent evaluations of the program as yet.

2.9 Independent living arrangements

A further important aspect of out-of-home care systems is what happens to young people when they reach the age at which the Government no longer has statutory responsibility for them. It is well known that young people who have spent many of their childhood years in statutory care face significant challenges when making the transition to independent living. These challenges can be compounded by factors such as their experiences before coming into care; lack of stability in care; poor educational

performance; low school completion rates; limited contact with family members; and lack of support through the early transition to independence. Consequently, they are at greater risk of homelessness and insecure housing, unemployment, poverty, limited social support networks, drug and alcohol use/abuse, early parenthood and poor mental health (Cashmore, 2003).

Given the increased likelihood of negative outcomes for young people leaving care, there is a widely recognised need for services that assist with making the transition to independent living and for aftercare support during a period following leaving care (Clay and Coffey, 2003; Crime and Misconduct Commission, 2004; Department of Community Services NSW, 2004; Flynn *et al.*, 2005).

Several States have introduced schemes of transitional housing and support. These include Victoria's Leaving Care Housing and Support Initiative, and 'lead tenant' programs in NSW, operated through community housing and other services organisations. Under the lead tenant model, a volunteer tenant lives rent-free with a household of young people and helps them develop independent living skills. A recent review of good practice models for meeting the needs of homeless young people in rural areas called for expansion of such schemes (Beer *et al.*, 2005).

Another concept that is gaining support as a potentially useful model for young people leaving care, as well as for other disadvantaged young people, is the 'foyer' – a combined housing/employment/education support program. The foyer concept originated in France, with the aim of tackling youth unemployment and youth homelessness. There are over 500 foyers in France, which are all fully funded by government and aimed at young people aged 16-25 years. The foyer concept has also been imported into the UK in recent years and after a number of pilot studies indicated positive outcomes (eg, Anderson and Quilgars, 1995) a national umbrella organisation has been established to oversee the roll out of the model more widely. There are currently some 150 foyers in the UK, which tend to work with more disadvantaged youth than those in France and have a greater emphasis on education and training. They are not without their critics, however. Allen (2001) has argued that the spread of foyers in the UK has taken place on the basis of ideology and without clear evidence of their effectiveness, citing qualitative research indicating that young people often find them repressive and more concerned with policing conduct than assisting with job search.

In recent years, pilot foyers have been established in two locations in Australia. Findings from an interim evaluation of the one of these pilot projects lend strong support for expansion of the model (Randolph and Wood, 2005). The Miller Live 'N' Learn Campus was established in Sydney in 2002. The campus provides accommodation, life skills and training opportunities for young people aged 16-25 years with low support needs who are in vulnerable housing situations. The development of the Campus model was based on a number of criteria:

- assisting vulnerable and disadvantaged young people;
- providing safe and affordable accommodation;
- supporting access and creative approaches to training, education and employment; and
- integrated and holistic response to the range of needs young people may have.

The Campus model aims to prevent a number of possible negative outcomes for the young people and evidence suggests that it has helped to stop young people dropping out of education and becoming homeless. Findings from the first year of the study show positive results, with residents remaining in education, completing courses and engaging in employment. Additional positive outcomes were reported in terms of life skills, social interaction and improved emotional resilience. The authors suggest that the foyer model is best viewed as a preventative initiative that 'reduces the risk of negative influences on the young residents, such as petty crime, poor mental health and homelessness' (Randolph and Wood, 2005: 66).

Clay and Coffey (2003) contend that the foyer model 'has some huge potential to provide young people with a 'half-way' option between SAAP and out-of-home care and provides them the opportunity of less intrusive support provision' (2003: 24). Beer *et al.* (2005) also conclude that foyer models have potential as a practical strategy for dealing with youth homelessness, particularly in rural areas. However, they argue that foyers should be re-badged as 'structured learning tenancies' to emphasise the housing component and the positive learning outcomes associated with the model.

2.10 OOHC options and the 'continuum of care'

Currently the vast majority of children in need of OOHC placement in Australia are placed in home-based care.[5] The policy preference for home-based care appears to have been driven by three major factors: a lack of alternative placement options; the relative cost compared to other more expensive options; and, not least, the 'continuum of care' perspective on the ideal hierarchy of options.

The continuum of care perspective

Traditionally, out-of-home care placement options have been viewed along a continuum, with the least intrusive and restrictive options at one end and the most restrictive at the other (Herrick, Williams and Pecora, 2004, cited in Delfabbro *et al.*, 2005). This continuum of placement options starts with keeping the child with its biological parents, but where this is not possible placement with relatives is considered to be the next best option. The next preferred placement option is adoption, followed by regular foster care, then treatment foster care. These are then followed by increasingly restrictive placement options: placement in a youth shelter, a group home, a residential centre, a psychiatric hospital and finally placement in a correctional setting.

According to Delfabbro *et al.* (2005), the continuum of care model has been the cornerstone of OOHC placement decisions for two reasons. First, it has been assumed that children fare better in settings that most resemble their own community. Secondly, reports of abuse in residential facilities have led to the conclusion that non-family-based forms of care are damaging to children and should be a policy of last resort.

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[5] In June 2004, 94 per cent of children in OOHC were placed in home-based care with either foster carers or kin carers, although the proportion with foster or kin carers varies from State to State (Australian Institute of Health Welfare, 2005).

Many experts in the field have recently begun to question the merits of the continuum of care perspective and the hierarchy of preferred placement options it sets out. Research highlighting placement breakdowns has led many to the conclusion that fostering is not an appropriate placement option for all children in need of out-of-home care (Ainsworth and Hansen, 2005; Delfabbro *et al*., 2005). The reliance on home-based care and a lack of alternative options means that foster carers who are caring for high needs children are simply provided with extra payments or loadings to supplement their regular foster care payment. When this is not an option, private not-for-profit organisations are called upon to provide support for high needs children (Delfabbro *et al.*, 2005: 12). Consequently, it is now widely accepted among practitioners, policy makers and researchers that there is a need to expand the range of OOHC options to cater for a heterogeneous OOHC population with differing needs (Bath, 2002-03; Ainsworth and Hansen, 2005; DHS, 2003; DoCS, 2004**;** DCS, 2004).

However, the continuum of care perspective still tends to dominate OOHC policy, despite the recognised need for an expansion of care options. Delfabbro *et al.* (2005) argue that the dominance of the model is based on simple categorisations of OOHC options and overly generalised views of different categories that 'may be open to considerable variation or flexibility.' (2005: 13).

Beyond the continuum of care

Anglin (2004) believes the term 'system of care', which has gained increasing currency in recent years, is an improvement on the term 'continuum of care', which tends to regard residential care as a last resort. He argues that this has led to what he terms foster care 'drift' (the tendency for young people to be passed on from one placement to another without a clear focus on longer-term planning) and the assumption that residential care is not appropriate for any child. He notes that while it is evident that placement in a group home can be the preferred option for some young people, there is much confusion about when and how to determine if a child needs a residential rather than a foster care placement. However, research by Delfabbro and Barber (2003) suggests that it is possible to make accurate predictions about whether children in foster care are likely to experience placement breakdown. They suggest that the methodology and analysis they undertook in their study could be useful for identifying the children most suitable for more intensive care arrangements.

Delfabbro *et al.* (2005) also support a move away from the continuum perspective and suggest instead that a 'dimensions of care' perspective should be taken. They argue that when making OOHC placement decisions it is important to move beyond 'arbitrary classifications' such as residential, home or foster care, and instead focus on the dimensions of care that may be most useful in differentiating between programs. The three most important dimensions they suggest are: the physical arrangement and location of the service; its staffing arrangements; and the nature of the living environment and the interventions or services provided.

Their argument is that this perspective provides a more flexible framework for designing programs based on combinations of different service elements 'that are not necessarily bound by debates concerning the relative advantages of residential versus foster care' (2005: 18). They also contend that this perspective makes it possible to move beyond rigid assumptions that all foster care or residential programs are the same. They suggest that the dimensions perspective 'would be one useful step towards

overcoming ideology and directing discussion towards the more central goal of what works most effectively to meet the needs of all children and young people in out-of-home care' (2005: 18).

Heterogeneity of OOHC population

A further factor driving the need to expand the range of placements options is the recognition of the heterogeneity of the OOHC population. As discussed earlier, in recent years there has been an increase in the number of children entering OOHC presenting with high needs and challenging behaviours. Too often, these children are placed in home-based care to which they are not suited and with carers who cannot manage their challenging behaviours. Therefore Bath (2005) emphasises the need for forms of OOHC that are not just about providing accommodation and containment but also incorporate therapeutic interventions.

Bath argues that the starting point for developing any models of OOHC for high needs children should be to consider who these children are, what their developmental needs are and what needs have not been addressed. It is also important to recognise that high needs children are themselves a heterogeneous group with a range of difficulties including intellectual, behavioural and trauma-based problems. Given this heterogeneity, it is vital to develop programs that are tailored to specific groups of young people with the same identified issue (Bath, 2005, personal communication).

2.11 Difficulties of identifying 'effective' OOHC models

A key challenge facing both practitioners and researchers in the out-of-home care sector is how to identify 'effective' OOHC models and programs. This task is complicated by the profusion of programs, variations in evaluation methodologies and the difficulties inherent in identifying and replicating models.

Profusion of programs

The sheer multitude of models/programs makes the task of assessing the worth of one program over another particularly difficult. To give an idea of the range of OOHC placement options that exist, Delfabbro and Osborn (2005) have described a review they are currently undertaking of international OOHC programs that have been specifically designed for children with significant emotional and behavioural disorders and which have a therapeutic/treatment focus. The aim of the review is to: document the range of international placement options; profile types of intervention; obtain evidence concerning best practice and evaluative evidence; and identify unsuitable options before they arrive in Australia. To date they have identified 725 programs falling into this category in the US, 50 in Canada and 20 in Australia.

Methodological concerns

A range of methodological concerns also adds to the complexity of identifying 'effective' OOHC models. While there exists a plethora of studies on outcomes of individual programmes, studies that attempt to aggregate outcome data from several programs suffer from some methodological problems (Ainsworth, 2001; Frensch and Cameron, 2002).

Frensch and Cameron conducted a review of studies of the effectiveness of residential treatment delivered in group home settings and residential treatment centres. They

highlighted a number of methodological problems in many of the studies considered in the review: general lack of progress in the evaluation of residential services; what constitutes residential treatment remains unclear; many evaluations have no identifiable design; the selection of outcome criteria can be problematic. Thus they concluded that the '[given] the methodological flaws in many studies of residential treatment, conclusions about the effectiveness of residential treatment need to be made cautiously' (2002: 310).

A similar attempt by Curtis *et al.* (2001) also highlights the methodological difficulties of trying to compare the outcomes of several residential group care and therapeutic foster care studies. Methodological inconsistencies including inadequate sample sizes, the lack of standardised measures, the lack of comparison groups and variation in statistical analyses undertaken were all noted by the authors as making the task particularly difficult. They concluded that a more systematic approach to evaluation and more longitudinal research are both imperative to achieve the goal of making informed and successful out-of-home placement decisions.

Even when longitudinal data are available, the example of the Odyssey Project (a multi-site US study of children and youth in residential and therapeutic foster care) underscores the difficulties inherent in such evaluations (Drais-Parillo *et al.*, 2004). The aim of the Odyssey Project evaluation was to describe the differences in outcomes for children based in residential group care compared with those in therapeutic foster care. The study sample was based on children who entered residential group care and therapeutic foster care programs between April 1994 and January 2000. The children were assessed when they entered care and post-care, at six months, 1 year and 2 years. A major limitation of the study, however, was that post-discharge outcomes data were available for only 10 per cent of the original sample. The available data produced very mixed results, with children in residential group care performing better on some outcomes than those in therapeutic foster care while the reverse was also evident for other outcome measures.

Another factor that complicates the assessment of effective models of OOHC is the independence or otherwise of the evaluators. As described earlier, one of the most influential OOHC models is the Oregon Social Learning Center's Multidimensional Treatment Foster Care. However, the developers of the model have themselves conducted most of the evaluation studies and promoted the model widely. This raises a question as to whether there may be a conflict of interest and a potential perception of bias in the findings.

Despite the methodological limitations of the research into models of OOHC, some commentators are prepared to argue for the implementation of certain categories of care in preference to others. Barth (2005), for example, is supportive of treatment foster care and multi-systemic therapy even though they have not been thoroughly evaluated, because 'in general, they appear to outperform group care' (2005: 625).

Identifying and replicating models

Ainsworth (2004) contends that only programs that have been rigorously evaluated and shown to be effective 'model programs' should be considered. Once an effective model of OOHC has been identified, the next challenge is how such a model can be to successfully replicated elsewhere. Ainsworth stresses the importance of maintaining

program integrity when attempting to replicate a model and gives the example of how the Oregon Social Learning Center has managed the replication of their Multidimensional Treatment Foster Care (MTFC) program in other locations.

After developing the MTFC model, the Center created a separate organisation (TFC Consultants Inc.) that focuses solely on planning, implementing and monitoring the replication of MTFC in other agencies. This aims to ensure that accountability and program integrity are maintained.

Ainsworth (2004) emphasises that technical assistance is essential if the programs are not being implemented by the program developers. He makes the point that unless the program is replicated in such a way that maintains the program integrity of the model then 'the evidence taken from the original program that indicated its effectiveness will no longer have any legitimacy' (2004: 34). One reason why model programs are not replicated exactly as they are intended in Australia is partly a matter of cost (Ainsworth, 2005, personal communication). There is a tendency to adopt overseas models but adapt them for the Australian context, predominantly because of resource limitations. This then yields a program model that differs from the original, reducing the likelihood that the evidence on program outcomes and effectiveness will remain applicable to the modified program.

The recent ACWA review of residential care in New South Wales (Flynn *et al.*, 2005) also warns of the dangers of replicating models of OOHC that have been developed overseas in an Australian context: 'There needs to be more discussion about what form therapeutic programs should take in NSW, acknowledging that residential treatment models used in other countries may not be appropriate in the NSW context.' (2005: 48).

Bath (2005) also emphasises the need to develop effective models for the Australian context. He stresses the importance of looking overseas to gather as much evidence as possible to identify aspects of programs that work. The next stage is to assemble conceptually robust models for the Australian context by selecting elements of programs that have a sound research basis.

3 Recent developments in out of home care for children in the States and Territories of Australia

3.1 Trends in the number of children in care

As stated earlier, the current emphasis of policy and practice is to keep children with their family wherever possible. If children are placed in care the goal is ultimately to reunite them with their family. Where removal from the original family is regarded as necessary, placement within the wider family or community is the preferred option, particularly for Indigenous children (under the Aboriginal Child Placement Principle).

States and Territories are responsible for funding OOHC, but non-governmental organisations are often contracted to provide these services. Children are placed in care either voluntarily or by court order.

In spite of the policy principle emphasising family maintenance, between June 1996 and June 2005 the number of children in out-of-home care in Australia increased by 70 per cent (Australian Institute of Health and Welfare, 2006). The placement rate of Indigenous children in out-of-home care over this period was more than six times that for other Australian children (Cashmore *et al.*, 2006).

The variety of living arrangements for children in OOHC include:

- Home-based care: a child is placed in home of a carer who is reimbursed for expenses incurred. This includes:
  - Relative/kinship care – carer is a family member or other person with pre-existing relationship with the child
  - Foster or community care
  - Other home-based arrangements
- Residential care
- Independent living (e.g. private boarding arrangements)
- Other

Table 1 shows the numbers of children in out of home care in June 2005, as collected by the Australian Institute of Health and Welfare (AIHW). It should be noted that there are limitations to these data because of widespread inter-jurisdictional differences in definitions and in methods of data collection. We need also to remember that many children live informally in care with relatives other than their biological parents – where these relatives do not necessarily receive any special support or financial assistance from the authorities.

The total number of children in formal out-of-home care across Australia in June 2005 was just under 23,695 – a nine per cent increase on the previous year (Australian Institute of Health and Welfare, 2005). There were wide variations by State and Territory that are only partly attributable to the relative populations of children (Table 1). For example there were just over 9,000 children in care in NSW, but only 4,400 in Victoria, suggesting a somewhat more interventionist approach in the former State. Four per cent of children in formal OOHC nationally were in residential care, 57 per cent were in foster care and 42 per cent were in relative or kinship care (not including

children in informal care). Only one per cent were in independent living arrangements and a further one per cent in some other unspecified form of home-based care.

The proportion of children in different types of care also varies significantly, as shown more clearly in Figure 1. It is apparent that home-based care (mostly foster and kinship care) predominates overall, accounting for 95 per cent of children in care across Australia. However, several of the jurisdictions, particularly South Australia, Queensland and the Northern Territory, are much more reliant on foster care than NSW, which in turn has easily the highest rate of kinship care. Although the overall number in residential care is small, the rate of use of this type of care varies significantly between jurisdictions, from one per cent in Queensland to seven per cent in Victoria and 16 per cent in the ACT. Most of those children in residential care are in Victoria or in NSW. These jurisdictional differences appear to stem from a combination of historical and recent supply and demand factors, as well as somewhat different policy emphases and to a smaller extent differences in definition of types of care arrangements.

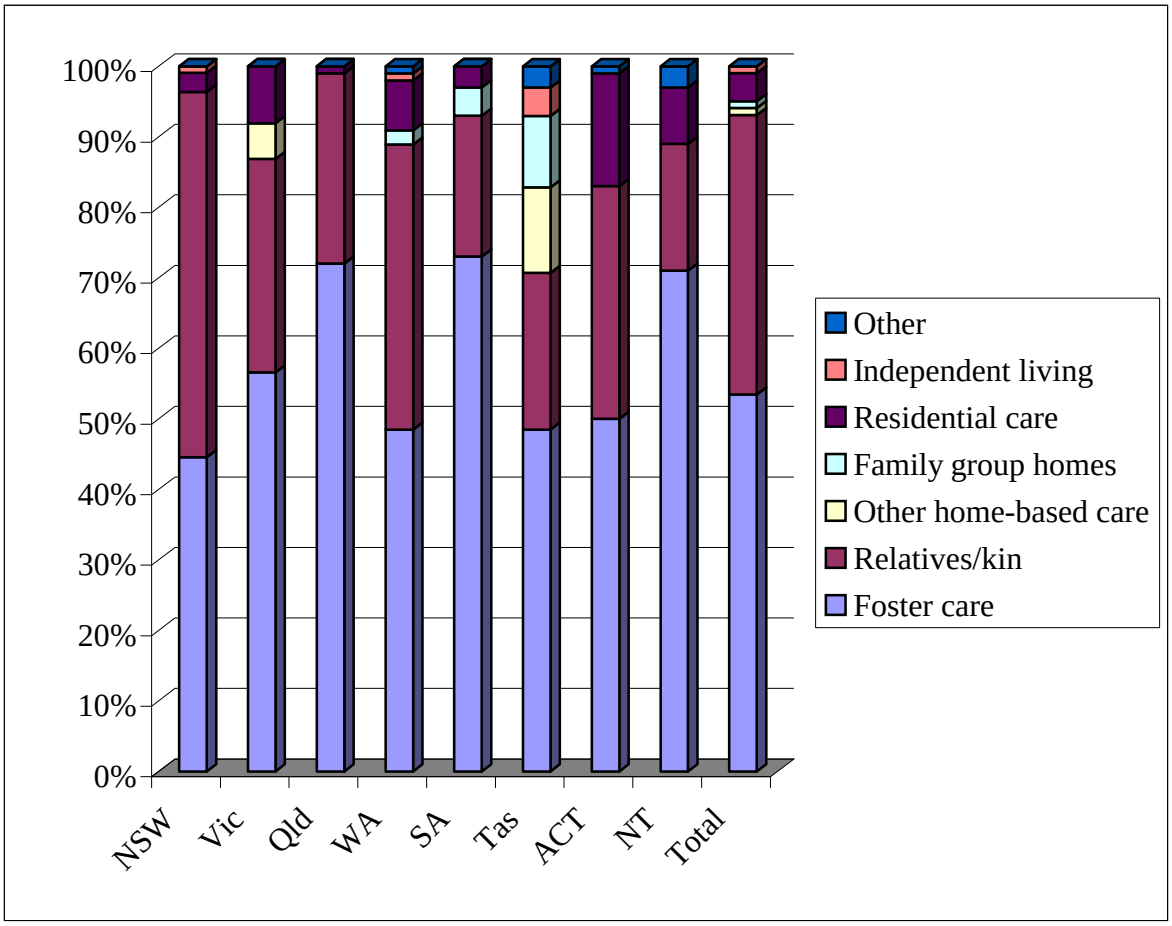
Table 1: Children in out of home care: type of placement, by State and Territory, at 30 June 2005

Type of placement	NSW	Vic	Qld	WA[(a)]	SA	Tas	ACT	NT	Total
				Number					
Foster care	3,620	2,448	4,085	882	967	278	170	230	12,680
Relatives/kin	5,292	1,335	1,511	737	264	126	113	57	9,435
Other home-based care	-	238	-	-	4	70	-	-	312
Total home-based care	*8,912*	*4,021*	*5,596*	*1,619*	*1,235*	*474*	*283*	*287*	*22,427*
Family group homes	..	..	..	43	54	58	..	..	155
Residential care	268	365	61	124	40	-	56	25	939
Independent living	50	22	-	26	-	25	1	1	125
Other[(c)]	-	-	-	17	-	19	2	11	49
Total	9,230	4,408	5,657	1,829	1,329	576	342	324	23,695
				%					
Foster care	39	56	72	48	73	48	50	71	54
Relatives/kin	57	30	27	40	20	22	33	18	40
Other home-based care	-	5	-	-	-	12	-	-	1
Total home-based care	*97*	*91*	*99*	*89*	*93*	*82*	*83*	*89*	*95*
Family group homes	..	..	..	2	4	10	..	..	1
Residential care	3	8	1	7	3	-	16	8	4
Independent living	1	-	-	1	-	4	-	-	1
Other[(c)]	-	-	-	1	-	3	1	3	-
Total	100	100	100	100	100	100	100	100	100

(a) The data include a small number of children who were placed with relatives who were not reimbursed.
(b) 'Other' includes unknown living arrangements.

Source: Australian Institute of Health and Welfare (2005), *Child Protection Australia 2004-05*, Child Welfare Series Number 38, AIHW, Canberra

Figure 1: Distribution of children in formal out-of-home care in Australia, June 2005, by type of care and State/Territory



1. The data include a small number of children who were placed with relatives who were not reimbursed (ie informal).

2. 'Other' includes unknown living arrangements.

Source: Australian Institute of Health and Welfare (2006), *Child Protection Australia 2004-05*, Child Welfare Series Number 38, AIHW, Canberra.

The numbers coming into care each year tend to fluctuate somewhat, so that in 2002-03, fewer children entered care than in the previous year across all jurisdictions except for the ACT and Queensland, but in 2004-05 the numbers rose again in most jurisdictions. However, each year fewer children are discharged than admitted, thus leading to a steady increase in the stock. In 2004, 38 per cent of those entering care were aged under five years and 13 per cent aged under one year.

3.2 Indigenous children in out of home care

Indigenous children are heavily over-represented in OOHC relative to other Australian children. Nationally the rate of ATSI children in OOHC at 30 June 2005 was 26.4 per 1,000 aged 0-17, but it varied from 8.9 per 1,000 in the Northern Territory to 40.7 per 1,000 in Victoria. In Victoria the rate of ATSI children in OOHC

was 12 times the rate for other children and in NSW and ACT it was nine times the rate. The underlying reasons for this over-representation are complex, and include historical patterns of trauma, socio-economic disadvantage and family violence, but the immediate causes include a much higher rate of reporting of child neglect and abuse amongst Indigenous communities than in non-Indigenous communities (Richardson, 2005).

The Aboriginal Child Placement Principle states a preference for placement of children with Indigenous carers. It has an order of preference starting with the child's extended family, followed by other members of the child's Indigenous kinship group, then with other Indigenous people. All jurisdictions have adopted the ACPP either in legislation or policy.

Since the late 1970s there has been some recognition of and funding for Aboriginal-controlled child welfare services through the Aboriginal and Islander Child Care Agency (AICCA). A recent review of these agencies concluded that they were awkwardly placed in terms of being mainly funded by the Commonwealth in an area of State and Territory legislative responsibility, and thus have received little support from government apart from their historic funding (RPR Consulting, 2005). The review found that the program has been isolated from most areas of policy development within the Department of Family and Community Services in recent years, which has compounded their marginalisation. While a number of the larger agencies have been successful, lack of resources has tended to lead to a diminished organisational capacity in some services. The report concludes that the AICCA program still has the capacity to form the basis of an effective child welfare service, but that it needs much better funding, support and management, within the context of new national strategy to address the needs of Indigenous children and families.

3.3 State/Territory policies

Summary

The main features of policy development in the States and Territories indicate that the different jurisdictions are experiencing similar overall pressures. What they have in common are increasing numbers of children needing care, greater demand from children - particularly adolescents - with high or complex needs, a consequent rise in the real costs of services, and a shortage of foster carers to meet these needs. For example, the average cost per child in NSW has been estimated as rising by around 25 per cent in real terms since 2000 as a result of more complex needs (Department of Community Services NSW, 2005).

Because of particular histories of policy and provision, the jurisdictions are differently placed to respond to these demands. A recent national comparison of child protection systems found that the statutory child protection services were providing very similar models of intervention, but that procedural and legislative frameworks guiding these interventions and defining the child protection population varied significantly (Bromfield and Higgins, 2005). The authors argue that any moves towards greater coordination between jurisdictions in definitions and procedures concerning child safety need to be benchmarked against international best practice.

That said, there are certain broad trends that are common to all jurisdictions. First, there is the continuing basic principle of least intrusive intervention and the hierarchy

of placements this implies. However, set against this is more discussion of permanency planning, to avoid drift and disruption in OOHC placements. Secondly, there is a greater reliance on kinship care, especially for Indigenous children, but with some recognition that this is not in itself a panacea for the pressures on OOHC. Third, there is interest in the development both of more professional foster care and a variety of specialist or therapeutic models of care, generally on a small scale, with community-based NGOs providing most of these services. Overall, there is greater emphasis on the development of a range of appropriate alternative forms of care suited to the needs of individual children.

Below we present an outline of recent policy developments and directions in each of the States and Territories. It should be noted that the information in this section is primarily based on official reports or documents from State and Territory departments or on other information provided by departmental officials. We have not been in a position to provide a critical analysis of these policies or of any gaps between policy and practice, except in so far as these have been identified in other published studies.

New South Wales

The legislative framework for the provision of OOHC in NSW is set by the *Children's and Young Person's (Care and Protection) Act (1998).*

Table 2 gives a breakdown based on NSW DoCS' own data of the numbers of children in different forms of out-of-home care in NSW in June 2004.[6] Table 3 shows where the 2,700 Indigenous children in care were placed. Just over 62 per cent were in relative/kinship care.

Table 2: Children and young people in care in NSW by placement type as at 30 June 2004

	Number	%
Parents	535	5.2
Relative & Aboriginal Kinship Care	4,836	46.8
Non-related person	628	6.1
Foster Care	3,746	36.2
Supported Accommodation	98	0.9
Residential Care	324	3.1
Independent living	160	1.5
Not stated	10	0.1
Total	10,337	100.0

Source: Integrated Substitute Care Database Annual Statistical Extract, DoCS Information Services

[6] It should be noted that the total number of children reported as being in out-of-home-care by NSW DoCS is greater than that given in the AIHW report for the same year and outlined in Table 1. The reason for this discrepancy is unknown, but may be related to differing definitions.

Table 3: Indigenous children and young people in care in NSW, by placement type as at 30 June 2004

	Number	%
Parents	85	3.1
Relative & Aboriginal Kinship Care	1,684	62.3
Non-related person	124	4.6
Foster Care	728	26.9
Supported Accommodation	7	0.3
Residential Care	52	1.9
Independent living	21	0.8
Not stated	2	0.1
Total	2,703	100.0

Source: Integrated Substitute Care Database Annual Statistical Extract, DoCS Information Services

NSW Department of Community Services (DoCS) and the non-governmental sector are undertaking a series of interrelated reforms of OOHC provision over a five-year period. In December 2002 the NSW Government pledged $1.2 billion over six years to strengthen the child protection and care systems, of which the greater part of expenditure occurs from 2005-06.

The key principles guiding these reforms are that:

- intervention should be the least intrusive possible;
- 'a safe, nurturing, stable and secure environment should be provided, where a child or young person can retain links with people who are important to them, including family members, peers, family friends and communities';
- ATSI children should be placed in care with extended family or kinship group, a community member, another ATSI person or another suitable person.

(Department of Community Services NSW, 2004a)

Other guiding statements include the following.

- Performance measures for the OOHC system should include 'good client outcomes (e.g. participation, permanency and stability of placement, rates of restoration or transition to independent living, educational attendance and attainment)' (p5);
- Current placement options: 'with relatives or kin, in foster care or in residential care. Where possible restoration to parents or placement with a family member is the preferred option' (p6); and
- 'There is a need to focus more concertedly on permanency planning as a means of providing children and young people with stable placements that offer long-term security and help to avoid drift in care' (p9).

Plans for the various types of OOHC placement are as follows (Department of Community Services NSW, 2004b).

Home-based care

- Relative/kinship care: has increased greatly in recent years and it is anticipated that this trend will continue because of the importance of identity and maintenance of significant relationships. These placements include both informal and formal arrangements, and court-ordered placements.
- Foster care: 'It is anticipated that capacity will be built in a range of foster care models including professional foster care and adolescent community placement'.

Residential care

- Capacity will be increased for young people for whom foster care is not appropriate – those with challenging behaviours and adolescents who do not wish to live in home-based environments. A small number of specialist services will be established – 'it is not expected that residential care services will comprise a large component of the system. Family groups homes are currently a small part of the service system and their future role in the service system will be explored.'

Independent living arrangements

- Services that help young people transition to independent living arrangements – such as 'lead tenant' models. 'In considering new service models consideration will be given to partnerships arrangements with other government arrangements'. These include the Department of Housing.

Placement and support services

- Must have capacity to provide a range of placement options;
- Anticipated that the enhanced funding for OOHC will build capacity in the existing foster care and residential care service system and allow for the investigation of new service models that may not currently exist in NSW;
- Need to focus on permanency planning – to provide stability, long-term security. Important that timely decisions are made, particularly for children in the 0-5 years age group;
- A range of support services to assist in stabilising placements and to promote personal, educational, health (including mental health), identity, culture and skill development for children and young people in OOHC;

Queensland

Out-of-home care for children in Queensland is governed by the *Child Protection Act (1999)*. The number of children in care increased by 30 per cent between 2001 and 2003. Twenty-seven per cent of these children were in kinship/relative care and 24 per cent were Indigenous. There has been a trend toward multiple placements before leaving care, with a decline in the proportion of children experiencing three or fewer placements from 86 per cent in 2001 to 63 per cent in 2003.

Table 4: Children in out of home care in Queensland, 2001-2 to 2003-04

Year	Number of children in out of home care
2001-02	2981
2002-03	3267
2003-04	3886
	Percentage of children on protective orders in out-of-home care placed with relatives or kin
2001-02	26.5
2002-03	26.4
2003-04	26.6
	Percentage of children on protective orders who are ATSI
2001-02	23.3
2002-03	23.0
2003-04	23.6
	Percentage of children exiting care after 12 months of more who have three or fewer placements
2001-02	85.8
2002-03	79.4
2003-04	63.2

Source: Department of Child Safety (2004) *Smart State, Annual Report 2003-04*, Department of Child Safety, Queensland

A report from the Crime and Misconduct Commission (2004) found that the current foster care system was not working effectively. It recommended the setting up of a new Department of Child Safety (DCS) in Queensland to focus on child protection. The key findings of the report were as follows.

Placement options

- The range of placement option for children taken into care was inadequate, with insufficient foster care and residential facilities.
- Residential placement options were in decline – children who were not suited to typical foster care placement often received expensive, individually funded packages or were given temporary accommodation in motels or caravans. 'In relation to the type of residential placements required, smaller group homes are more likely to benefit most children than are larger-scale institutional care facilities, which have already been shown to create potentially dangerous situations for young people.'
- Home-based foster care should remain the preferred placement option, but it is not suitable for all children and there was a need for more placement options, including foster care, residential services, family group homes, intensive support and supported independent living.
- Many children entering OOHC had varying degrees of emotional and behavioural problems – some may need therapeutic care. One option was 'treatment foster care' (citing the Oregon Multidimensional Treatment Foster Care model discussed above). Despite evidence supporting the value of therapeutic placements and the need for them, there were only limited services available to meet this need. Only one recurrently-funded agency provided intensive family-based services and another a one-year pilot service.

- Recommendation: 'That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated.'
- Immense pressure on foster care system. Three types of foster carers: approved, limited approval and relative carers. Relative and limited approval carers are not currently required to undergo the same assessment and approval process as approved foster carers.
- Recommendation: 'That a central registry be set up containing details of all carers, children currently in their care and their availability for further placements. The registry should flag when carers are due for re-approval, whether they have been denied their initial approval or re-approval, and whether they have been or applied to be a carer in another state. Also, it should be possible for staff to search the registry by regions, to that they can easily obtain and up-to-date list of cares and placements in their area'.
- Recommendation: 'That a framework be developed for supporting relative care that includes enhanced screening and monitoring of carers and the provision of training opportunities and other support for carers. There should be an extensive consultation process, especially with Indigenous communities, in the development of the framework'.

Reunification versus permanency planning

The Queensland report notes national and international differences in the emphasis placed on reunifying children with their families. Until recently all States and Territories favoured reunification, whereas in the US and UK the emphasis is on permanency planning.

- 'Permanency planning has been designed to avoid having children experiencing indeterminate periods in care or oscillating between reunification and placements in care. This instability is known to pose a serious risk to children's long-term well-being.'
- While reunification is the goal, time limits are placed on attempts, e.g. if the child has been in care for 15 of the previous 22 months the State must petition for the termination of parental rights (with exceptions).
- Arguments for increasing the number of children in care who can be adopted: no consistent evidence that reunification automatically leads to better outcomes for children.
- NSW has implemented permanency planning legislation – but the Act does not specify a time limit on reunifications.
- US has had permanency planning legislation for a long time and several problems with the adoption provisions are now becoming apparent.
- Recommendation: 'That the DCS evaluate research into the effect of reunification or permanency planning on children'.

The Department of Child Safety was established in September 2004 and reported having implemented 18 of the CMC's recommendation (Department of Child Safety, 2004b). An additional 134 alternative care places have been funded (delivered by 15

NGOs across 29 individual services), with an investment of $13.2 million in 2004-05. In 2005, DCS in collaboration with Queensland Health and Disability Services commenced a program to expand therapeutic care options and treatment programs for children in care with severe psychological and behavioural problems. This includes establishing five additional specialist mental health units for children and young people with specialist needs.

More recently the Department stated that the CMC's recommendations are to be implemented over a three-year period. In its first year, it reports that 30 of the 110 recommendations have been fully implemented (Department of Child Safety, 2005) Two reports from the DCS outline the direction and processes of reform (Department of Child Safety, 2004b, 2004c). The CMC required effectiveness of alternative placement options to be evaluated. The high-level outcomes that should be expected are:

- increased safety and well-being of children and young people in alternative care;
- an increase in placement stability;
- better matching of child needs and placement;
- an increase in foster care recruitment and retention rates through better levels of support and cost reimbursement; and
- capacity to re-direct departmental staff hours towards casework for children.

A model is proposed that would reflect an effective alternative care system. This must have 'the capacity and diversity to meet the range of intervention and placement needs of children and young people'. The paper uses a framework developed by PeakCare Queensland (2002) as the basis for the model proposed. Essential elements of the alternative care system include: a child focus; an integrated, coordinated response across systems; diversity in the range of support options; diversity and flexibility in the range of care options; external accountability mechanisms and monitoring, review and evaluation procedures in place; case management and care coordination; and adequate service system supports.

Selection of appropriate care option should be based on the individual needs of the child assessed and the changing needs of the child and their family over time, based on:

- placement where the living conditions and person responsible for the child have the capacity to promote the child's ongoing safety from harm;
- meeting the daily care requirements of the child, including nurture, support, and stimulation to enable their physical, intellectual, emotional, social and cultural needs;
- providing appropriate environment for the child's access to individualised, needs-based services, provided in a complementary and integral partnership; and
- fulfilling the defined purpose of the intervention.

Inclusion of in-home care as a care option represents a key conceptual shift, in terms of viewing the care system as an alternative to family members as providers; and

viewing the care system in a more holistic way, where the potential role of the child's family in contributing to the care of the child is recognised and promoted.

The alternative care system envisages a package of the following types of care:

- *Family-based care - standard*: care provided by a family in the family's own home, including in-home care, relative care and foster care. Family-based care requires that children and their families are supported through the provision of various services (access to respite care and or ongoing shared care arrangements); that children and their families have timely access to counselling, health and support services; that relative and foster carers have timely access to the training and support they require; and that levels of reimbursement reflect the real costs of providing care.
- *Family-based care - enhanced*: care provided to a child by a family within the family's own home where the carers provide levels of specialised care – includes therapeutic foster care and paid foster care.
- *Therapeutic foster care:* day-to-day care provided by foster carers who have been formally approved by DCS to provide care for defined groups of young children for whom specialised care is required.
- *Paid foster care* - day-to-day care provided by foster carers who have been formally approved by DCS to provide care for defined groups of young children for whom at least one carer is required to provide full-time, specialised care. The care may be provided to children individually or within a congregate care model providing care for small groups of young people including sibling groups.
- *Non family-based care – standard to complex***:** care not provided in a family type setting including residential care and semi-independent/independent living.
- *Residential care*: 24-hour care provided by salaried residential care workers within small-scale licensed facilities. The care is to be provided for defined groups of children for specified purposes as defined by each service's target group. Residential care requires that:
    - children in residential care and their families have timely access to counselling, health and support services, that are responsive to their high support and/or complex needs;
    - residential care workers have timely access to the training and support to effectively carry out their role including their responsibilities in working with and delivering interventions as members of a therapeutic team;
    - levels of remuneration paid to care workers conform with relevant industrial award entitlements; and
    - funding levels of services reflect the full costs of their service delivery.
- *Semi-independent/independent living* – accommodation arrangements with associated support services that facilitate young people's capacity and skills to live independently or semi-independently and assist their transition to adulthood.
- *Family/non-family based care – extreme***:** care provided to a child who presents with extremely complex needs and is unable to have those needs met in a standard or enhanced family-based placement or in residential care.

- *Respite care*: the availability of respite care is recognised as essential to support carers and provide them with temporary relief from the stresses of caring.

Victoria

Protection of children in Victoria is governed by the *Children and Young Persons Act (1989)*. Out-of-home care in Victoria is subject to the *Minimum Standards and Outcome Objectives for Home-based Care in Victoria* (2003) and the *Minimum Standards and Outcome Objectives for Residential Care in Victoria* (2001). OOHC becomes an option when the child is unable to remain in the family home due to risk of abuse and neglect. OOHC is also available for voluntary placements where the family requires temporary or ongoing support.

Home-based care is preferred over residential care. Residential care is more likely to be used for children displaying challenging behaviours or for large sibling groups. 'The objective of residential care is to provide temporary, short or long-term accommodations to children and young people who are unable to be placed in home-based care' (Department of Human Services, 2003: 12).

Home-based care

This is provided by volunteers in their own home – intended as a normalising, family-like and supportive environment. The majority of children in home-based care are likely to have experienced some abuse or neglect, and are therefore likely to have additional emotional, psychological, medical and/or behavioural needs. 'Over the last decade the structure of the home-based care program has evolved incrementally in response to an in crease in demand for services and the changing needs of children and young people in care. This has resulted in a range of separately funded service types, offering varying levels of caregiver reimbursement rates and agency payments' (Department of Human Services, 2003: 13), as follows:

- *Kinship care:* the preferred form of home-based care, defined in Victoria as care by relatives, other than natural parents, or significant other adults in the child/young person's life, such as teachers, neighbours or friends;
- *General home-based care***:** for children and young people aged up to 18 years who are unable to live with their families of origin, either in the short term or long term;
- *Intensive home-based care***:** intensive home-based care incorporates 'specialised home-based care', 'innovative home-based care' and 'shared family care'. Specialised home-based care and innovative home-based care are for children and young people where previous, less intensive, placements have been inappropriate or unsuccessful because of the child's or young person's behaviour, additional needs, or high demands associated with placing large sibling groups together. Shared family care is for children and young people with a developmental delay (aged up to six years), or an intellectual disability (six to 18 years). A community service organisation worker provides support and helps people to access specialist services and other local community resources. There is also a special fund to meet exceptional costs related to disability needs;

- *Adolescent Community Placement***:** for young people aged 12 to 18 years who are experiencing crisis and are unable to live with their families for a range of reasons. The program helps young people to access a temporary, but safe and secure home with a volunteer placement provider in their local area;
- *Complex home-based care:* for very high needs young people who need an individualised home-based care option with intensive support and supervision. Caregivers are reimbursed and supported according to the complexity and intensity of the clients' needs;
- *Permanent care*: A home-based care service type unique to Victoria, which recognises that not all children placed in OOHC will be able to return home to their family of origin. A 'permanent care order' can be issued under the *Children and Young Persons Act*, vesting guardianship in the named individual until the child turns 18. The Children's Court can make a permanent care order when the child has been in care for at least two years and the Court is satisfied the parent is unwilling or unable to resume custody and guardianship, or if return to the family is not in the best interests of the child.

Most home-based care is provided by (currently 34) Community Service Organisations (CSO) funded by DHS. They provide all home-based care, including adolescent community placement, shared family care, one-to-one care, specialised home-based care and innovative home-based care. Victoria is noteworthy for the number of placements provided by the CSOs, although many agencies individually only provide a small number of placements.

In 2001-02, there were 8,628 children in OOHC in Victoria, a two per cent increase over the previous year. The numbers fluctuated over the previous five years, but there was an overall increase of two per cent between 1997-98 and 2001-02.

Table 5: Children in out-of-home care, Victoria, 1997-98 to 2001-02

Placement type	1997-98	1998-99	1999-2000	2000-01	2001-02
Foster care (a)	6,101	6,251	5,932	5,291	5,164
Kinship care	1,027	1,035	1,173	1,396	1,595
Permanent care	528	556	664	850	945
Residential care	789	933	972	904	924
Total	8,445	8,775	8,741	8,441	8,628

Note: (a) Includes ACP, shared family care, one-to-one care, specialised home-based care and innovative home-based care.

Source: Department of Human Services 2002 (unpublished data)

The composition of demand for OOHC has changed markedly over the five year period, with a shift towards kinship and permanent care (and to a lesser extent, residential care) and away from foster care. While foster care remains the leading form of OOHC, 'there has clearly been a substitution away from the type of care in recent years' (Department of Human Services, 2003: 25).

Table 6: Children in out of home care, Victoria, 1997-2001, by placement type (percentage)

Placement	1997-98	2001-02
Foster care	72	60
Kinship care	12	19
Permanent care	6	11
Residential care	9	11

The trend towards kinship care is expected to continue, with implications for child protection resources, as this form of care is more labour intensive than traditional foster care. Figures for the 2002 intake of children into care were 62 per cent in kinship care, 25 per cent in foster care and 13 per cent in residential care.

Table 7 below gives a breakdown of different types of foster care.

Table 7: Children in foster care by service model, Victoria 1997-98 to 2001-02

Placement type	**1997-98**	**2001-02**
Foster care - general	4,660	3,913
Adolescent community placement	1,117	1,123
Innovative home-based care	27	56
One-to-one care	6	109
Shared family care	211	129
Specialised home-based care	80	136
Total	**6,101**	**5,446**

Source: Department of Human Services 2002 (unpublished data)

Directions for reform

A White Paper, *Protecting Children: The Next Steps (*Department of Human Services, 2005), sets out a new policy framework for vulnerable children and young people and this will be underpinned by two new pieces of legislation to be proclaimed in March 2007: The *Child Well-being and Safety Act 2005* (CWSA) and the *Children, Youth and Families Act 2005* (CYFA).

The CYFA articulates a range of best interests and decision-making principles and aims:

- To promote children's best interests, including a new focus on children's development
- To support a more integrated system of effective and accessible child and family services, with a focus on prevention and early intervention
- To improve outcomes for children and young people in the child protection and out-of-home care service system.

The foundation of the Act, and the basis for all decision making and actions taken under the Act, is the best interest principle. All practitioners in child and family services and the Children's Court must take account of the best interest principle in their practice and decision making.

The Act also provides additional principles to provide a framework for decision making in relation to Aboriginal children and families. These provide for a stronger basis for ensuring that Aboriginal children remain within, or connected to, their community and include the nationally agreed Aboriginal Child Placement Principle. The Act places increased emphasis on promoting stability in care arrangements, with the introduction of tighter timelines for decision making on whether to pursue reunification of children with their parents, or to pursue long term or permanent care arrangements; a framework for the registration and quality assurance of community services and carers; and clearly authorised information sharing to promote children's safety, wellbeing and development.

Reform is being guided by the following principles:

- Individual assessment of needs: 'The clearest point from the research literature about placement outcomes for children and young people in care is that '*it depends'*. To an important extent it depends on factors outside the influence of out-of-home care programs, in particular the characteristics of the clients and their families. The available evidence points to the importance of being non-prescriptive in placement type and having a range of types available that are most appropriate for different clients and their families' (Department of Human Services, 2003: 119, original emphasis).
- Residential care needs to be reappraised as one of a number of placement options available to meet assessed need, rather than only as a last resort when home based care placements have disrupted.
- Evidence that therapeutic foster care and therapeutic services can be beneficial for children with behavioural and emotional problems.
- Kinship care should be considered as one option among many. It is unwise to see kinship care as a total substitute for foster care and that increasing use will solve the problem of the shortage of foster carers
- The Stability Planning framework – degree of intrusion should be commensurate with the degree of risk the child faces. It also challenges the view that reunification is something that can and should be actively pursued without regard to the potential risk to the child.

Progress on reforms to date has included the following.

- 320 children and young people in care have benefited from specialised therapeutic services delivered through the Take Two program. Take Two is an innovative, specialist service targeted solely at clients of child protection who are displaying or are at risk of displaying serious behavioural and emotional disturbances as a result of the trauma associated with child abuse and neglect. It provides on-site services across all regions, employs 37 specialist practitioners, including one specialist Aboriginal worker. Delivered by a consortium of Berry Street Victoria, the Austin Hospital Child and Adolescent Mental Health Service, La Trobe University and Mindful. Take Two is the only specialist service targeted solely at victims of child abuse in the country. It incorporates a research and training component and will be evaluated, with findings to be shared nationally and internationally.

- The Looking After Children[7] framework was introduced to strengthen communication and collaboration between carers, DHS staff, community service organisation staff, other professionals, clients and their families to promote improvements in the quality of care children receive in OOHC. It provides a framework for identifying the needs of children and young people and developing plans which aim to meet these needs.
- Children in care have benefited from additional resources for carers for medical and education expenses and from increase in residential care funding.
- New mentoring programs introduced for young people aged 16 to 18 as they prepare to leave OOHC. The 2003-04 budget allocated $100,000 over four years to deliver a mentoring service for young people aged 16-18 years as they prepare to leave care. This will provide a service to 45 young people in the Barwon South Western and the North and West regions. Funding increased in the 2004-05 budget.
- Leaving Care Housing and Support Initiative to be extended to all regions – one specifically for Aboriginal young people.
- Professional therapeutic foster care: 'Victoria, unlike many other Australian jurisdictions, is in the fortunate position of having maintained a viable residential care service system which is often better suited to the needs of young children in particular' (Department of Human Services, 2004: 14). However there is a need for new models that are able to meet the complex needs of all clients. 'Victoria already has some enhanced models of foster care that would be considered professional or therapeutic foster care in other jurisdictions, such as the 1:1 model of care initiated under the High Risk Adolescent Quality Improvement Initiative in 1998. There is a need to explore additional models of care and to this end Victoria has commenced a process of consultation on a professional or therapeutic model of foster care which reflect the Victorian service delivery system'.
- The Placement and Support Residential Care Renewal Strategy will replace the existing residential care facilities with houses that have been specifically designed or refurbished and practically laid out to maximise the quality of care and supervision provided to the children and young people who live there.

South Australia

Out of home care in South Australia is governed by the *Children's Protection Act (1993).*

Two reviews of care provision were carried out in 1992. Dini and Olivieri (1993) found that there was an urgent shortage of foster carers, particularly in rural areas. They also found the system to be inefficient, with too many providers and barriers to co-operation. Denley and Wilson (1993) found the system under-resourced and demonstrating particular problems in foster care services for children with disabilities – 'in crisis primarily because of the closure of residential facilities in pursuit of a policy of 'deinstitutionalising' children 'to the community''. They also suggested that

[7] The Looking After Children (LAC) case management system was developed in the UK to ensure that children placed in out-of-home care for their protection receive 'good enough parenting' from the state.

the unit cost of public provision was lower than that of non-government foster care and that successful tenderers from the NGO sector would have to settle for far less funding per child if they took over foster care.

Nevertheless, in 1997 child protection in SA was restructured and foster care services were outsourced to the NGO sector. 'Through the application of the purchaser-provider model, the government successfully created a quasi-market in alternative care in which the State has managed to shed responsibility for the crisis which is largely of its own making' (Barber and Delfabbro, 2004: 56).

A further review was carried out in 2001 by Des Semple and Associates (Semple, 2002). This found that reliance on family care has meant limited options for many young people in care, including sibling groups, Aboriginal children, difficult to care for children, 8-11 year olds, and those with special needs such as disabilities or substance abusers. Some experienced carers were interested in having more involvement with more intensive, integrated placement models (such Remand INC Program for Young Offenders – RINC, and the Special Placement Services Pilot).

The DHS had contracted a number of Individual Packages of Care (IPC) to manage difficult children and youth who are not suited to family care. The review recommended that a policy framework be established for Individual Packages of Care (IPC) and they continue to be contracted out for the most difficult to place children and young people.

An evaluation in 1999, following restructure, identified problems with the purchaser-provider model and difficulties with its application to the alternative care demands and pressures in SA. These included an increase in need for placement of ATSI children and lack of appropriate carers; increased demand, particularly for children with high needs; scarcity of placements; increased placement breakdown; difficulties accessing support services; reduced communication between FAYS and carers; and inadequate transfer of information to ACSPs. The Semple review found many of same problems continuing in 2001. Semple did not recommend abandonment of the purchaser-provider model but argued for greater inclusiveness, collaboration and transparency in arrangements.

The South Australian Government issued a report in 2003 that described the system following the 1997 restructure of services (Layton, 2003). Layton noted that the Semple Review had not argued for abandonment of the purchase provider model, but stated: 'However, the difficulty is that the model itself is significantly responsible for a culture of blame' and that responsibility for the provisions of services to high needs children who need specialised care 'should not be automatically delegated to non-Government ACSPs but through Individual Packages of Care to appropriately qualified and paid carers which may not be necessarily identified through current ACSPs' (Layton, 2003: 11.5).

The Department of Human Services reports that:

- Properties have been purchased on behalf of FAYS to provide emergency housing for children and young people requiring emergency housing or alternative care;
- A range of new service models and service providers have been introduced into the State's alternative care system, increasing care options and improving placement outcomes for children and young people;

- FAYS, in partnership with Aboriginal alternative carers service providers, has developed a Kinship and Community Care Manual of Practice. FAYS has established a Relative/Kinship Care Working Group to support the development and implementation process. (Department of Human Services South Australia, 2004)

Western Australia

Out-of-home care in Western Australia is governed by the *Children and Community Services Act 2004*, proclaimed on 1 March 2006. The Act is designed to reflect current research evidence and contemporary practice. It aims to provide a model of best practice, with an emphasis on supporting family wellbeing and the capacity of families to care safely for their children.

The Act includes the following:

- The principle that the best interests of the child are paramount, including a range of factors that must be taken into account when determining the best interests of the child
- A principle of child participation
- The Aboriginal and Torres Strait Islander Child Placement principle
- Provision for the development of guidelines for the placement of children from culturally or linguistically diverse backgrounds
- A number of guiding principles relating to the wellbeing of children.

The Act provides for flexible options for court orders to meet the needs of children in need of protection, namely:

- Protection Order (supervision)
- Protection Order (time limited)
- Protection Order (until 18)
- Protection Order (enduring parental responsibility) - which transfers parental responsibility to another person, such as a relative or carer, until the child turns 18 years of age.

The Act provides for thorough and regular care planning and review at all stages of a child's or young person's care experience. It also recognises that long-term planning is critical before young people leave care, and enshrines in legislation for the first time the provision of support services to certain young people between the ages of 15 and 25 years who have left care and who require assistance.

The Act also provides for the development of a Charter of Rights for children in care within 12 months of proclamation.

At 30 June 2005, there were 2,100 children and young people in care. Of these children and young people, 1,358 were in Department foster care (which includes general carers, relative carers, 'self-selected' carers and pre-adoptive foster carers) and 150 children in funded external foster care services.

Over one third (36 per cent) of children and young people in care at 30 June 2005 were Aboriginal or Torres Strait Islander. Over half (53 percent) of Aboriginal and Torres Strait Islander children in care were living with family other than their parents, or their friends.

Types of care

Foster care – care provided by registered volunteer carers, including relatives, in their own home. Carers are supported through mandatory preparation training, payment of a subsidy and respite care. Foster care is provided by the Department and by funded placement agencies.

Group care – care is provided either by full-time carers in a family setting or by rostered staff. Group care is provided by the Department and by funded placement agencies.

Table 8: Living arrangements of children and young people in care in Western Australia at 30 June 2005

	Aboriginal & Torres Strait Islander		Non Aboriginal & Torres Strait Islander		Total	
Type of living arrangement	No.	%	No.	%	No.	%
Parent/guardian	57	7.5	153	11.4	210	10.0
Foster care with family member	345	45.4	278	20.7	623	29.7
Department non-relative foster care	134	17.6	601	44.9	735	35.0
Funded service foster care	81	10.7	69	5.1	150	7.1
Department residential	31	4.1	52	3.9	83	4.0
Funded service residential	36	4.7	62	4.6	98	4.7
Family/friend	56	7.4	63	4.7	119	5.7
Independent living	6	0.8	22	1.6	28	1.3
Prospective adoptive placements	0	0	23	1.7	23	1.1
Other	14	1.8	17	1.3	31	1.5

(a) Excludes children and young people in Supported Accommodation Assistance Program agencies apart from a small number placed there by the Department.
(b) The percentage for all children is not directly comparable with data from annual reports prior to 2003-04 due to inclusion of children in prospective adoptive placements for the first time in last year's report.
Source: Department for Community Development WA, Annual Report, 2005

One-to-One service – provides specialist foster care program for children with particularly challenging behaviours. Carers receive ongoing intensive training and a higher rate of remuneration than general carers.

'Spectrum' professional foster care - for children and young people up to 12 years of age who display extremely high risk or difficult behaviours. Often they have a history of unsuccessful placements and may be isolated or disengaged from their families and communities. This service is provided by a funded placement agency.

Intensive support and placement services – provided through a panel of pre-qualified providers for children with extreme, challenging and high-risk behaviours in the Great Southern and South West Region. This service started in January 2006. The Department has implemented a process for the provision of placements in the remainder of the State through direct negotiation with existing funded service providers on a fee-for-service basis.

Professional home-based care – currently being developed by the Department to provide placements for children and young people with high risk behaviours and complex needs, supported by an Intensive Placement Support Team.

Reunification and prevention of placement services

The Department funds three tertiary family preservation services in the Perth metropolitan area, of which one service is specifically for Aboriginal and Torres Strait Islander families. They are specialised services that work with families whose children are at immediate risk of being taken into provisional protection and care as a result of child protection concerns or severe neglect.

The Department also funds a Reunification Service in the Perth metropolitan area. This is for children who are in out-of-home care for serious and/or prolonged harm or neglect reasons, and provides intensive, specialist intervention to address safety issues, strengthen family functioning and create the possibilities for significant change within high risk families. The service also provides an advice and consultation service to the Department on reunification issues where the Department is working directly with families towards reunification.

Five other placement agencies are also funded to also provide reunification services.

Leaving care services

Western Australia has three Preparation for Leaving and Aftercare Services funded in response to the State Homelessness Taskforce, and a Transitional Support Service funded under the Commonwealth/State Supported Accommodation Assistance Program (SAAP).

Fostering services

The Department provides a centralised service for the Statewide recruitment, assessment, training, support and quality assurance of practice and care standards for all general and relative foster care. The Department has established a Central Carer Register to monitor general and relative foster carers with the Department and funded non-government placement agencies across the State.

The Department has been strengthening practice in relation to children and young people in relative or kinship care. Relative carers have the same rights and responsibilities as general foster carers, which includes support and training. An Indigenous-specific training package is provided for Indigenous carers and non-Indigenous relative carers of Indigenous children and young people.

It is compulsory that relative carers complete the Mandatory Preparation for Relative Carers: Supportive Learning Package within 90 days of the placement. This has been compiled especially for relative carers, to strengthen their understanding of protective behaviours and safety care plans, and attachment and identity needs of children in their care. Recent initiatives have strengthened support to carers. These include:

- funding to provide free counselling services to carers and their families through an external agency;

- a 33 per cent increase in the foster carer subsidy over four years from 1 January 2003;
- Foster Carer's Charter, a handbook and Statement of Commitment for foster carers in partnership with the Foster Care Association of WA;
- regular respite care; and
- foster carer insurance.

Duty of care

A Duty of Care Unit was established in 2003 to ensure the needs of children and young people abused or injured in care are responded to appropriately. Allegations relating to foster carers have been reviewed to ensure that where the allegation was substantiated, the foster carer has either been de-registered or if continuing to provide care has been thoroughly assessed as being fit and proper to do so. Policy has been implemented to ensure the Department meets its responsibility and duty of care to refer a child or young person injured or abused whilst in Departmental care to a competent legal practitioner for legal advice.

Quality improvement for children in care

The Department has undertaken and commissioned a number of reviews of its work, including the care for children area. In 2004, the Department engaged independent consultants to quality assure the systems, practices and processes aimed at protecting children in care. The report *Quality Assurance of the Department for Community Development's Systems and Processes for Children in Care* highlighted significant strengths as well as areas where improvements were required (Cant and Downie, 2004). The report identified the following areas for consideration:

- Expanded range of placement options
- Rigorous recruitment, screening, assessment, training and support for carers
- Improved training and supervision for staff
- Increased support for children
- Ensuring a voice for children in care.

The Government's response have included:

- funding for a new service model, Professional Home Based Care, providing 16 placements for children and young people with high risk behaviours and complex needs, supported by an Intensive Placement Support Team and an additional clinical psychologists to provide therapeutic services to children in care who have been abused.
- Establishment of the Advocate for Children and Young People in Care. The Advocate began providing complaint management and advocacy services in January 2006.
- Expansion of the Department's Fostering Services to provide State-wide recruitment, assessment, training, support and quality assurance of practice and care standards for all general and relative foster care.

An enquiry was also carried out into the circumstances surrounding allegations of abuse in care involving 57 children that occurred between April 2004 and September 2005 (Murray, 2005). The findings emphasised:

- the importance of a quality, ongoing relationship between the caseworker and the child;
- the importance of training, mentoring and support for carers;
- a need for additional child protection, specialist and administrative staff; and
- a need for a range of placement options.

A committee chaired by the Director General of the Department has developed an Implementation Strategy to implement all 43 recommendations of the Murray Report.

Tasmania

Out-of-home care for children in Tasmania is governed by the *Children, Young Persons And Their Families Act (1997).*

The range of out-of-home care options in Tasmania varies according to children's circumstances and the length of time that they need to remain in the placement. Services are provided either by the statutory authority or by funded community sector agencies. Placements options for children and young people include:

- Kinship care (extended family/friends or community network)
- Family group home (short-term placements in a home provided by the Department)
- Foster care (emergency, short and longer term placements in the home of the carer/s)
- Sibling group care (longer-term placements for sibling groups in a home provided by the Department)
- Cottage care (provided through community organisations)
- Adolescent community placement (provided through community organisations)
- Rostered care (an agency-run placement with trained carers, for high needs adolescents)

In the first instance, placement options for the child or young person within the extended family unit and their immediate family network are explored. The practice of placing children with people that they know and trust is generally preferred to a placement with people unfamiliar to them. Placing children with their siblings is also preferred and where the kinship or community network does not have the capacity to provide this, the Department aims to create stability and continuity for the sibling group by setting up a specific care placement.

Rostered care is used in situations where adolescents with complex needs require extra personal support and supervision to ensure their safety. The target group of rostered care includes young people who may:

- exhibit aggressive/violent behaviour

- have high levels of mental health problems and/or a disability that impacts on the young persons capacity to cope
- be involved with juvenile justice
- have a history of multiple educational placement breakdowns.

All placement decisions regarding Aboriginal children and young people should be made in reference to the Aboriginal Child Placement Principle.

Looking After Children

Tasmania's Child and Family Services has recently implemented the Looking After Children (LAC) case management system, developed in the UK to ensure that children placed in out-of-home care for their protection receive 'good enough parenting' from the state. Its introduction aims to provide a consistent approach to case management that is evidence-based and grounded in child development theory. The LAC materials have been adapted for use in Tasmania under licence by a joint venture of Barnardos Australia and the School of Social Work at the University of New South Wales.

LAC provides a case-planning framework for children and young people in out-of-home care based on key health and welfare dimensions, including health, education, identity, family and social relationships, social presentation, emotional and behavioural development, and self-care skills.

Tasmania is the first State in Australia to implement the LAC case management system using the electronic version (LACES 3) and the first government Department to implement the system for all children and young people in out-of-home care.

Northern Territory

The existing legislative framework for the delivery of out-of-home care in the Northern Territory is the *Community Welfare Act (1983)*. However, the Northern Territory is currently in the process of legislative reform. In 2004 the Territory Government issued a discussion paper, *Review of the Community Welfare Act*, and held community consultations about its replacement. It put forward plans to introduce legislation to implement a *Caring for Our Children* reform agenda: 'Currently, the principles that guide intervention and service delivery in relation to out-of-home care are all located in policy rather than legislation' (Department of Health and Community Services, Northern Territory, 2004a: 35).

A discussion draft of a proposed *Care and Protection of Children and Young People Bill* was issued in December 2004 (Department of Health and Community Services Northern Territory, 2004b). The Bill is still under discussion and has yet to be enacted.

The Bill is principally concerned with children protection procedures. It enshrines several key principles:

- The central role of the family in the upbringing of children
- The best interest of the child being paramount

- The need to respect children's dignity and privacy, and to make decisions about them promptly, in accordance with their cultural, religious or ethnic values and traditions
- Children to be allowed to participate in decision making about their future in accordance with their level maturity and understanding
- Self-determination for Indigenous people, with a child placement hierarchy based on the Aboriginal Child Placement Principle, and Indigenous community participation.

It also legislates for the establishment of a position of Children's Commissioner, but it does not specifically discuss the provision of out-of-home care services for children.

Plans for development of the out-of-home care system for children are outlined in a new *Strategic Framework* document for 2006-2010 (DHCS Northern Territory, 2006). This notes that the Territory is experiencing a number of trends, challenges and areas of growing need, including:

- More children and young people entering care;
- a steady increase in the number of Indigenous children and young people entering care;
- a widening gap between the number of children and young people entering care and the number of registered carers;
- growing complexity of the needs of children and young people entering care;
- increasing use of kinship and relative care placements, without defined parameters for how the Department extends support to these placements;
- increasing cost of delivering these out-of-home care services; and
- an increased focus upon the delivery of quality services, and the inherent need to be able to measure quality in order to improve service delivery.

The framework document outlines how the Territory intends to meet these challenges, under four Key Action Area headings. These are listed below, along with the main actions to be pursued.

1. *Getting the Fundamentals Right*

- review and update of case management policies and procedures, including ensuring that these promote full stakeholder participation;
- audit of care placements to ensure all carer registrations and safety clearances are up to date;
- review of Abuse in Care policies and procedures to ensure sensitive, timely responses and to examine ways to prevent and address systems abuse;
- review of procedures for collecting and maintaining client demographic information, and implementation of standards for information to be provided to carers at time of placement;
- examination of ways to improve effectiveness of support services to carers, including by a survey or other consultation with carers about their support needs,

development of placement support guidelines, and exit interviews with carers who discontinue caring;

- continued exploration of ways to prevent children and young people entering out-of-home care, through intensive support to birth parents and Family Group Conferencing; and
- building collaborative partnerships with OOHC stakeholders, through the Partners Reference Group and by developing alternative ways of consulting stakeholders.

2. Aboriginal and Torres Strait Islander Children

- development and implementation of kinship and relative care policies and procedures;
- identification of the placement support requirements of kinship carers, and ways to improve delivery of such support;
- implementation of 'cultural care plans' for all ATSI children in out-of-home care and consultation with Indigenous stakeholders about improving cultural continuity for children entering out-of-home care;
- sample audit of Indigenous client files to examine and enhance compliance with Aboriginal Child Placement Principle;
- development of practice guidelines for birth and extended family contact to promote and maintain connections to family, land and culture;
- establishing mechanisms for Aboriginal Community Workers to become a major resource in planning and delivering support to Indigenous children in out-of-home care; and
- review of cultural appropriateness of current carer recruitment, assessment and training materials, and sourcing and delivery of appropriate training packages for ATSI carers.

3. Building Better Systems

- regular scrutiny and improvement in collection of OOHC data on clients and carers;
- identification of and access to priority client data needed by Family and Community Services from other program areas;
- monitoring of internal compliance with Department policies and procedures;
- development of a Panel to appraise carer assessment and re-registration reports;
- implementation of standards in *National Plan for Foster Children, Young People and Their Carers 2004-2006* and development of local 'add-on' standards; development of compliance review mechanism;
- development of an OOHC feedback and complaint mechanism, including a means for children, young people and their carers to voice their views;
- review of existing Policies and Procedures Manual to ensure consistency with new draft legislation;

- review of case data and procedures to inform child and family reunification and, where this is not possible, to aid permanency planning; consultation with OOHC stakeholders to inform policy development; and
- development and promotion of priorities for research in out-of-home care, including by OOHC stakeholders and partners, and through relationships with tertiary education institutions.

4. Building Capacity

- enhancement of the range of specialist care options for children unable to be placed in family environments;
- implementation of the Family and Community Services High Needs Service for children and young people with disabilities and/or high daily support needs;
- reconfiguring the Darwin and Alice Springs Anglicare services to become Stabilisation and Assessment Units;
- development and implementation of a Transitional Care Program service model;
- review of existing carer policies, standards and resources to ensure their suitability for application to other placement types;
- examination and development of Independent/Exit Care living options for young people leaving care, including revision of existing Leaving Care/After Care policies and procedures in line with new legislative requirements;
- work with other stakeholders to improve young people's access to Transition to Independent Living Allowance;
- recruitment of a diverse range of carers to provide a variety of placement options;
- development of carer recruitment materials, through a focus group of people with marketing and promotion expertise;
- engagement with South Australia and Western Australian family services counterparts to improve the delivery of OOHC services to children and young people living in the cross border areas;
- development of protocols to enhance working relationships around case based practice;
- enhancement of OOHC training opportunities;
- annual review of caregiver reimbursement rates; and
- development of partnerships with other programs and departments regarding the delivery of services to children and young people in OOHC.

The Framework does not include specific dates by which particular actions are to be completed; it is intended as a working document for annual review by the Territory's Out of Home Care Partners Reference Group.

Australian Capital Territory

In the ACT, child protection is regulated by the *Children and Young People Act (1999)*. In 2000, foster care was contracted out to the private sector, but numerous

problems were identified, including an over-reliance on foster care and residential care – with too few adequate care options.

A report on child protection measures in the ACT by the Commissioner for Public Administration was presented to the ACT Government in May 2004 (Vardon, 2004) and various improvements to child protection have been introduced since then. The report identified a critical shortage of foster care placements – many were not suitable for all children. Many young people also have to seek assistance from SAAP services because there are no other options. The ACT was also found to be too reliant on foster care and needs more residential care capacity, more therapeutic care options and other innovative care facilities, more small group homes and emergency placements – 'Additional resourcing is necessary, but so too is clever, innovative policy work aiming to expand care options and create better solutions for individual children' (Vardon, 2004: 10).

Currently four agencies are funded to approve all foster carers in the ACT. The Marlow facility operated by the Richmond Foundation provides residential support but is reported to be frequently over-stretched.

The Report states that 22 per cent of children and young people in care in the ACT are in residential care – this differs from the data published by the Australian Institute of Health and Welfare.

4 Discussion and conclusions

All Australian States and Territories have experienced a substantial increase in the number of children entering the out of home care (OOHC) system in recent years. Not only has demand for OOHC support increased, but many of the children entering OOHC these days are presenting with increasingly complex needs and challenging behaviours. The task of meeting this demand is placing the OOHC systems under considerable pressure and all jurisdictions are confronting similar challenges in providing support to children in need of protection. Among the key factors putting the system under stress are: a limited range of placement options; difficulties attracting and retaining foster carers; and a decline in residential placement options.

The current emphasis of policy and practice in all jurisdictions is to keep children with their family wherever possible. To this end, a range of early intervention, prevention and family support programs have been funded at both Commonwealth and State level. Where children are placed in care the goal is ultimately to reunite them with their family, although there is also a growing emphasis on permanence planning, which may at times conflict with attempts at family reintegration.

The majority of children in need of OOHC in Australia are placed in home-based care. This is mostly foster and kinship care, although the proportion of children in these different types of care varies significantly by State and Territory. The policy preference for home-based care in all jurisdictions is consistent with the basic principle of least intrusive intervention evident and the hierarchy of placements this implies.

At the same time, however, all jurisdictions are experiencing difficulties attracting and retaining foster carers, which has major implications for this policy preference. This is partly attributable to the increasing numbers of high needs children entering the system, as many carers struggle to meet the demands of caring for these children and are often poorly trained to manage their difficult behaviours. This often leads to an increase in placement breakdowns, carer 'burnout' and carers leaving the system.

A consequence of the policy emphasis on home-based care together with the shortage of foster carers has been an increase in the use of kinship or relative care. Kinship care is now the fastest growing form of OOHC both in Australia and overseas, and the most common form of placement for Indigenous children, who are heavily over-represented in OOHC relative to other Australian children. Kinship care occurs on both a formal and informal basis and while there are no precise numbers available of children in informal kinship care they appear significantly to outnumber those in formal kinship care.

A review of the literature on the increasing use of kinship care raises a number of concerns. First, there appear to be minimal guidelines for caseworkers in respect to kinship care for non-Indigenous children. Second, the increasing reliance on kinship care appears to have occurred in the absence of compelling research evidence to support the trend. Little detailed research has been undertaken on kinship care in Australia and much of the overseas research presents a conflicting picture of the perceived benefits and disadvantages associated with it. Third, the legal status of kinship care within the child welfare system, and the level of support and provision can and should be provided for these carers, remains a topic of ongoing debate.

There is, however, broad agreement that greater support is needed for relative carers as well as improvements in overall standards of care both in fostering and kinship placements. To this end several of the jurisdictions have initiated both increased levels of assessment and supervision of kinship carers and new training and support programs, particular for Indigenous carers and for grandparents, who are the most significant single group providing such care. While a number of reports have highlighted the difficulties many grandparent carers face, the most effective ways of supporting kinship carers as a whole is one topic needing further research.

The increasing number of 'high needs' children entering the system has focused attention on the need for more structured placement options which are not solely concerned with containment and accommodation but also incorporate therapeutic interventions. Overseas, particularly in the US and the UK, this has led to the development of a number of foster care options that incorporate a therapeutic component. The aim of these treatment foster care programs is to provide children with structured interventions in a family environment. There has been increasing interest in the development of specialist or therapeutic models of care in all Australian jurisdictions, generally on a very small scale, with community-based NGOs providing most of these services. Many of these programs are based on US models, such as the multi-dimensional treatment foster care program in Oregon.

The decline in the provision of residential care for children in Australia over the last four decades is broadly consistent with overseas trends and is another factor placing additional pressure on an already overburdened foster care sector. Yet despite the historical decline, residential placements are still, and in some States increasingly, provided by privately run for-profit residential providers, at considerable cost, for children who cannot be placed in a foster care environment. There has been renewed interest in recent years in the provision of residential care for children who are unsuited to conventional home-based settings. This includes children with complex needs and challenging behaviours and sibling groups. While most States and Territories recognise the need for increasing residential care capacity, it is likely to remain a comparatively small component of the OOHC system as a whole.

There has also been increasing recognition of the need for services and placement options to assist older children in care make the transition to independent living. The current limited range of placement options for adolescents in need of state protection means that many end up in homeless youth programs or in the juvenile justice system. Several States have been or are currently in the process of developing various models of transitional support for young people leaving care and there is increasing interest in versions of the 'foyer' model of combined employment and housing support, that derived originally from France.

Most States and Territories are also now engaged in the development of alternative packages of care that expand the range of OOHC placement options in a way that is better suited to the needs of individual children. This includes devising culturally appropriate models for Indigenous children and those from other culturally and linguistically diverse backgrounds. However, a key challenge is how to identify 'effective' OOHC models and programs. This task is made all the more difficult by the profusion of programs, variations in evaluation methodologies and the difficulties inherent in identifying and replicating models. Even when a 'model program' is identified that has been subject to rigorous evaluation and shown to be effective, this

may only be effective in another context if program integrity is maintained. In other words, modification of an effective overseas program for the Australian context will yield a program model that differs from the original. Such programs may still be effective, but the particular research evidence of outcomes and effectiveness on which adoption of the programs are based may no longer be fully applicable. This has been identified by a number of experts in the field as another key area for future research.

There has been concern about discrepancies between jurisdictions in their procedures for child safety and definitions of the population at risk. Certainly because of particular histories of policy and provision, States and Territories are differently placed to respond to the common demands on their resources. There is an argument that moves towards better alignment of legislation and procedures on child protection need to be benchmarked against international best practice. However, in terms of out-of-home care policies there seems to be considerable convergence taking place, with broadly similar approaches being pursued across all the jurisdictions currently engaged in reform of their provision and practices.

In terms of priorities for further research, this review has highlighted a need for a better understanding of trends in fostering generally and in kinship care in particular. More information is needed about the outcomes being achieved in different types of out-of-home care and for different types of children, in particular those achieved in kinship care, and about the models and structures of support that are required to meet the full range of future needs in out-of-home care placements.

While recent studies have highlighted the pressures experienced by grandparents taking on primary care of their grandchildren, further research is also needed on how they can be supported to provide a high quality of care without detrimental effects on their own health and wellbeing.

More work is also needed on evaluation of different forms of treatment foster care in the Australian context, so as to aid the development of a range of effective types of intervention for children with high and complex needs. This would include further research on the circumstances in which forms of residential care might be the preferred option.

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