Psychosocial Safety and Security for Children following Maltreatment.

Study 1: Factors Associated with Placement Stability for Children in Out-of-Home-Care

Study 2: Multi-systemic and Psychosocial Safety (MAPS): Inter-rater Reliability & Clinical Utility of a Clinician-Rating Tool for Therapeutic Child Protection Intervention Services

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This thesis meets requirements for
Masters Philosophy (M. Phil) in Psychology.
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After all,

A person's a person, no matter how small.

Horton Hears a Who.

Dr. Suess

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Statement of Originality

I certify that the work contained in this thesis: *Psychosocial Safety and Security for Children following Maltreatment*, has not been previously submitted for a degree or diploma at any other higher education institution. To the best of my knowledge the thesis contains no material previously published or written by another person, except where due references are made.

The second study of this thesis investigates the inter-rater reliability of a clinician-rating tool that was co-developed by this student and Ms. Britt Sedgmen (Child Protection Counselling Service; Western Sydney Local Health District). Ethics approval was granted by Macquarie University Ethics for study 1 (5201200456) and by the Western Sydney Local Health District Ethics department for Study 2 (4043) AU RED LNR/14/WMEAD/243).

Sydney, August 21st, 2017.

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Mia Markovic

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Abstract

This thesis presents a literature review, two clinically oriented empirical studies and an integrative discussion. The studies focus on factors involved in placement stability and psychosocial safety of children within the child protection system. In Study 1, thirty-nine foster and kinship carers were surveyed to explore factors associated with carer concerns about placement breakdown and caregiver satisfaction. Standardised questionnaires assessed demographic and support factors and the contributions of child behaviour and emotional functioning, carer parenting style, empathy and attachment style. The small sample size of this study limits interpretation and generalizability of results. However, the findings indicate that concerns about placement breakdown were uniquely associated with carer age and that caregiver satisfaction was associated with level of partner support and the number of previous placements the child had experienced. Caregiver comments were also analysed thematically, and these showed that a poor carer-agency working alliance impacted on carer's views on their ability to maintain placements, their sense of support and overall satisfaction.

The second study first reports on the development, and then the face validity, clinical utility and inter-rater reliability of a clinician-rating tool developed by the researcher. The Multi-Systemic Assessment of Psychosocial Safety (MAPS) was developed to assist clinicians to assess the ongoing psychosocial safety of children (aged 6-16 years). Consultation was undertaken with specialist child protection counselling teams. Additionally, nine specialist child protection counsellors, across three area health districts, participated in an inter-rater reliability study of the tool using clinical vignettes, and provided additional written feedback on the face validity and clinical utility of the tool. Moderate to very good inter-rater reliability for risk ratings on the tool was obtained for two vignettes. Poor inter-rater reliability was evidenced for a third, more

complex vignette. Participants reported that the MAPS was relatively easy to use, clinically useful in identifying risks and protective factors in child and family contexts, and in identifying therapeutic intervention objectives.

Overview

Decades of research has demonstrated that humans are especially vulnerable to trauma during their early years. Child maltreatment, a common source of early trauma, impacts children at the neurobiological level, compromising brain development and subsequent intellectual, emotional and cognitive functioning (Gaskill & Perry, 2012). Over time, compromised brain and biopsychosocial development can result in profound limitations on a child's ability to function and participate across their social environments. This is evidenced through national and international research demonstrating the numerous and long term impacts of child maltreatment, including drug and alcohol abuse, mental illness, poor health, homelessness, criminality and incarceration, injury, disease, disability and premature death (Australian Institute of Family Studies [AIFS], 2015; Kezelman, Hossack, Stavropoulos, & Burley, 2015). A recent North American study of 1038 adults with a history of foster care has emphasised the prevalence of mental health problems and emerging life-time needs of this population, revealing that one in ten had three or more comorbid mental health disorders (Jackson et al., 2015).

In addition to the psychological and social domains, the estimated economic costs of childhood maltreatment are overwhelming. In Australia, between 2013-2014, 3.3 billion dollars were spent on child protection and out-of-home-care (OOHC) services alone, with an annual increase of national expenditure occurring at 4.6% since 2009 (AIFS, 2015). These estimates do not include the indirect costs to the community, accumulated through crime, poverty and homelessness, or the less tangible costs victims experience, such as the 'fear, mental anguish, loss of leisure, physical pain and disability' associated with child maltreatment (Taylor et al., 2008, p. 129). These authors note that this 'burden of disease' has been estimated to add billions of dollars of cost to the economy for substantiated child maltreatment victims alone.

Australia, like other developed countries, implements a hierarchy of voluntary and/or non-voluntary social and legal responses to child maltreatment. These include preventive strategies, such as the provision of universal, primary or secondary multi-disciplinary child and family supports (e.g. health care home-visiting initiatives, parent education, counselling), as well as more directive interventions, such as supervision orders and obliged engagement in family support services or therapies (e.g. drug and alcohol rehabilitation, specialist counselling services directed towards offending behaviours and/or trauma recovery). At the most intrusive level, the removal of children, either temporarily or on a long term basis, from the birth family may occur, depending on the nature of the maltreatment and the ability and willingness of caregivers to provide the necessary care and protection to a given child (Australian Institute of Health & Welfare [AIHW], 2012a). These interventions reflect the increasing recognition of the complex recovery needs of children following maltreatment. In particular, following early trauma, children require stable, predictable, responsive caregiving with a primary carer to 'allow the brain to either break false associations or decrease the overgeneralisation of trauma-related associations' (Perry, 2006as cited in Gaskill & Perry, 2012, p. 34).

There remain, however, significant challenges in adequately supporting foster and kin carers to provide the therapeutic care necessary to mitigate the effects of childhood trauma. Research has identified that carers face strains in their direct relationship with their foster/ kin child, as well as with their supervising care agency. The significant mental health, behavioural, emotional and developmental problems many children have when they enter the care system (Perry, 2008; Proctor, Skriner, Roesch, & Litrovnik, 2010; Royal Australian College of Physicians [RACP], 2006; Scott, 2011, Tarren-Sweeney, 2008a, 2008b), are believed to contribute to difficulties in forming positive relationships and secure attachments with new

caregivers (Dozier et al., 2009; Stovall-McClough & Dozier, 2004). Additionally, carers report being inadequately supported, practically and professionally, and at times feeling victimised by their care agencies (Coakley, Cuddeback, Buehler, & Cox, 2006; Murray, Tarren-Sweeney, & France, 2011; Osborne, Ponazzo, Richardson, & Bromfield, 2007). Not surprisingly, one of the most significant challenges to the OOHC system, both within Australia and internationally, is that of securing permanency of care placements for children in foster and kinship care. A substantial proportion of Australian children in care experience multiple placement changes (Johnson, Natalier, Liddiard, & Thorensen, 2011). Once children begin a trajectory of placement breakdowns it is likely to continue, with children who have two or more behaviour-related placement disruptions having only a 5% chance of achieving stability two years later (Kelly & Salmon, 2014). As placement disruption impedes the ability to form an enduring attachment to a stable caregiver, placement instability itself remains a significant risk to children's mental health (Delfabbro, King, & Barber, 2010; Ockenden & Goldsworthy, 2016).

Adverse outcomes after trauma exposure are not inevitable, however. Promising evidence emerging from the Bucharest Early Intervention project, indicates that quality caregiving can mitigate the effects of even significant and early deprivation and trauma at the biochemical level. In this project, the development and psychosocial outcomes of children randomly allocated to foster institutionalised care ('care as usual'), are compared to typically raised children who have never been institutionalised (McLaughlin et al., 2015). The authors found that, while institutionalised children showed impaired stress responses at age 12, the stress responses of children who had been placed into quality foster care environments approximated stress responses of typically developed children who had never been institutionalised. Moreover, a significant portion of the children in quality foster care also failed to display callous-unemotional

traits that are associated with early deprivation, compared to the children who remained institutionalised (Humphries et al., 2015). Clearly, an appropriate, stable placement for children, following maltreatment, is a critical and effective intervention.

There is a dearth of research regarding what makes placements stable for children in care and how to best assess the ongoing psychosocial needs of children following maltreatment. Research on placement stability to date has predominantly focused on child factors associated with breakdown, namely behavioural, especially externalising behaviour problems (Rubin, O'Reilly, Luan, & Localio, 2007). Much less is known about caregiver characteristics associated with success or failure of placements. Research on the assessment of child well-being within child protection has primarily focused on the identification of immediate risk of harm (Ager et al., 2012; Gillingham & Humphreys, 2010). As such, there is a lack of assessment and outcomes-focused measures to assist professionals who work with children following child maltreatment, to evaluate risk and protective factors, assess placement stability, and the well-being of children across their key care environments. The current thesis seeks to address these issues.

Two studies are presented. The first study explores child and carer variables implicated in caregiver satisfaction and perceptions of placement stability for children in foster or kinship care. This study uses a mixed methodology and aims to extend current knowledge on carer-related factors and experiences associated with placement stability. The second study turns attention to the assessment of children's psychosocial safety and well-being, following maltreatment. The development of a clinician-rating tool, the Multi-Systemic Assessment of Psychosocial Safety (MAPS), to assess the ongoing psychosocial safety of children following maltreatment is discussed. In addition, this study provides preliminary evidence regarding the inter-rater reliability and clinical utility of the MAPS. This study aims to provide a user-friendly assessment

measure that staff in specialist services can use to not only assess and monitor the therapeutic needs and progress of children in care, but to provide, over time, highly relevant outcomes data.

Chapter 1 provides an introduction to the prevalence of child maltreatment, the development of current child protection practices, and difficulties experienced in the child protection and out-of-home-care (OOHC) field currently in Australia. A review of current literature on child and carer factors associated with placement stability is provided. The Social Ecology Model (Bronfenbrenner, 1977, 1986; Bronfenbrenner & Ceci, 1994), which underscores the development of Study 1, provides the fundamental theoretical framework and is described in detail, along with Morton & Salovitz's (2006) Model of Safety, which extends Bronfrenbrenner's model, to explain the development of child safety and maltreatment.

Study 1, *'Child and carer factors associated with placement stability in out-of-home-care',* is set out in two chapters. Chapter 2 (Part A) outlines the aims, methodology and quantitative findings regarding factors associated with placement stability and caregiver satisfaction. Chapter 3 (Part B) outlines the aims, methodology and a summary of the qualitative findings, collated from kinship and foster carers participating in the study.

Chapter 4 sets the scene for the second empirical paper and discusses the development and practices of the assessment of risk within the child protection field. A literature review of factors critical to the assessment of ongoing safety, well-being and health promotion following child maltreatment is provided. The Model of Safety (Morton & Salovitz, 2006), which extends Bronfenbrenner's model to consider the assessment of child risk, harm and safety, and which underscores the development of Study 2, is presented.

Study 2, *'Multi-Systemic Assessment of Psychosocial Safety (MAPS); inter-rater reliability & clinical utility of a clinician-rating tool for therapeutic child protection intervention*

services', is also set out in two chapters. Chapter 5 (Part A) outlines the aims, methodology and outcomes of an action research project, which culminated in the development of the MAPS tool. Chapter 6 (Part B) outlines the aims, methodology and a summary of the quantitative and qualitative findings of a study investigating the inter-rater reliability and clinical utility of the MAPS tool.

Chapter 7 provides an integrative discussion of the findings of both studies. Clinical implications of the study results are considered and research directions, for both placement stability and the assessment of children's psychosocial needs following maltreatment, are presented.

Chapter 1

Introduction

Children are dependent on adults and their social system for their survival and nurturance. Because of their vulnerability, children's rights to safety and protection are recognised internationally (United Nations International Children's Emergency Fund [UNICEF], 2013). The compromised safety of children, or child 'maltreatment', is defined as all forms of physical or emotional abuse, including neglect and sexual exploitation of children under the age of 18 years, resulting in either '*actual or potential harm to a child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power*' (Butchart, Harvey, Mian, Furniss, & Kahane, 2006, p. 9). Importantly, maltreatment includes acts of commission, such as physical abuse, as well as acts of omission, such as the failure to adequately supervise or facilitate medical treatment for a child.

Consequently, parental or caregiver behaviours are not considered abusive or neglectful on the basis of their intentionality but, rather, with respect to the extent to which they present a risk to a child in the immediate, short or long term future (Holzer & Bromfield; 2010). Despite the concern for child protection, child maltreatment and death resulting from abuse or neglect is a global problem that occurs at every socio-economic and educational level, and across ethnic, cultural and religious contexts (ChildHelp, 2013). How societies can best assess children who are at risk of immediate or ongoing harm, and how they can intervene following child maltreatment to best support recovery and optimal development, remains a significant challenge.

The Prevalence of Child Maltreatment in Developed Nations

There are no reliable global estimates for the prevalence of child maltreatment, due to the lack of consistent definitions of maltreatment as well as difficulties in measuring its occurrence

(World Health Organisation [WHO], 2016). Over the past several decades, legislative bodies, child protection agencies and researchers have developed overlapping definitions of maltreatment, based on whether the purpose is to assess criminal culpability, parental capacity or the *impact* of maltreatment on the developing child and the child's current safety (Goldman, Salus, Wolcott, & Kennedy, 2003). Consequently, guidelines for accepting and recording child maltreatment in national child protection registries vary widely, both between and within developed countries, such as Australia, the US and the UK (AIHW, 2017; Bentley, O'Hagan, Raff, & Bhatti, 2016; Child Welfare Information Gateway, 2014).

Currently, child protection registries are the most commonly used indicators for prevalence statistics. They are considered underestimates of child abuse for a number of reasons. Firstly, they depend on individuals or services to report incidents of child abuse and neglect to statutory authorities. Child abuse reports are then coded dichotomously (i.e. either an incident did or did not occur) and typically only one type of maltreatment is collated for national figures. The abuse type collated tends to be that which presents the most immediate, or suspected, risk of harm to a given child. As such, the figures do not consider the severity, frequency, duration, chronicity, age of onset, and perpetrator type that influence the nature and impact of maltreatment (English, Bangdiwala, & Runyan, 2005), or the rate of polyvictimisation[1] (Greenson et al., 2011; Price-Robertson, 2012; Price-Robertson, Bromfield, & Vasallo, 2010).

Neglect has typically accounted for the majority of child protection reports among child protection registries, followed by physical abuse, sexual abuse and emotional abuse (or

[1] Perhaps the most comprehensive and quantitative classification of child maltreatment to date, is the Modified Maltreatment Coding Scheme developed by Diana English and the research team of the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN, 1997). The Maltreatment Coding Scheme takes into consideration key types of child maltreatment; physical, sexual, neglect and emotional maltreatment in a framework that subsumes a myriad of other maltreatment factors such as exposure to domestic violence, parental drug and alcohol abuse and parental criminality. The use of such a tool for the recording of maltreatment in national child protection registries would better account for child age, developmental stage, frequency and chronicity of child maltreatment and thus allows for more sensitive analysis between maltreatment and child outcomes.

'psychological maltreatment'), in both the UK (England, Northern Ireland and Scotland) and USA registries (Radford et al., 2010, Sedlak et al., 2010). Whilst differences in the collation of child abuse and neglect statistics continue to differ between countries, more recent and comprehensive procedures are identifying the prevalence of child abuse and neglect experiences through exposure to parental domestic violence and mental health (e.g. Bentley et al., 2016; National Society for the Protection of Cruelty against Children [NSPCC], 2016).

These findings parallel Australian figures. Estimates of child maltreatment are based on reports made to each state and territory key child protection service annually. Between 2015 and 2016, 355,935 reports of suspected child abuse and neglect were made. Almost half of the notifications were investigated (46.4%), in relation to 115,024 children. Of these, 60,989 instances of abuse and/or neglect were substantiated or confirmed, in relation to 45,714 children aged 0-17 years. Notifications were classified into only one of four forms: physical abuse, sexual abuse, emotional abuse or neglect[2]. Of the total notifications, emotional abuse accounted for 43%, neglect 27%, physical abuse 18% and sexual abuse 12% (AIHW, 2017). Importantly, reports of emotional abuse continue to increase across Australia, the UK and USA. Considered the most nebulous of abuse types, emotional abuse is recognised as inherent to all other abuse types and, within family environments, is typically associated with parental drug and alcohol misuse, domestic violence and mental health issues (Holzer & Bromfield, 2010; Sedlak et al., 2010).

Another key method for ascertaining prevalence rates of child maltreatment is the use of retrospective data. Retrospective studies asking adults about childhood maltreatment capture abuse experiences which may not have been reported or disclosed to authorities. In Australia,

[2] Only the abuse type for the first substantiation in a given reporting year that is most likely to place the child at risk or be the most detrimental in the short term is reported.

these studies have focused on five key maltreatment types: physical abuse, neglect, emotional abuse, sexual abuse, and exposure to domestic violence. Price-Robertson, Bromfield, and Vasallo (2010) found prevalence estimates to vary widely, depending on the type and number of questions used to collate experiences of child maltreatment. Physical abuse was reported as occurring among 5-18% of community samples, emotional abuse and neglect at 11% and 12%, respectively, and exposure to domestic violence in the range of 4-23%. Sexual abuse varied greatly between genders and by type, that is, for males, penetrative sexual abuse ranged from 1.4-8.0%, and non-penetrative sexual abuse 5.7-16%, whereas for females, penetrative sexual abuse ranged from 4-12%, and non-penetrative 13.9-36%. Studies that asked about abuse experiences and contained behavioural descriptions (e.g. "were you hit/ slapped?" vs. "were you physically abused?"), yielded higher positive responses, compared to questions without behavioural descriptions. These results are comparable to retrospective data gathered from the UK (Radford et al., 2010).

The Development of 'Child Protection'

The principle that children and young people should be protected from maltreatment, including that perpetrated by their own caregivers, was socially and politically embraced only relatively recently. Advocacy for children's rights to safety were spearheaded by designated child protection agencies: The New York Society for the Prevention of Cruelty to Children, in 1874 in the US, and The Liverpool Society for the Prevention of Cruelty to Children (NSPCC) in 1883 in the UK. The efforts of these early agencies led to the development of the legal mandate for government to intervene to protect children against abuse (Lamont & Bromfield, 2010).

Australia later established similar agencies, firstly in New South Wales in 1890, which was then followed by Victoria and Western Australia in 1894 and 1906, respectively. These

agencies were charged with the role of investigating and reporting child abuse and neglect well into the 20th century. Simultaneously, designated Children's Courts and legislation to protect children from maltreatment had been established in most Australian states by the end of the 1900s. Despite states being united under federal rule in 1901, the provision of child protection services remained a state responsibility. Consequently, child protection legislation and practices continue to differ somewhat across states and territories to this day (Lamont & Bromfield, 2010).

Across Australia, and in parallel with North America and Western Europe, perceptual shifts in regard to child maltreatment occurred across the 1960s and 1970s. By the 1990s increasing public awareness of children suffering from abuse helped expand the definition of what constituted child maltreatment, from concerns of mainly physical abuse and 'battered baby syndrome', to the physical and sexual abuse and neglect of children. In accordance with this change, public and professional interest moved towards child protection through abuse prevention, while also broadening the focus of care and protection to include young people up to the age of 18 years (Anglin, 2002; Lonne, Parton, Thomson, & Harries, 2009). Legally, the responsibility to recognise child maltreatment became increasingly shared between 1975 and 1980, extending from statutory child protection workers, to include medical doctors and later, teachers, health professionals and police (Scott, 2014).

Statutory child protection agencies hold the primary responsibility to assess risk of harm, to investigate allegations of maltreatment of children, and to provide or coordinate community services for families in need. Agency titles differ across states and territories[3], but are hereafter referred to as Child Protection Services (CPS) collectively. If investigated, reports to the CPS

[3] Family and Community Services (New South Wales), Department of Communities, Child Safety and Disabilities Services (Queensland), Department of Children and Families (Northern Territory), Department of Education and Child Development (South Australia), Department of Human Services (Victoria), Department for Child Protection (Western Australia) and the Department of Health and Human Services (Tasmania).

will be deemed 'substantiated', indicating sufficient reason to believe that a given child has been or is likely to be abused, or 'not substantiated'. Depending on the assessed level of risk of harm, CPS may apply for a hierarchy of court orders to protect the child, ranging from a supervision order where a child remains with their birth parent under the supervision of CPS, a guardianship order where parental responsibility is legally transferred to the government and the child is placed into alternate, or out-of-home-care, (hereafter referred to as OOHC). Placement of children into OOHC is considered a last resort, occurring only when there are significant concerns for the safety and well-being of a child due to parental resistance to intervention and supervision and/or when adequate progress towards safe and responsible caregiving by the parent is not made (AIFS, 2016a).

The number of children on care and protection orders across Australia has almost doubled over the last decade, from 25,065 in 2005 to 51,972 in 2016. Similarly, the number of children in OOHC placements has risen every year, from 23,695 in 2005 to 48,000 in 2017 (AIFS, 2005, 2017). The overwhelming majority of children placed in OOHC reside in either kinship or foster care, 38% and 34%, respectively[4]. Kinship carers are family members other than the child's parents or, in some circumstances, adults who are well known to the child through a pre-existing relationship (AIFS, 2017). Although kinship carers are required to undergo an assessment and approval process prior to caring for a child, they are not typically required to undertake training and, to date, the training and support provided to kinship and foster carers has varied enormously. Foster carers are not family members, and in addition to an

[4] Of the remaining children, 9% are living in third party parental care arrangements, 8% with parents, 5% in residential care and the remaining 6% in unknown circumstances (AIFS, 2017).

assessment and approval process, they are required to undertake varying levels of formal training and receive varying levels of ongoing agency support (AIHW, 2012b).

The assessment of child well-being in the context of risk and protective factors, and the stability of placements in foster and kinship placements are the two key issues addressed in this thesis. Of note, the terminology used within the literature to describe children, young people and their care contexts varies. Within this thesis, the term 'child protection' is applied broadly to the statutory system which oversees the assessment and legal care of children either at risk of, or following, substantiated abuse and neglect. These children may reside with biological families or be living in alternate care placements. The term 'out-of-home-care' refers specifically to children who have been removed from birth parents and reside in alternate placements such as with kinship or foster care. The first study, which explores factors relating to placement stability within kinship and foster care settings predominantly refers to out-of-home-care. The second study, however, discusses an assessment tool for clinicians working with children, young people and their care contexts, be they biological, kinship or foster, and thus the termed child protection or out-of-home-care are used interchangeably. Importantly, the author acknowledges that foster and kin carers are 'parents' to their children. In this thesis, however, the terms foster and kin carers are used – only to demarcate them from each other and biological parents. Furthermore, reference to children 'following maltreatment' refers to contexts where abuse and/or neglect has been substantiated.

Strains within the out-of-home-care system. Given the extent of child maltreatment and need for OOHC placements, the recruitment and retention of carers is a central area of concern within the OOHC field. There has been little research, however, into the experiences of foster and kinship carers within the Australian context. A review of qualitative research

published between 1994 and 2006, indicated that foster carers lacked specialised training, systemic support, and assistance from governmental agencies, in relation to the care and management of children's complex needs. Additionally, the difficult behaviour of children, children's ongoing contact with birth parents, and carers' own workloads and stress negatively impact foster carers' experiences of caregiving and their decision to stop fostering (Osborne et al., 2007). More recently, Kiraly (2015) conducted a systematic review of kinship carer surveys, published between 2009 and 2013. Similar to foster carers, kinship carers reported a myriad of unmet practical and emotional support needs. Other key challenges reported were having to fund expensive and protracted legal contests over carer arrangements and having high levels of contact with children's parents and extended families. Unlike foster carers, substantial numbers of kinship carers reported having their own long term illnesses or disabilities, and many also reported having multiple caring roles, such as caring for another elderly person or their partner. These studies suggest that carers' experience numerous strains, both within the care system and outside of it that likely impact their capacity to care for children who have been abused. In addition, kinship carers appeared even less supported legally and therapeutically, than foster carers, and to be more exposed to problematic birth family dynamics.

Significant changes have been made, however, to the OOHC system over the last few years, in response to the Special Commission of Inquiry into Child Protection Services (Wood, 2008), and these may influence the contemporary experiences of carers. One fundamental change has been the transfer of case management and support from CPS agencies, of both foster and kinship carers, to non-government foster care agencies. This change was motivated by a desire to achieve a greater level of direct service provision to carers, including training, case management and the coordination and provision of therapeutic services to support placement stability

(Coalition for Children in Care, 2012). Theoretically, kinship and foster carers under the auspices of a foster care agency, might receive greater support and assistance with the children in their care, than they would have previously.

A second significant shift in the management of children in care is the focus on establishing greater stability for children in care, referred to as 'permanency planning'. Compared to other developed countries, Australia has tended to have a greater focus on family reunification. Ideally, the placement of children into temporary care ensures their safety while simultaneously providing parents with the opportunity to address concerns and increase parental capacity (Osborn et al., 2007). However, when parents take a long time to sufficiently address these concerns, extended time in care can compromise a child's development and ability to form stable attachments (Department of Community Services [DoCS], 2007). As a result, government bodies have recently recommended that parenting capacity assessments be finalised in a timelier fashion. The Children's Court is now required to decide whether family preservation or reunification is viable within specified time frames (6 months if the child is under 2 years, 12 months if the child is over 2 years). If restoration of children is unviable, permanency placement principles recommend that children are placed with relatives, or following this, adopted by foster carers. If these options are exhausted, children would remain in the legal care of the government, whilst placed into foster care (without adoption) or residential care (Roth, 2013). The objective of these changes was to address carers' concerns regarding extended problems with reunification or family contact. Both shifts in policy might be expected to provide enhanced support for carers, but they have only relatively recently been implemented.

Currently, stability of OOHC placements is difficult to achieve for a substantial proportion of children in care. The most informative Australian study of placement stability, to

date, is a longitudinal study of children in alternate care undertaken in South Australia between the years 1998 and 2000. Delfabbro, Barber, and Cooper (2000) found that 20.5% children in care experienced one or two placements, 19.7% experienced three to five placements, 17.5% experienced six to nine and an astonishing 23.5% had experienced at least 10 previous placements (Osborn & Bromfield, 2007). These findings were similar to both national and international data, indicating that placement instability is common and poses a significant risk to children's mental health outcomes (Delfabbro et al., 2010). As such, better assessment and identification of risk and protective factors associated with placement stability are needed, to inform interventions and improve outcomes for children in care (Bromfield & Osborne, 2007; DoCS, 2007).

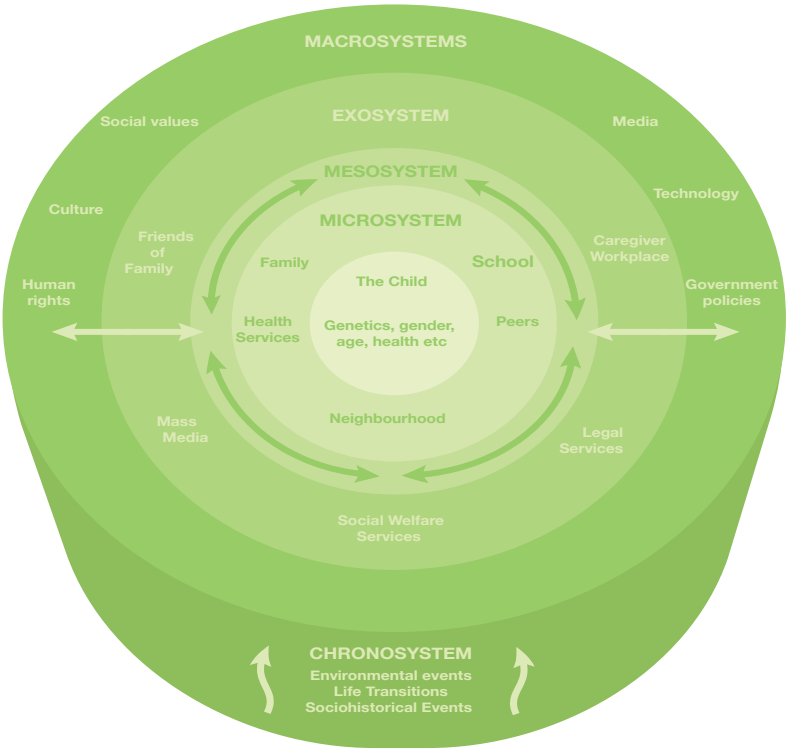
In sum, there is a need to better understand the factors that lead to placement stability problems for children in OOHC. The first study in this thesis explores child and carer variables implicated in placement instability and caregiver satisfaction, for children in foster or kinship care. The theoretical frameworks for understanding the development of child risk, harm and safety, and their application to both studies are discussed below.

Theoretical Models of Child Development, Risk, Harm and Safety

There is international consensus that both child maltreatment and safety evolve from the complex interaction of individual parent and child characteristics, and characteristics of the parent-child relationship in combination with socio-cultural influences and community and societal support (Stowman & Donhue, 2005). One of the most influential models outlining the systemic influence on child development and well-being is Bronfenbrenner's Social Ecology Model (Bronfenbrenner, 1977, 1986; Bronfenbrenner & Ceci, 1994). Bronfenbrenner's Social

Ecology Model is best represented diagrammatically (see Figure 1), and illustrates the transactional and reciprocal inter-relationships between the child and their proximal environment (e.g. family, neighbourhood, school), and how these influence and are, in turn, influenced by social, cultural and political systems.

Figure 1. The Social Ecology Model



Source: Based on Bronfenbrenner (1979, 1995). Adapted from AIHW (2012a) and Bowes, Grace, and Hodge (2012).

Bronfenbrenner and Ceci (1994), extended the model to highlight the importance of *proximal processes*: the developmentally sensitive experiences in a child's life that encourage them to meet their genetic potential across time. For instance, a child allowed to roam freely within a safe environment, with sensitive and responsive caregivers, will likely master their

potential of walking within an expected timeframe, compared to a child bound to a cot. Finally, the *Chronosystem*, signifies the interplay between the developing child and significant social, historical events or transitions across time, such as changes to a child's family structure through births or divorce, moving or leaving home, or changes to the political climate, social policy and laws (WHO, 2014).

The Social Ecology Model helps identify individual and contextual factors which contribute to a child's developmental outcomes. For example, a child's temperament, in conjunction with poverty, parental mental health issues, poorer access to educational opportunities, or the presence of war, can all help explain a child's exposure to harm, and poorer developmental and mental health outcomes (Bowes, Grace, & Hodge, 2012). As such, awareness of both child and systemic factors assists professionals to view and understand both safety and maltreatment as a totality of factors – with both problems and solutions lying in the child's surroundings (Bowes et al., 2012).

Morton & Salovitz's (2006) *Model of Safety* further explains how child safety or maltreatment may be understood from the framework provided by Bronfenbrenner's model. The authors propose that the degree of safety experienced by the child is explained by the interaction of three categories within and across systems: individual child vulnerability, family protective capacities, and threats of serious harm. For example, a child is likely deemed safe when there is low intrinsic vulnerability (e.g. the absence of health problems or disability), there are high protective factors across the micro- and meso-systems (e.g. positive parenting capacity, good parental mental health, high motivation, accessible quality day care), and there is low threat across the exo- and macro-systems (e.g. safe neighbourhood, adequate financial security, access to health services and educational facilities, human rights) (Morton & Salovitz, 2006).

Both child vulnerability and types of threats to child safety are further divided into categories. Child vulnerability is divided into two categories: those within the child (e.g. young age, medical problems) and those that interact with caregiver style and may lead to harmful caregiving (e.g. impatience with child's externalising behaviours). Categories of threats include those present within the caregiver, as well as the child's and caregiver's surrounding systems. At an individual and relational level, threats to a child may include parental emotions (e.g. depression), perceptions (seeing the child as a 'devil'), behaviours (e.g. parental assaults, impulsive behaviour), capacities (e.g. intellectual disability, parenting knowledge), and situations (e.g. unsafe neighbourhood, criminal activity) (Holder & Morton, 1999).

The Model of Safety suggests that child safety and maltreatment are not dichotomous contexts fixed in time, but occur across a continuum. Contexts where there is *present danger*, are those where the child is likely to experience immediate or active threats of harm, such as when a child is exposed to domestic violence or severe and debilitating parental mental health. *Emerging danger* refers to a context where the threshold of immediate danger or serious harm has not been reached, but the underlying conditions or contributing factors of child vulnerability, and insufficient protective factors, are approaching risk of harm. An example of this may include a parent resuming drug use, increasing parent-child relationship strain and/or deteriorating child behaviour. Conversely, *prospective safety* refers to the extent to which the underlying conditions and contributing factors related to serious harm have diminished. In this context, protective capacities have been increased and/or child vulnerability has been reduced (American Public Human Services Association [APHSA], 2009; Morton & Salovitz, 2006). Importantly, the developmental stage of the child is significant to the assessment of safety across time. For example, an adolescent with good coping skills, self-care, and engagement in school, may be less

susceptible to, and impacted by, a parent suffering depression, than a dependent infant. As the authors warn, *'the absence of threat is not necessarily the same as protective capacity'* (Morton & Salovitz, 2006, p. 1323). As such, the child's individual needs and contexts should dictate the level of safety and support required and assessment should include a constellation of factors within and across the child's system in real time.

The Social Ecology Model and Model of Safety were the key theoretical models guiding the current research, as they can inform understanding of the systemic factors that impact placement stability for children in OOHC, and also underpin any comprehensive assessment of child functioning in a particular family context. The influence of child and carer characteristics, and their impact on placement instability, are discussed below.

Child Factors Linked to Placement Instability

There is considerable evidence to indicate that children in OOHC demonstrate numerous compromised capacities and vulnerabilities. Child maltreatment, often characterised by early, multi-type, chronic and interpersonal abuse, is referred to as complex trauma and is known to impede children's developmental trajectories (Kezelman & Stavropoulos, 2012). Early maltreatment can disrupt brain growth and development, and impair the immune and nervous systems, physical development and social, emotional and behavioural outcomes (Perry, 2014; Perry & Hambrick, 2008; van der Kolk, 2003; World Health Organization, 2010).

Physically, an estimated 50% of children entering OOHC display developmental deficits, such as significant delay or deficiency in vision, hearing, movement, growth and health indices, including appropriate immunisation, compared to children not in alternate care (Crawford, 2005; RACP, 2006). Maltreated children are also more likely to have clinically significant problems with emotional regulation (e.g., depression, anxiety, anger, dissociation), behavioural control and

adaptive functioning, such as the development of living and social skills (English et al., 2005; Higgins & McCabe, 2001; Sawyer, Arney, Baghurst, Clarke, & Gratez, 2001; Sawyer, Carbone, Searle, & Robinson, 2007). Moreover, these outcomes have far reaching effects, as children with maltreatment histories are more likely to develop substance abuse and criminality, and experience social exclusion, poverty and housing problems as they develop into adulthood (Child Welfare Information Gateway, 2013; Crawford, 2005; Lee, Courtney, Harachi, & Tajima, 2015).

Despite these established findings, well coordinated access to medical and mental health services has only been established for children in OOHC in the last few years (Department of Communities, 2012). Routine bio-psycho-social screening assessments, within the first two months of children entering care, have indicated that 60% met diagnostic criteria for a major psychiatric disorder (e.g. post-traumatic stress disorder, behaviour, mood, attachment and adjustment disorders) and nearly one fifth met criteria for two disorders (Milburn, Lynch & Jackson, 2008).

Behaviour disorders. Behaviour disorders, particularly those involving dysregulation of emotions, executive function and attention, are recognised as detrimental for the foster and kinship caregiving experience (Osborne et al., 2007). Behaviour problems are typically categorised as internalising (inwardly directed responses that include depression, anxiety, withdrawal and psychosomatic complaints) and externalising (outwardly directed responses such as aggression, delinquency and antisocial conduct) (Yahav, 2006).

Recent studies indicate that upon entering care, children display elevated levels of emotion and behaviour problems across both spectrums, especially externalising problems. Tarren-Sweeney (2008a) reviewed behaviour problems in children in OOHC across Australia, North America and Europe and concluded that children in care were between three to four times

more likely to have clinically significant problems with externalising problems, and almost twice as likely to have internalising problems than the general population. Disentangling internalising and externalising problems, as a cause or consequence of compromised placement stability, is difficult, however. A few studies indicate that externalising behaviour problems are strongly implicated in placement breakdown, but also acknowledge that placement breakdown itself is associated with the development of externalising behaviours. Newton, Litrownik, and Landsverk (2000) undertook a prospective study to examine the relationship between changes in placement and emotional and behaviour problems, among 415 foster children (0-17 years) in California. Data was collated at 5 and 17 months after entering care. Externalising problems at Time 1 were the strongest predictors of placement breakdown. Those children who were disruptive, aggressive and/or dangerous to others at the start of the placement were more likely to be moved to a different setting. However, placement changes were also the strongest predictor of externalising and internalising problems in the foster children at Time 2, and children who experienced multiple placement changes were at particular risk of behaviour deterioration.

The establishment of a secure placement for children following removal is crucial, with respect to their behaviour and emotional well-being. Rubin and colleagues (2007) examined the contribution of a child's placement stability towards their risk of mental health outcomes, 18 months after entering care, in a large North American sample (n = 729). The strongest predictor of mental health problems at 18 months after removal, were children's baseline rates of behaviour problems or 'well-being'. However, placement stability was also a significant predictor of well-being outcomes: 31% of children who achieved early stability (permanency within 45 days of removal), 38% of children who achieved late stability (> 45 days) and 51% of children in unstable placements had poor clinical outcomes at 18 months, respectively. Even

among children who carried a low risk for placement instability (no evidence of externalising or internalising problems), one in five failed to achieve any stability in the first 18 months of care.

Finally, data from large samples within the US suggest that child gender and type of carer may be important factors to consider in relation to behaviour problems among children in care, with boys reported by caregivers and teachers to have more behaviour problems than girls. Further, kinship carers tend to report lower behaviour problems among children in their care, than do either foster carers or teachers, yet teachers report greater behaviour problems among children in kinship – as opposed to foster care. The authors suggest that kinship carers may "under-perceive" or under-report problem behaviour, as they may feel a greater sense of responsibility for the child's outcomes, due to intergenerational problems (Rosenthal & Curiel, 2006).

These studies provide evidence that children entering care typically present with considerable personal challenges and that these individual factors influence the contexts and inter-relationships within their micro- and mesosystems. Specifically, children who display externalising problems appear at greater risk for placement instability, and placement instability itself is a risk factor for social, emotional and behaviour problems.

Sexualised behaviours. In addition to externalising behaviours, studies over the last decade have recognised that a number of children in care display sexualised behaviours, and these behaviours are also implicated in placement instability. Research and clinical assessment of sexualised behaviours amongst children and young people is relatively new, and accurately defining these behaviours has been challenging. A confounding issue is the fact that children may be both a *victim and initiator* of a continuum of behaviours ranging from developmentally

inappropriate to sexually abusive behaviour[5] (Bonner, Walker, & Berliner, 1995). In the last decade, terminology has developed to differentiate the nature and severity of sexualised behaviours. The term 'Sexually Abusive Behaviours' is often ascribed to children over the age of 10 years, is based on legal culpability, and requires comprehensive assessment of contextual and developmental factors (O'Brien, 2010). 'Problem Sexual Behaviour' (PSB) refers to a spectrum of behaviours such as excessive stimulation, sexual approaches to adults or other children, obsessive interest in pornography, and making sexual overtures to other children that are outside typical developmental bounds and may or may not involve coercion.

Although most data on the prevalence and treatment of PSB has been collated from North America, research in the Australian context is growing. While no single cause has been identified, Australian data indicates that children with problematic sexualised behaviours are more likely to have experienced childhood trauma, compromised educational outcomes, adverse socio-economic conditions, homelessness or unstable living conditions (including alternate care), intellectual impairment or developmental delay, social isolation and exposure to drug or alcohol misuse (O'Brien, 2010). Associated psychological problems include high levels of internalising and externalising problems, low levels of empathy and restricted affect. Additionally, more sexually abusive or sexually aggressive behaviours are associated with greater rates of conduct disorder and hyperactivity (Staiger, 2005).

The few studies investigating PSB amongst children in OOHC, indicate a high prevalence and strong links to child maltreatment and placement history. Baker and colleagues (2008), examined the relationship between current sexualised behaviours, past traumatic events

[5] There are especial concerns amongst specialists to avoid assigning character labels to children (i.e. "perpetrator") and erroneously attributing culpability in contexts where a child or young person has an intellectual disability, developmental delay or other significant cognitive limitation (Bonner, Walker & Berliner, 1995).

and clinical symptomatology among 97 children aged 10-12 years in OOHC in North America. Up to 23% of children met clinical criteria for PSB and this group of children were also more likely to have clinically significant behaviour problems, as assessed by the Child Behaviour Checklist (CBCL). A large Australian epidemiological study found slightly higher rates of PSB amongst children in alternate care. Tarren-Sweeney (2008b), found up to one-third of the 347 children in foster or kinship care (aged 4-11 years), were reported by their carers to display some form of problematic sexualised behaviour. In addition, independent predictors of problematic sexualised behaviours included being older at entry into care and a history of placement instability.

The course of PSB has been found to vary depending on the care context. Friedrich and colleagues (2005), investigated the trajectory of sexualised behaviours over a one-year period, among children in foster homes and residential treatment centres in North America. While sexualised behaviours tended to be persistent, reductions in, or cessation of these behaviours were far more likely to occur for children who resided in foster care, compared to those in residential settings, despite children in the latter setting receiving mental health intervention.

These studies suggest that PSB may be a common, yet typically under-assessed, problem for children, young people and their carers within the OOHC system. A proportion of children with abuse histories are vulnerable to the development of PSB and placement breakdown. The successful treatment of PSB appears more likely to be achieved when a child experiences an alternate family-style care context, suggesting that stable attachment experiences are crucial. At the same time, children with PSB also display interpersonal difficulties in their relationship with their carers. Carers of children with PSB are more likely to report that these children ‘bothered’

them and experienced them as ‘mean’ and ‘demanding’ (Baker et al., 2008). Problematic sexualised behaviours likely add to the overall caregiver challenges for foster and kinship carers.

In sum, externalising behaviours and sexualised behaviours appear to be key vulnerabilities experienced by children in OOHC that may impact placement stability. Study 1 proposes that both externalising behaviours and sexualised behaviours impact placement stability and carer satisfaction.

Carer Factors Linked to Placement Instability and Carer Satisfaction

An extensive body of research has identified parent characteristics that interact with and contribute to children’s social and emotional well-being (Eschel, Daelman, de Mello, & Martines, 2006; Fonagy, Steele, Steele, Moran, & Higgit, 1991; Hoffman, Cooper, Powell, & Marvin, 2006; Mash & Barkley; 2014, White, 2005). In brief, these highlight the contribution of the caregiver’s ability to sensitively attune to the child’s emotional needs, their capacity to support appropriate autonomy and engagement with learning and social opportunities, and their ability to provide effective behavioural management (WHO, 2014). Despite this, research on carer factors in relation to placement stability has focused on relatively extrinsic or demographic variables, such as placement characteristics, for example, foster versus kin placement, number of other children in placement, and caregiver income and education level (Briggs & Broadhurst, 2007; Bromfield et al., 2005; Carter, 2002; DoCS, 2007; Smith, 2004). As such, much remains unknown about the interplay between foster and kin carers’ parenting capacities, their responses to child vulnerabilities at placement, and placement outcomes. Foster and kin carers play a central role in assisting children to recover from maltreatment, in the context of prior attachment trauma (Berrick & Skivenes, 2012; Dozier, 2006a). Arguably, parenting skills demonstrated by birth parents and associated with positive outcomes for children, are equally, if not even more

critical, amongst foster and kin carers and likely to influence child development and placement stability.

Parenting style. One of the most influential theoretical frameworks for conceptualising the balance between care (emotional responsiveness and support) and control (limit setting) is Diane Baumrind's (1966, 1991, 2013) typology of permissive, authoritarian and authoritative parenting styles. From this perspective, a permissive parenting style is characterised by parental submissiveness to a child's desires and demands, and the use of inconsistent and indirect discipline strategies. Parents with this style may be warm and emotionally responsive in their interactions with their children, but they make few demands for mature behaviour and self-regulation, and generally try to avoid confrontation. Authoritarian parenting, on the other hand, is characterised by demanding, directive parental strategies that may include stern discipline and harsh enforcement of rules, corporal punishment, a tendency to shame children, withdrawal of love and affection, and a lack of emotional support and respect for the child's individuality and needs. The authoritative parenting style is considered optimal. Authoritative parents are both appropriately demanding (provide adequate control and structure) and supportive and emotionally available. They impart clear expectations of, and consequences for, positive and negative behaviour. Authoritative parents share their reasoning with their children, whilst also supporting their children to express their needs, experiences and views, even if they are different from their own. Importantly, authoritative parents are sensitive to their children's emotional experiences and developmental needs, and discipline is supportive and educative rather than punitive (Baumrind, 1991).

Numerous large cross-sectional and longitudinal studies of biological children and their parents have demonstrated that both authoritarian and permissive parenting are associated with

more problematic behaviours across childhood and adolescence. An authoritarian parenting style has been shown to predict emotional dysregulation and conduct disorders in middle and late childhood (Morrel & Murray, 2003; Thompson, Hollis, & Richards, 2003), and elevated levels of externalising behaviours among boys and girls across childhood and adolescence (Benzies, Keown, & Magill-Evans, 2009; de Haan, Prinzie, & Dekovic; 2010; Grogan-Kaylor, 2004; Mash & Barkley, 2014; McCloyd & Smith, 2002; Prinzie et al., 2003). Permissive parenting has also been associated with childhood externalising behaviours, but appears more strongly associated with internalising problems (Baumrind, 1991; Fite, Stoppelbein, & Greening, 2009). Conversely, authoritative parenting is associated with fewer child externalising and internalising problems and is generally predictive of adaptive, self-regulatory skills in childhood and adolescence (Fuentes, Salas, Bernedo, & Garcia-Martin, 2015; Rinaldi & Howe, 2012; Tan, Deng, Zhang, & Lu, 2009).

There is a dearth of research exploring the impacts of individual differences in parenting style of foster parents on children's behavioural problems across time. One small longitudinal study, however, strongly implicates negative parenting practices in the maintenance and development of behavioural problems. Vanderfaeillie and colleagues (2013) investigated the development of problem behaviours across two years, amongst 49 children aged 6-12 years, in long term foster placements (1-11 years, Mean = 4.8 years). A substantial number of children in this study (n = 23), maintained problems over time, 18 had an increase in behavioural problems, and only eight improved. An increase in overall behaviour problems (internalising and externalising), was associated with authoritarian parenting styles and elevated parenting stress. Specific parenting behaviours found to be associated with poor outcomes were the use of harsh punishment, such as verbal blaming and/or corporal discipline and ignoring the child. Parenting

stress focused on the carer's experience of their child, such as feeling unable to cope and experiencing the child as a burden. No child factor or level of educational attainment by the foster mother was associated. A decrease in overall behaviour problems was associated with supportive parental behaviour (e.g. problem solving and involvement with the child).

Although behaviour problems are implicated in placement breakdown, and parenting practices are associated with the development or reduction of these, the research on parenting practices and placement stability is limited and results are mixed. O'Neil and colleagues (2012) examined the impact of carer's emotional support of the child (i.e. parental verbal responsiveness to their child, the reported use of physical affection and physical discipline), but found no associations with placement stability. The researchers speculated that the measure used, the HOME Inventory short form (Caldwell & Bradley, 1984, 2003), may not have adequately captured important aspects of the parent-child relationship.

Other studies have demonstrated that aspects of authoritative parenting styles are associated with better placement outcomes. For example, caregiver insight into their child's needs (Hartnett, Leathers, Falconnier, & Testa, 1999), warmth and empathy (Wilson, 2006), positive parental communication, limit setting and support (Crum, 2007), have been positively associated with placement stability in cross-sectional studies. It is difficult, however, to compare findings across studies because of methodological issues. Measures vary, are not typically standardised, and in some cases, rely on child protection caseworker accounts of carer's parenting style and are thus open to bias. These studies do suggest, however, that an authoritative parenting style may be at least as important amongst foster carers as it has been shown to be in birth parents. Indeed, it could be speculated that parenting style may be particularly important in addressing emotional and behavioural problems, especially for older children with entrenched

difficulties and those who are more vulnerable to placement breakdown (Gavita, David, Bujoreanu, Tiba, & Ionutiu, 2012). The first study of this thesis considers the influence of parenting style on placement stability.

Parental empathy. As noted in the previous sections, children with difficult attachment histories may bring complex behaviours and a limited capacity for emotional regulation into their new relationship with their foster carer. In this sense, caregivers need a range of resources or protective capacities to help them manage not only the child's vulnerabilities, but also their own responses to them. Perry (2001) and Dozier (2001) suggest that in order to provide a corrective attachment experience for children, caregivers need to recognise the underlying emotional needs of their child, as well as be able to discriminate these needs from their own and to manage their own personal distress. These specific capacities have been encompassed in the construct of parental empathy.

Empathy includes both emotional and cognitive processes and has been defined as the capacity to recognise and tolerate one's own and another's emotional states, and to take the perspective of another's experience (Davis, 1980, 1992; Thorensen, 2008). These capacities assist parents to model emotion regulation and social competence to children (De Paul et al., 2008; Denham, Mitchell-Copeland, Strandberg, Auerbach, & Blair, 1997; Joireman, 2001; Lipscombe, Farmer, & Moyers, 2003; Manczak, Delongis, & Chen, 2016; Smith, Stormshak, Chamberlain, & Whaley, 2001) and influence the effectiveness of positive parenting strategies (Benbasset & Priel, 2012).

Parental empathy has also been associated with abuse risk. Parents who report problems with taking the perspective of others are also more likely to report parental aggression, inappropriate discipline style and higher scores associated with child abuse potential (McElroy &

Rodriguez, 2008; Rodriguez, 2013). Moreover, maltreating parents (where abuse is substantiated), report lower levels of emotional compassion and ability to take the perspective of others, compared to non-maltreating parents (De Paul et al., 2008; Perez-Albinez & De Paul, 2004; Swick, 2007). The ability to manage personal distress, and not be overwhelmed by one's own emotional responses also appears to differ across at-risk, maltreating and non-maltreating parents. Maltreating parents and parents considered at high risk of abusing their child(ren), both report higher tendencies towards personal distress, compared to low risk and non-abusing parents (De Paul et al., 2008). Substantiated child abuse perpetrators also reported significantly less emotional compassion, less perspective taking and greater personal distress compared to foster carers who were conceptualised as a non-abusive comparison group (Wiehe, 2003). Together, these studies provide support for the link between parental empathy and parenting style.

Empathy may also directly influence placement stability. Testa and Slack (2002) examined the effect of carer empathy on reunification (child being placed back in care of natural parent) and placement breakdown rates for kinship care. In this study, levels of empathy were derived from carers' ratings of the quality of their relationship with the child, and those reporting poor relationship quality were significantly more likely to terminate the placement. These findings were independent of financial remuneration or the level of cooperation of natural parents in visiting and addressing child protection concerns. The authors suggested that empathy influenced the quality of the carer-child relationship and carer satisfaction, and thus the ultimate stability of placement. It should be noted, however, that while the study findings were interpreted with reference to empathic capacity, the researchers did not use a validated empathy measure and no measure of carer satisfaction was included.

The impact of empathy on foster care placement stability has also been extrapolated from two qualitative studies examining adolescents' and adults' perceptions of their relationship with their carers. In a retrospective Australian study of young people, up to five years after leaving care, Cashmore and Paxman (2006) found that the assigned level of 'felt security' to their foster family significantly predicted current positive outcomes in young adults who had been in care (i.e. social support, employment, education, stable housing). Schofield (2002) also interviewed 40 adults (18-30 years) who had grown up in long term foster care, about their experiences. Both studies provide narratives of experiences of foster care and reveal how 'felt security' may develop. A common response was that as children, they had relied on their foster carer to make the first overtures in developing the carer-child relationship. Specifically, they reported that when their carer was sensitive and available, their childhood defences and anxieties subsided, and they, in turn, perceived their carer as available, both emotionally and practically. Participants indicated that in these contexts, they then felt increasingly able to rely on their carer, positively reinforcing a mutual relationship.

The studies on parental empathy, together with the retrospective studies of adults who had directly experienced foster care, strongly suggest that empathy influences the caregiver's ability to attune and effectively respond to the needs of a child, and that a child's sense of security depends on the caregiver's persistence in providing sensitive caregiving over time, regardless of the child's insecure responses and acquired defensive strategies. Parental empathy may help explain the differences between appropriate, under- or over-controlling parenting practices. Parents with lower empathy, who may not adequately consider the child's emotional and cognitive context, and thus the meaning of their behaviours, may assume an authoritarian or permissive stance, based on their own immediate internal experiences and needs. Parents with

greater empathy, who consider the perspectives of the child and regulate these alongside their own needs, may be better equipped to employ explanation, reasoning, coaching and fair consequences inherent to authoritative parenting.

Attachment formation & the unique challenges for foster & kinship carers.

Originally conceptualised by John Bowlby (1960, 1977, 1982), attachment theory asserts that the formation of a stable emotional connection with a primary caregiver is essential for infants to secure their survival, as well as achieve optimal physical, emotional, and social development. Infants are born with the biological capacity to express attachment behaviours that typically evoke care and protection (e.g. crying, orienting body towards caregiver), and which become more sophisticated as the child matures (e.g. walking towards carer, verbally seeking comfort). Importantly, the infant and child's experiences of caregiving are said to shape their affective states and beliefs about themselves and their caregiver. These beliefs or 'internal working models' are theorised to also influence the developing child's experiences and interactions in other important relationships, such as with peers and romantic partners and, in time, with their own children.

Mary Ainsworth and colleagues (e.g. Ainsworth, 1979; Ainsworth, Bell, & Stayton, 1972; Ainsworth, Blehar, Waters, & Wall, 1978), developed an empirical paradigm to explore individual differences in attachment quality. Ainsworth and colleagues (1978) identified three distinct attachment strategies or styles, through observations of children's behaviour in response to separation and reunion with their caregivers, in the Strange Situation Procedure: Secure, Insecure Avoidant, Insecure Ambivalent/Resistant. A fourth 'Disorganised' attachment strategy was later identified by Main and Solomon (1986, 1990), based on observations that children from very high risk backgrounds often displayed atypical behaviours that did not fit the three

previously identified strategies. Drawing on observations of infants in the Strange Situation Procedure, and extensive observations of their interactions in the home, Ainsworth and colleagues were able to demonstrate that caregivers who provided sensitive, predictable and timely comfort and reassurance, tended to have infants classified secure, who were readily soothed by their caregiver when distressed and also able to engage in confident exploration. Caregivers who frequently displayed rejecting behaviours towards the infant, particularly in the context of contact seeking, emotional expression and attachment bids, were more likely to have infants classified avoidant, based on a tendency to turn away from their caregiver rather than seek comfort. Caregivers who were inconsistent in their parenting responses, and thus often emotionally unavailable to the child, had children who showed ambivalent/resistant attachment with high levels of distress, which was not ameliorated by proximity to the caregiver, and low levels of exploration (Ainsworth, 1979; Ainsworth et al., 1978). Finally, disorganised attachment, characterised by an infant's display of confusing or disoriented behaviours when under duress or threat, has been observed amongst children who have experienced frightening caregiving or interactions with caregivers who appear frightened at times of high emotional arousal (Dozier, Higley, Albus, & Nutter; 2002; Stovall & Dozier, 1998). In the context of parent-child interactions, insecure strategies can be viewed as strategic attempts by the infant to manage distress, when under the care of an unpredictable, rejecting or frightening caregiver, while maintaining physical and/or psychological safety (Crittenden, 2005). Disorganised behaviours are less adaptive and coherent, and reflect the child's inability to achieve emotion regulation through their relationship with their caregiver (Sroufe, Carlson, Levy, & Egeland, 1999).

Not surprisingly, attachment-related problems are prevalent amongst children and adolescents entering care (Gleason et al., 2014; Tarren-Sweeney, 2013). While research generally indicates that attachment styles tend to be stable across time, this is contingent on stable caregiving contexts (Jacobsen, Ivarsson, Wentzel-Larsen, Smith, & Moe, 2013; Lewis, 2001; Pinquart et al., 2013; Tucker & McKenzie, 2012). The stability of attachment styles for children in foster and kin placements has received little empirical attention. An informative study with foster families indicated that maltreated infants continue to display problematic attachment strategies, even within the context of new, non-abusive caregiving. Tyrell & Dozier (1999), interviewed 25 foster carers and 25 birth mothers, in relation to their experiences of their children (aged 6 months to 5 years), and their knowledge of attachment strategies. Foster and birth mothers were also videotaped engaging in free play with their child. Foster mothers of children as young as one year of age reported their infants to display avoidant and resistant behaviours; difficulties with being soothed and rejecting of physical contact, compared to caregivers of children not in OOHC. In this study, there were no differences between these foster and birth mothers, with regards to parental sensitivity or knowledge of attachment strategies (Tyrell & Dozier, 1999). The stability of problematic attachments in children in foster and adoptive care has continued to be evidenced in numerous studies, and strongly suggest that these children require particularly sensitive, consistent and persistent caregiving, in order to develop trust and security with their new caregiver (Bakermans-Kranenburg et al., 2011; Cassidy & Shaver, 2016; McClean, 2016).

Children may continue to exhibit attachment-related problems for a number of reasons. In addition to maltreatment experiences, children entering care are often grieving. Separation from parents is often accompanied with the loss of siblings, pets, friends, school, personal belongings

and cultural and historical identity. Adults who have left foster care often recall a history of losses that were not adequately recognised by workers and caregivers, and which leave emotional scars long after leaving care (Eagle, 1994; Fineran, 2012; Herrick & Piccus, 2005; Unrau, Seita, & Putney, 2005). This grief has long been considered a threat to the development of an alternate attachment figure. As the birth parent continues to remain unavailable, typical grief responses of hostility, despair, withdrawal and regression continue to be activated, but can only be redirected towards the new caregiver (Bowlby, 1960, 1977). In this regard, problematic attachment strategies, compounded by grief, pose significant challenges to the new caregiver and the formation of the parent-child relationship.

Individual differences in caregiver capacity. How foster and kin carers respond to their child's emotional cues likely effects the child's attachment security and the caregiver's experience of parenting. Alongside the child's attachment system, there is a reciprocal caregiving system. Within birth families, research has consistently shown that the security of an infant's attachment can be predicted from the caregiver's attachment state of mind. This state of mind is derived from his/her own history of caretaking and is a robust predictor of the child's attachment security (Verhage et al., 2015). Three different patterns of parental attachment representations have been demonstrated, to map onto the different child attachment classifications (Maine, 1990, 1996). Secure parents with 'autonomous' states of mind, tend to present coherent representations of their own attachment relationships and are able to interpret and respond appropriately to their children's needs, acting as a secure base from which the child can explore their environment (Dozier & Sepulveda, 2004; Main, 1990, van Ijzendoorn, 1995). Parents with insecure attachment styles, or 'non-autonomous' states of mind (i.e. dismissing, preoccupied or unresolved) present incoherent accounts of their own attachment history and its impact on their

current functioning and do not interact with sensitivity to their child's needs. Dismissing parents tend to idealise current and past relationships and lack coherent, consistent narratives of their attachment relationships. They may also minimise the attachment behaviours of their children and may be emotionally distant towards them as the attachment behaviours evoke their own feelings of vulnerability (Dozier & Sepulveda, 2004). Preoccupied parents tend to have confused mental representations of attachment, characterised by a preoccupation with ongoing reactive emotional responses to early caretaking experiences. They provide inconsistent caregiving, and may encourage dependence in their children, while at other times failing to respond to distress and, as a result, tend to have children who display ambivalent and resistant behaviours. Parents with unresolved issues of trauma and/or loss often describe themselves as feeling inadequate as caregivers and may fear losing control. Their representations of their early attachment experiences may be incoherent and characterised by lapses in reasoning and dissociation or disorganisation (Caltabiano & Thorpe, 2007; Cassidy & Shaver, 1999; Zeanah, Berlin, & Boris, 2013).

Few studies have examined the process of attachment formation amongst children in OOHC and their new caregivers. Recent studies suggest that the process by which children experience security with their new caregiver may take a significant amount of time and may, in part, depend on the age of the child at placement. Van Ijzendoorn & Juffer (2006) conducted a meta-analysis of 270 studies, with respect to over 230,000 adopted and non-adopted children and their parents. They investigated if, and to what degree, adopted children were able to 'catch-up' to expected developmental milestones, including height, attachment security and academic achievement, compared to peers who remained with their family of origin or in institutional care. Overall, adopted children largely outperformed their peers residing in birth family or institutional

care. In particular, adoption within the first 12 months of life was associated with a more complete catch-up. Catch-up, however, remained incomplete in some developmental domains, including attachment security. Specifically, adoptive children were found to be less secure than children from nonclinical, non-adoptive families, 47 vs 67% respectively (van Ijzendoorn & Juffer, 2006). A prospective longitudinal study undertaken by Vorria and colleages (2003, 2006), suggests that for children placed into alternate care after 2 years of age, attachment security formation may require a significant amount of time. The authors examined attachment amongst 52 Greek children, raised in orphanages until 2 years of age, and their parents post adoption. At 2-year follow up, the children displayed lower levels of security than children within a community comparison group. However, at age 13 years, the adopted children displayed generally positive attachment relationships with their adoptive parents (Vorria, Ntoumi, Varami, & Rutter, 2015). This study did not examine caregiver behaviours and it was thus unclear what contributed to the improvement in the parent-child relationship over time.

Two earlier studies (Stovall & Dozier, 2000, 2004) provide insight into the co-creation of relationship security and the critical nature of caregiver responses. The authors examined the development of attachment formation within the first few months of placement, in a sample of 48 foster carers and infants. Foster parents of children placed into care prior to 12 months of age, who had secure states of minds themselves, tended to respond to children's insecure behaviours with nurturing behaviours, and these children tended to exhibit secure attachments. These carers were able to recognise the needs of the child, despite the child's avoidant or resistant behaviours. Importantly, they seemed able to override their own cognitive and affective responses to the child's alienating behaviours, in order to provide an environment that helped the child develop self-regulatory capacities (Dozier et al., 2009). Dozier and colleagues (2009), also found that

foster parents with insecure attachment styles tended to turn away in response to infant avoidant behaviours, and show frustration or anger in response to resistant behaviours. Infants of these carers also exhibited insecure attachments.

Maladaptive attachment strategies for infants placed into care after 12 months of age appeared more impervious to change after placement. Even among carers with an autonomous state of mind with respect to attachment, a subset was observed to mimic the child's insecure attachment styles with either avoidance or frustration, and these infants continued to exhibit insecure attachments. Dozier and colleagues (Dozier, 2005; Dozier, Stovall, Albus, & Bates, 2001; Dozier et al., 2002; Dozier et al., 2009), suggest that this dynamic may occur for a number of reasons. Infants placed later have likely experienced maltreating and disruptive environments for longer periods. Subsequently, these infants have more difficulties trusting and being soothed by their carer, as well as less experience and success in showing clear proximity-seeking behaviours towards their carer. These infants may need prolonged experiences of sensitive nurturing, in order to build trust that enables them to depend appropriately on their carer. Carers who mimic their child's insecure attachment behaviours may do so consequent to feeling unneeded by an avoidant child, and ineffective with a resistant child. Nonetheless, these responses inadvertently reinforce the child's experience of caregiver unavailability and likely serve to maintain the child's and carer's insecurity within the relationship and the overall caregiving experience.

Children removed from maltreating environments and placed into new caregiving contexts relatively later in life, would be expected to require significant and prolonged caregiver responsiveness if they were to develop appropriate attachment strategies. A recent study suggests that there is potential for older children in stable placements to develop mental representations

indicative of secure attachment with their foster carer, despite having mental representations indicative of insecure or disorganised attachments with their birth parent. Joseph, O'Connor, Briskman, Maughan, and Scott (2014), administered the Child Attachment Interview to 62 adolescents, to ascertain the mental representations they held with regard to their attachment with both their birth parents and foster parents, and compared these to a sample of 50 adolescents living within the same geographical location in London. Almost all (90%) of the adolescents in foster care displayed mental representations indicative of insecure attachment with their birth mother, and all (100%) indicated insecure attachment with their birth father. Despite this caretaking history, almost half were classified as having a secure attachment with their foster mother and father (46%, 49% respectively). More than half of the adolescents likely experienced long term maltreatment, having entered care relatively late (between 5-10 years of age). Most had also experienced significant relationship disruption with an average of four prior placements. The strongest predictor of attachment security to foster mothers was the duration of the current placement and the foster mother's observed positive interaction with the adolescent, notably warmth, assertiveness, communication, and involvement. In this study, the attachment style of the carers was not assessed, however results suggest that caregiver's ability to persistently and positively respond to their child's needs, despite likely attachment challenges, can directly influence the quality of the parent-child relationship over time, even in cases of late placement.

There is growing evidence that caregiver attachment style influences parenting experience and parenting satisfaction. Vincenzo and Francesca (2015) studied the quality of caregiving experience amongst 118 couples (236 participants), of children aged 0-6yrs. Attachment anxiety negatively influenced caregiving satisfaction. In line with previous research, the authors surmised that caregivers with attachment security (i.e. low anxiety and low

avoidance) are better able to withstand relationship stress, without experiencing a perceived loss of that relationship, and are thus more likely to report higher levels of relationship satisfaction. Whilst this study focused on birth parents, the link between adult attachment style and caregiver satisfaction amongst foster and kin carers would appear similar. Caregiver attachment anxiety is likely to exacerbate feelings of inadequacy and ineffectiveness, typically experienced in response to children's problematic attachment behaviours and, in turn, impact caregiver satisfaction.

In sum, children entering care typically bring attachment-related difficulties, which pose significant challenges for caregivers in their task of developing secure relationships with their children. A caregiver's own attachment style influences his/her ability to respond to the child's underlying needs for nurturance and therefore seems likely to be an important contributor to the co-creation of relationship quality and caregiver satisfaction. This may be particularly the case in the context of responding to children with complex and traumatic histories. In addition to child-related factors of externalising and sexualised behaviours, the first study explores the associations between parenting style and parental empathy on placement stability, and caregiver attachment style on carer satisfaction.

Carer training, support and strain and stress. Caregiver capacity is likely to be influenced by their context, particularly the availability of, and access to, supports (Belsky, 1984). The relative strengths or weaknesses of caregivers' internal resources and supportive systems across micro-, meso- and exo-systems, and the impact of these on placement stability, have been investigated. Specifically, the level of training and experience, support, strain and type of caregiver have been implicated. In a large, North American longitudinal study of 436 children, aged up to 11years, O'Neil and colleagues (2012) considered both child and caregiver characteristics predictive of placement stability across an 18-month period. For younger children,

(aged 1-5 years), carer type, number of household members and level of carer experience predicted placement breakdown. Foster carers were up to 83% less likely to maintain stability of placement than kinship carers. The researchers speculated that, unlike with foster carers, children may have already established attachments with kinship carers, and this may help buffer placement strains. Both foster and kinship carers of younger children were also less likely to maintain stability with each additional number of people in the household, be they adult or child. For older children (aged 6-11years), externalising behaviour problems and carer age predicted placement breakdown. Notably, for each unit increase in caregiver age, a child was almost twice as likely to achieve placement stability. Finally, caregiver experience also predicted stability but the effect was very small. This suggests that carer maturity, and to a lesser degree formal experience, helped carers withstand the challenges experienced with taking on the care of older children. In this study, carer income, education and marital status were not found to impact placement stability.

To help children in care maintain familial connection, cultural identity, and where possible, established emotional ties, placement of children in kinship care remains the preferred option in current legislation (Roth, 2013). Theoretically, kin carers are considered to possess a greater degree of responsibility for, and affinity towards, the child – and their biological relatedness is believed to contribute to resiliency in the face of parenting challenges (Helton, 2011). However, burgeoning research into kinship care suggests that kin carers may face additional challenges over and above those faced by non-related carers, and that this may impact children's outcomes. Historically, studies have indicated that foster placements provide greater stability for children in care (Helton, 2011; Koh, 2014; Timmer, Sedlar, & Urquiza, 2004). However, a recent large, longitudinal study of children in care, aged 0-17 years in Denmark (*n* =

13,157), found that kinship care was as stable as foster care (Andersen & Fallesen, 2015). Yet, when caregiver strains are considered, kin carers report greater levels of parenting stress, depressive symptomatology and higher scores on the Abuse Potential Scale, compared to foster carers (Timmer et al., 2004). While kinship care seems inherently protective, these studies draw attention to the need to consider individual contextual factors and the unique complexities that kinship carers may face.

Surprisingly, the impact of carer training and ongoing support on placement stability has received little empirical attention. A systematic review of six existing studies on the effectiveness of (foster) carer training and support on children's well-being in OOHC, across the US and UK, provides mixed findings. Only one study investigated the impact of training on actual placement stability and found no relationship. Training was found to positively impact younger children's emotional and behavioural outcomes, but only in the US, where the training provided was of longer duration (Everson-Hock et al., 2012). Another systemic support provided for carers is children's access to psychological therapy. Two studies have found that timely access to mental health support services for children has been associated with better placement stability (DoCS, 2007), regardless of length of time in placement (Hartnett et al.,1999).

Overall, research currently suggests that over time there is no difference in the stability of care offered by foster versus kin carers. The literature also indicates that there may be different caregiver experiences and needs between these types of carers, and that these, in turn, may impact the quality of care provided to children. The impact of professional training, therapeutic support on carer satisfaction and placement stability has not, however, been adequately addressed. While not the primary focus of this study, the impact of these systemic factors on

placement satisfaction and stability will be considered, in the current study along with carer age and family size.

Measuring Placement Stability

Carer satisfaction and carer concern for placement breakdown. Studies examining factors associated with placement breakdown have not adopted consistent criteria for measuring placement stability, disruption or actual breakdown, and are difficult to compare. A number of studies have not considered medium term respite placements (resulting from carer stress) or changes of carers, as part of an overall measurement of placement breakdown. For example, one study (Testa & Slack, 2002) referred to children's re-placement to another kin carer, as a '*placement transfer'*, rather than actual breakdown. Similarly, a large study did not differentiate between placement breakdowns and failed restorations (Espositio et al., 2014). These placement changes are important to identify, as moving a child from one carer to another – even a related one – likely involves significant loss and disruption from the child's perspective. Additionally, views on when a placement achieves 'stability' differ. Some studies assess stability as achieved from three months onwards (e.g. Meloy & Phillips, 2012), despite retrospective studies indicating that stability is more likely to be attained following two years into a placement (Taplin, 2005). Currently, there are no standardised instruments available to help assess placement stability in situ. However, overt statements from a carer that they do not consider that they can continue to manage a placement, appear, at least in practice, to be a clear indicator of placement stress and risk of breakdown. Given this, the present study includes a measure of carer's concern about placement breakdown.

Carer satisfaction with the caregiving role may influence the ongoing commitment to providing care and placement stability, but remains under-researched. In one study of 539 foster

carers in eight urban counties in North America (Denby, Rindfleisch, & Bean, 1999), carer satisfaction with their role predicted their intention to continue fostering into the future. In Australia, qualitative studies with foster carers indicate a growing dissatisfaction with the role of fostering (Briggs, 2007; Kennedy, 2004; Smith, 2004) and this has corresponded with a decline in carer availability (AIHW, 2013; Bromfield, Higgins, Osborn, Panzanno, & Richardson, 2005).

Although carer satisfaction appears a useful construct to help explain stability of placement, studies to date have not generally employed standardised tools to assess this. It would seem that both carer perception of current placement stability and carer satisfaction are important when considering placement outcomes. A central assumption in the studies discussed has been that carer satisfaction with their role is independent of the specific child they are caring for. In reality, many carers who relinquish care of one child may continue to foster siblings of that child and/or other children. Assessing carer satisfaction in general may overlook individual carer-child factors that result in placement breakdown. It may well be that carers who are generally satisfied with their caregiving role may be dissatisfied with the role in relation to a specific child. Given the research evidence to date, both carer satisfaction and carer concerns for placement breakdown in relation to a specific child were included in the first study.

Summary Study 1: Child and Carer Characteristics Associated with Placement Stability for Children in Out-of-Home Care

In sum, child development, safety and maltreatment depend on a complex interplay between the individual, dyadic and group systems surrounding a child over time. As the previous sections outline, a majority of children in OOHC enter placements with significant mental health issues, behaviour problems and vulnerabilities that are exacerbated by placement breakdown. Child-related factors associated with placement instability include behaviour problems

(specifically externalising behaviours and sexualised behaviours). Carer-related factors have been less widely researched, but studies with biological parents suggest that over-reactive, harsh or lax parenting may maintain children's externalising problems, a factor implicated in placement breakdown and worth considering in research among foster and kin carers. Caregiver empathy, namely the ability to be emotionally and cognitively compassionate and understanding of their child and to manage personal distress, influences capacity to engage in child-focused parenting strategies and parenting style. Caregiver attachment style may influence their ability to respond to children's underlying needs for nurturance and, therefore, seems likely to be an important contributor to parenting style. There is some indirect evidence from qualitative studies suggesting this is particularly important for children establishing trusting relationships with foster carers and reducing the likelihood of placement breakdown.

The first study in this thesis investigates the relationships among children's externalising and sexualised behaviours, caregiver parenting style and empathy, and caregiver concerns that they will not be able to maintain the placement long term (or for the term they have agreed to)[6]. This study also examines the impact of child behaviour difficulties, caregiver attachment style and empathy on caregiver satisfaction with the placement.

[6] A proportion of carers may undertake to provide medium care to a child while a long term placement is found. Breakdowns also occur at times for children in this situation. Carers engaged in such agreements were also invited to participate in the study.

CHAPTER 2

STUDY 1: Child and Carer Characteristics Associated with Placement Stability for Children in Out-of-Home Care

Research Questions and Hypotheses

This study investigates the relationships among children's externalising and sexualised behaviours, caregiver parenting style and empathy, and caregiver concerns that they will not be able to maintain a foster or kin care placement long term, or for the term they have agreed to. This study also examines the impact of child behaviour difficulties, caregiver attachment style and empathy on caregiver satisfaction with the placement. Firstly, it is hypothesised that higher levels of externalising (e.g. aggressive) and sexualised behaviours of the fostered child, will be associated with greater carer concern about placement breakdown. Secondly, it is expected that more negative parenting styles (i.e. authoritarian or permissive) and low carer empathy will be associated with greater carer concern about placement breakdown. Thirdly, it is expected that children's externalising behaviours and problematic sexualised behaviours, and caregiver attachment anxiety and low empathy will be associated with lower caregiver satisfaction for a given child.

Method

Participants

Of the 44 carers who participated in this study, 39 (29 foster and 10 kinship carers) met inclusion criteria. Five carers were excluded because their child was outside of the age range (6-12 years). Of the kinship carers, seven were grandparents, two were godparents and one was an aunt. A summary of carer demographics, including level of training and care experience is presented in Table 1. Of note is the broad age range (28-71 years) and the relatively low level of

education (the majority having completed 10 years of schooling or less). Most carers were involved in additional work outside the home (M = 12.6, SD = 15).

Table 1

Foster and Kinship Carer Demographic Characteristics (n = 39)

	Foster *n*	Kin *n*	Total *n* (%)	Range	M (SD)
Gender					
Female	26	8	34 (87)		
Male	3	2	5 (13)		
Age				28-71	49.9 (9)
Ethnic-Cultural background[a]					
Anglo-Celtic	21	9	30 (77)		
European	6	1	7 (18)		
Aboriginal/ Torres Strait Islander	2	0	2 (5)		
Highest education level completed					
Year 8-10	14	6	20 (51)		
High School Certificate	5	1	6 (15)		
Trade Certificate/ Diploma	7	1	8 (21)		
University Degree	3	2	5 (13)		
Level of carer training					
No training	3	8	11 (28)		
< 1week	21	1	22 (56)		
>2 weeks	6	0	6 (15)		
Level of experience[b]					
Up to 2 years	5	1	6 (15)		
2-5 years	6	5	11 (28)		
5-10 years	11	2	13 (33)		
> 10 years	7	2	9 (23)		

[a] Participants could report multiple cultural/ ethnic backgrounds.
[b] In providing foster and/or kinship care.

The children in OOHC were 25 boys and 14 girls, with a mean age of 9.21 years (SD = 2.2, range 6-13 years). The majority were of Anglo-Celtic background; eight children were Aboriginal/ Torres Strait Islander (21%). Three carers did not know if their child was indigenous and a further seven carers did not know the ethnic background of their foster child. Carers were asked if their child had been diagnosed by a paediatrician, psychiatrist or clinical psychologist

with any of the following diagnoses: Learning Disorder, Post-Traumatic Stress Disorder, Oppositional Defiant Disorder and/or Conduct Disorder, Autism Spectrum, and/or an intellectual disability. More than half of the children were reported to have a current diagnosis, seven (18%) had two, and five (13%) were reported to have three comorbid diagnoses. The majority had experienced multiple prior placements with varying lengths of time; 21 (54%) had spent less than one year in alternate placements, five (13%) between one and two years, three (8%), between two and three years, and six (16%) had spent over three years in alternate placements. The majority of the children had been in their current placement for over three years. Table 2 provides a summary of these child demographic details.

Measures

Approval for this study was granted by the Human Research and Ethics Committee, Macquarie University and cooperation obtained from 16 agencies. Participants were informed of the current study through an information flyer distributed by their foster care agency or an established foster and kin carer support agency. After providing informed consent, participants completed a confidential online survey, developed on Qualtrics software, which took approximately 30-40 minutes to complete, and were eligible to enter a drawer to win a $100 shopping voucher. The survey collated information on carer and child demographics, including their child's placement history, psychiatric diagnoses and the level of psychological support provided to the child and carer. Questions were developed for the study to assess carer concerns about placement and satisfaction (dependent variables of interest) and standardised questionnaires were used to assess the independent variables, three related to carer characteristics (parenting style, empathy, attachment style) and three to child characteristics (internalising, externalising, problematic sexualised behaviour). See Appendix C. for copy of survey.

Table 2

Child Demographics and Placement History (n = 39)

	n (%)	Range	M (*SD*)
Gender			
Male	25 (64)		
Female	14 (36)		
Age		6-13	9.2 (2.2)
Ethnic-Cultural background[a]			
Anglo-Celtic	20 (51)		
Aboriginal/Torres Strait Islander	8 (21)		
Filipino	1 (3)		
Maori	1 (3)		
South American/Pakistan	1 (3)		
Sudanese	1 (3)		
Unknown	7 (18)		
Known Psychiatric Diagnosis[b]			
Nil	16 (42)		
Learning Disorder	7 (18)		
PTSD	6 (16)		
ODD/CD	6 (16)		
Autistic Spectrum Disorder	4 (10)		
Intellectual Disability	3 (8)		
Placement history			
Time in current placement			
<1yr	2 (5)		
1-3yrs	13 (33)		
>3yrs	24 (66)		
Number of prior placements			
Nil	4 (10)		
1-2	11 (28)		
3-5	17 (43)		
6-9	5 (13)		
>10	2 (5)		

[a] Participants could report multiple cultural/ ethnic backgrounds.
[b] Carers could report multiple psychiatric diagnoses.

Placement stability concerns. In a question designed for the current study, carers were asked to rate, on a 10-point Likert scale ranging from '*strongly disagree*' (1) to '*strongly agree*' (10), how true the following statement was for them: *"I am concerned that I will not be able to continue to care for this child long term (or for the amount of time asked of me)"*. High scores indicate more concerns about placement stability. Participants were also invited to give reasons for their response, after they provided their rating.

Carer satisfaction. The Satisfaction with Parenting sub-scale of the Parent-Child Relationship Inventory (PCRI; Gerard, 1994) was used as a measure of caregiving satisfaction. The sub-scale is comprised of 10 statements, with some items reverse coded (e.g. *'I get a great deal of satisfaction from having this child in my care'*, *'I often wonder what the rewards are in raising this child'*), and respondents rate the extent of their agreement on a 4-point Likert scale, with responses ranging from *'strongly agree'* to *'strongly disagree'*. Permission was provided from the publishers to modify positive and negative items to ensure carers focused on the caregiving experience for the specific child they were reporting on in the study (e.g. '*I regret having children*' was changed to '*I regret having this child'*). High scores on this scale indicate greater satisfaction. The PCRI has been used extensively to assess parenting attitudes, including with parents and foster carers, has good psychometric properties, and is culturally sensitive (Gerard, 2000; Hurley, Huscroft-D'Angelo, Trout, Griffith, & Epstein, 2013). Cronbach's alpha in the current study was .85.

Child externalising behaviour problems. The Eyberg Child Behavior Inventory (ECBI; Eyberg, 1990), is a 36-item parent-report questionnaire containing statements about externalising behaviours in children aged 2-16 years (e.g. *'Does not obey house rules on own'*, *'Physically fights with friends own age'*). Specific behaviours are rated on a 7-point Likert scale,

ranging from "*never"* (1) to "*always"* (7), and summed to provide an overall Intensity score. The ECBI demonstrates good reliability and validity (Eyberg & Robinson, 1983; Eyberg & Ross, 1978) and correlates highly with other measures of externalising behaviour problems (Gross et al., 2007; Weis, Lovejoy, & Lundahl, 2005). Cronbach's alpha in the current study was .96.

Child internalising behaviour problems. The Revised Child Anxiety and Depression Scale - Parent Version (RCADS-P; Chorpita, 2001), is a 47-item parent-report questionnaire of depression and anxiety in children and adolescents aged 6-17 years (e.g. *'My child worries when he/she thinks someone is angry with him/her'*, *'My child starts to tremble or shake when there is no reason for this'*). The RCADS-P has been used in Australian community and clinic samples and demonstrates good convergent and divergent validity (Ebensutani, Bernstein, Nakamura, Chorpita, & Weisz, 2010), correlating highly with the internalising scales of the Child Behaviour Checklist (Achenbach, 1991). It is composed of six subscales; Separation Anxiety Disorder, Social Phobia, Generalised Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder and Major Depressive Disorder, with items rated on a 4-point Likert scale ranging from '*never'* (0) to '*always'* (3). The Total Internalising Scale score (sum of all six subscales), was used in this study. Cronbach's alpha for this scale in the current study was .93.

Problematic child sexualised behaviours. The Child Sexual Behaviour Inventory (CSBI; Freidrich, 1997) is a 38-item parent-report questionnaire about sexual behaviours in children aged 2-12 years, (e.g. *'Tries to undress other children against their will'*, *'Puts objects in vagina or rectum'*) It is comprised of two scales: a developmentally-related sexual behaviour score and a sexual abuse-specific score, which together yield a total CSBI score. Items are rated on a 4-point Likert scale ranging from '*never'* (0) to '*at least once per week'* (3). The CSBI has been widely used, and demonstrates good reliability and discriminant validity (Friedrich et al.,

2001; Strand, Pasquale, & Sarmiento, 1999). The total CSBI scale score was used in the current study; Cronbach's alpha was .90.

Carer parenting style. The Parenting Scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993), is a widely used, 30-item self-report measure, for the assessment of dysfunctional discipline practices. Each item is anchored using a 7-point Likert scale, by a 'parenting mistake' at one end and an 'adaptive parenting response' at the other. The scale assesses Laxness (parenting behaviours that fail to set or enforce limits or rules, reward misbehaviour with positive consequences, give in to coercive behaviour), over-reactivity (parenting behaviours characterised by anger, meanness, irritation or frustration, including parental use of threats or physical punishment) and Verbosity (parental reliance on lengthy, verbal responses to misbehaviour). Item examples include *'I am the kind of parent that lets my child do whatever she/he wants'* (Laxness), *'When my child misbehaves I spank, slap or hit my child'* (over-reactivity), and *'When my child misbehaves I give my child a long lecture'* (Verbosity). The over-reactivity construct resembles Baumrind's (1968) description of authoritarian parents and the Laxness scale that of the permissive parent.

Overall high scores for this measure indicate more problematic parenting. In previous research, this scale has yielded good internal consistency, test-retest reliability (Arney, Rogers, Baghurst, Sawyer, & Prior, 2008), discriminative validity, and sensitivity to problematic parenting of children up to 13 years of age (Irvine, Biglan, Smolowski, & Ary, 1999). A total score (an average of all items) is considered a useful global index of dysfunctional parenting and was used in the current study; Cronbach's alpha for the total scale score in the current study was .83.

Carer empathy. The Interpersonal Reactivity Index (IRI; Davis, 1980) is a 28-item, self-report instrument. Items are rated on a 5-point Likert scale with response options ranging from '*does not describe me well'* (1) to '*describes me very well'* (5). Three of the four original subscales that have been used in research examining parental empathy are used in this study. Emotional Compassion pertains to an individual's other-oriented emotional responses, such as warmth and compassion towards others in distress (e.g. *'I often have tender concerned feelings for people less fortunate than me'*). Perspective Taking reflects a tendency to think about and anticipate the point of view of others, their inner experience, and motivations (e.g. *'I try to look at everybody's side of a disagreement before I make a decision'*). Personal Distress relates to feelings of anxiety and discomfort when observing others in distress (e.g. *Being in a tense emotional state scares me'*). This is considered a maladaptive state in which the carer, upon seeing a distressed child, experiences an aversive state, which is not congruent with the child's experience and that leads the carer to respond in self-oriented or reactive ways (Joireman, 2001). Consistent with prior research, each scale was included as a distinct measure of empathy. Cronbach's alpha scores for the Emotional Compassion, Perspective Taking and Personal Distress scales were .62, .70, and .68, respectively.

Carer attachment style. The Attachment Style Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994), consists of 40 statements and respondents rate their degree of agreement on a six-point rating scale, ranging from '*totally disagree'* (1) to '*totally agree'* (6). The ASQ comprises five subscales: Confidence, Discomfort with Closeness, Relationships as Secondary, Need for Approval, and Preoccupation. Item examples include; *'I find it relatively easy to get close to others', 'When I talk over my problems with others I generally feel foolish and ashamed'*, *'Achieving things is more important than building relationships'*. Factor analysis

yielded two primary domains: *Attachment Anxiety* and *Attachment Avoidance* (Brennan, Clark, & Shaver, 1998), used in the current study. The ASQ has been used widely and demonstrates good reliability and validity (Ravitz, Maunder, Hunter Sthankiya, & Lancee, 2010). High scores indicate more avoidance and anxiety, respectively. Cronbach's alpha scores for *Attachment Anxiety* and *Attachment Avoidance* were .86 and .82, respectively.

A number of potential covariates that may influence placement stability were considered, namely: carer age, education, foster care training, partner and agency support.

Carer ratings of agency support. Questions developed for the study asked participants about the types of support provided by their government and/or non-government foster care agency.

Frequency of support. Carers were asked how frequently they had face-to-face or phone contact with their government or non-government foster care agency over the previous 6 months, with response options including *none, once, every 2-3 months, monthly, fortnightly, weekly*, and responses were ranked 0-5 with higher scores indicating greater contact. An aggregate score of agency support was created from the total amount of contact provided.

Total psychological support. Similarly, carers were asked if they and/or their child had been provided with a range of psychological supports (*for carer*: parent training, group training, parent-infant therapy, individual, family and/or group counselling; *for child*: individual and/or group counselling). An aggregate score provided an index of the total psychological support for each.

Partner support. Carers were asked to rate their partner's support in caring for the child, on a 10-point Likert scale ranging from '*low support*' (1) to '*high support*' (10). An open-ended

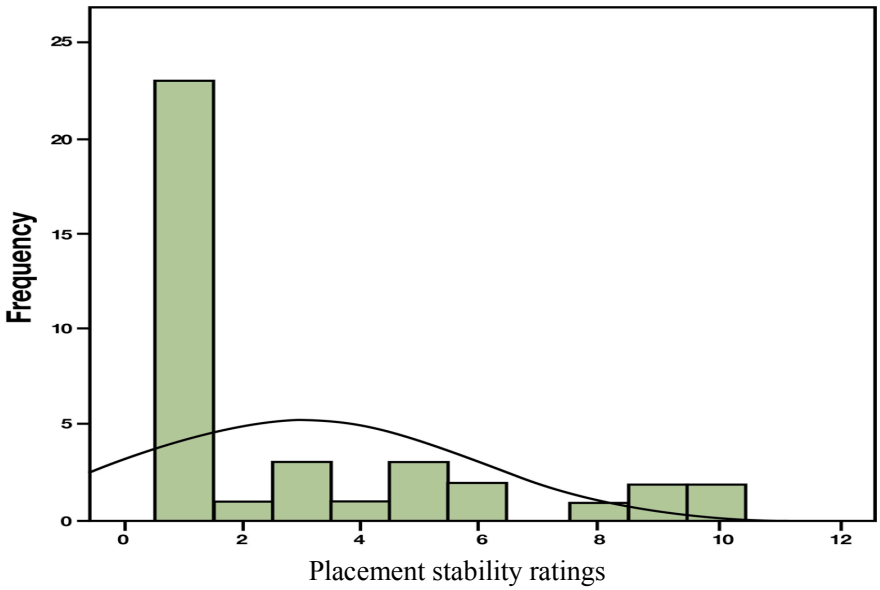
question invited participants to provide further comment on the level of support they or their child received from their foster care agencies.

RESULTS

Descriptive Statistics

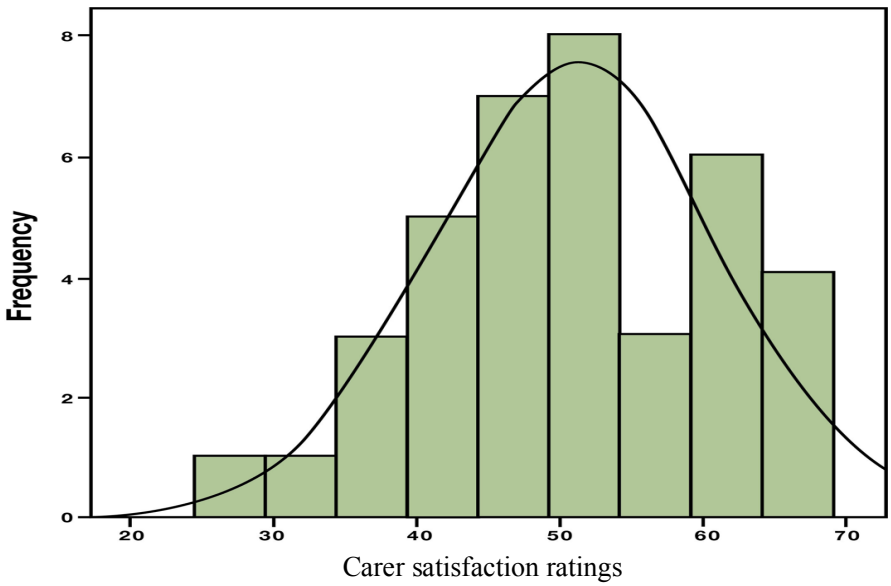
Dependent variables were inspected for normality. The dependent variable *Placement Stability* was non-normally distributed, (range 1-10, $M = 2.92$, $SD = 2.94$, *mode* = 1), with a skewness of 1.37 (SE = .383) and kurtosis of .582, as illustrated in Figure 2. The majority of participants reported no concern (rating of 1) regarding their ability to maintain the placement for their foster child, while 15 (39%), reported concern (i.e. a rating ≥ 2). A logarithmic transformation did not normalise distribution, (skewness = .799, $SE = .383$, kurtosis = 1.084). Accordingly, Spearman's Rho was used for bivariate analyses, data were categorised into those who expressed concern and those who did not, and for multivariate analyses regarding extent of concern, the participants who reported no concern ($n = 24$, 61%) were excluded.

Figure 2. Histogram of Placement Stability Ratings



The dependent variable *carer satisfaction* was normally distributed, (*range* = 27-66, *M* = 50.92, *SD* = 10, *mode* = 48), with a skewness of -.382 (*SE* = .383, $p < 0.05$), and kurtosis of .750, and is illustrated in Figure 3. Five carers (13%), indicated problematic levels of satisfaction while the majority (87%) indicated good to high levels of carer satisfaction.

Figure 3. Histogram of Carer Satisfaction Ratings



Parenting style, empathy & attachment style. Carer scores on the Parenting Scale, Interpersonal Reactivity Index and the Attachment Style Questionnaire are presented in Table 3. The percentages of scores indicating problems within each scale are displayed, based on norms provided by the respective scale developers.[7] With regard to the Parenting Scale, six carers (15%), reported using parenting behaviours characterised by anger or frustration at a problematic

[7] IRI: Davis (1980) derived comparison means and standard deviation values using a university sample (n = 1161). Sex differences were found and the problem range was determined by one standard deviation below EC and PT and one above PD (according to gender), as suggested by the author.

level (Over-Reactivity) and four (10%) reported using parenting behaviours characteristic of a permissive style (Laxness). Overall, total scores for five carers (13%), fell within the problem range, based on clinic samples (O'Leary et al., 1993).

With regard to the empathy measure, the Interpersonal Reactivity Index, scores for five carers (13%) fell within the problematic range for Perspective Taking. These carers reported difficulty thinking about and anticipating the points of view, inner experiences and motivations of others. Scores for two carers (5%) fell within the problematic range for Emotional Compassion. These carers reported difficulty with orienting responses of warmth and compassion towards others. Scores for two carers (5%), fell within the problematic range for Personal Distress. These carers reported difficulties containing their own emotional responses of discomfort and anxiety when seeing others in distress.

On the attachment measures, Attachment Anxiety and Attachment Avoidance, overall scores for both foster and kin carers appeared lower than norms reported in previous studies. Using recent norms, four carers (10%) in the current sample on Attachment Avoidant and one carer on the Attachment Anxiety scale (2%) fell within a clinically significant range.[8]

[8] Norms were derived from a non-clinical sample; 168 adults, mean age 53.8 (*SD* = 11.56) (Kivlighan, Lo Coco, Gullo, Pazzagli, & Mazzechi, 2017), as these most closely resembled the age group of participants in the current study. In their study, means of 49.84 (*SD* = 11.75) and 53.47 (*SD* = 12.33) were yielded for Attachment Anxiety and Avoidance respectively. These were subsequently divided by the number of scale items to derive the final score, as is recommended by the scale authors. A one standard deviation above the norms was demarcated to indicate problem range in the current study, as this is typically considered clinically significant (Kazdin, 2003).

Table 3

Descriptive Statistics for Parenting Questionnaires and Child Behaviour Problems

	Foster Carer[a] *M* (*SD*)	Kin Carer[b] *M* (*SD*)	Total *(n=38)*	*Problem Range*
Parenting Questionnaires				
Parenting Scale				
Laxness	2.56 (0.65)	2.15(0.81)	2.27 (0.81)	10%
Verbosity	2.43 (0.82)	3.28 (0.80)	3.40 (0.77)	8%
Over-reactivity	3.73 (0.57)	2.29 (0.82)	2.32 (0.81)	15%
Total	2.86 (0.36)	2.49 (0.61)	2.52 (0.70)	13%
Interpersonal Reactivity Index				
Perspective Taking	20.57 (4.14)	18.30 (6.36)	19.97 (4.84)	13%
Empathic Concern	24.50 (2.76)	22.10 (3.90)	23.87 (3.22)	5%
Personal Distress	7.39 (4.19)	9.00 (5.50)	7.82 (4.55)	5%
Attachment Style Questionnaire				
Attachment Avoidance	2.82 (0.62)	2.94 (0.68)	2.75 (0.63)	10%
Attachment Anxiety	2.56 (0.87)	2.78 (0.60)	2.69 (0.80)	2%
Child Behaviour Questionnaires				
	Boys[c] *M* (*SD*)	Girls[d] *M* (*SD*)	Total (*n=38*)	*Clinical Range*
Internalising Problems RCADS-P (total T-Score)	56.00 (15.98)	61.15 (22.95)	57.68 (18.33)	24%
Externalising problems ECBI (total problem score)	136.29(42.87)	155.14(42.68)	142.46(42.92)	68%
Problem Sex. Behaviour CSBI (total T-Score)	63.38 (22.08)	69.54 (23.33)	64.92 (22.43)	41%

Note. [a]*n* = 29, [b]*n* = 9, [c]*n* = 24, [d]*n* = 14.

Child behaviour problems. Children's scores on internalising, externalising and sexualised behaviours are also presented in Table 3. Twenty-four percent of children were rated within the clinical range for internalising problems, 68% for externalising problems, and 24% for problematic sexual behaviours.

Agency support. Approximately a quarter of carers and children had not received any therapeutic support since the child entered the placement. The majority of carers, 41% (*n* = 16), and children, 51% (*n* = 20), had received at least one form of therapy. These are displayed alongside details regarding psychological supports reported by carers and children in Table 4.

Table 4

Summary of Agency and Psychological Support provided to Carers and Children

	Range	M (SD)	n (%)
Total Agency Contact	1-8	4.4 (1.5)	
Carer - Total Psychological Support	0-5	1.3 (1.2)	
Parent Training			17 (44)
Parent-Child Interaction Therapy			12 (31)
Individual Counselling			10 (26)
(Additional Group Training)			8 (21)
Family Counselling			3 (8)
Group Counselling			1 (3)
Child - Total Psychological Support	0-3	1 (0.9)	
Individual Counselling			27 (71)
Group Training (skills development)			7 (18)
Group Counselling			5 (13)
Partner Support[a]	3-10	8.9 (1.9)	31 (80)

Note. Participants could report on multiple number of supports received.
[a]*n* = 31.

Preliminary Analyses

Foster and kin carers. There were no statistically significant differences between foster and kin carers, with respect to demographic variables (age, education level, level of experience as a carer, hours worked outside the home). Nor were there differences for placement factors (age of child, child placement history). There were also no statistically significant differences between foster and kin carers, with respect to the dependent variables of placement stability, concern about placement breakdown, or carer satisfaction. Nor were there differences for child-related independent variables (internalising, externalising, or sexualised behaviours) or for carer characteristics of empathy and attachment style, all *p'*s > .10. There was a statistically significant difference for the total scores on the parenting scale, $t(35) = -2.47$, $p = .02$, with foster carers having an overall higher (more problematic) mean score ($M = 2.86$; $SD = 0.36$), than kin carers ($M = 2.49$; $SD = 0.61$).

There were no differences in the level of partner support reported by foster and kin carers. There were significant differences, however, in the amount of training carers had prior to the child coming into their care, $t(36) = 9.33$, $p < .001$, with foster carers reporting more training. No differences however, were found in the overall amount of contact with, or psychological support that carers reported receiving for themselves or their child, from their foster agency. Consequently, foster and kin carers were combined for analyses.

Child age and gender. There were no statistically significant differences on child behaviour measures, placement stability, or parenting measures according to child gender. Data were dichotomised into two child age-groups (6-10 years and 11-13 years). A cut-off at age ten years was chosen, based on the physical and cognitive changes typically associated with this stage of development (Bradley, 1993). There were no differences related to child age for

placement stability, parenting style or child behaviour, with the exception that older children had more problematic scores for sexualised behaviours (M = 74.07, SD = 24.54), than younger children (M = 58.96, SD = 19.19), $t(36) = -2.12$, $p = .041$. Therefore, child age and gender were not included in multivariate analyses.

Bivariate Relationships Among Study Variables

Pearson's correlation coefficients, for ratio and interval data, and Spearman's Rho correlation coefficients for ordinal and non-normal data, were calculated to assess the bivariate relationships among the independent and dependent variables. A correlation matrix for key variables is presented in Table 5. Significant associations with respect to the dependent variables of interest are briefly summarised here. Given the small sample size, factors showing a moderate, but not significant relationship ($rs \geq .30$), are also noted.

Placement stability concerns. As predicted, lower carer empathy, but only the Perspective Taking scale, was associated with more concerns about placement stability. Additionally, greater length of time in prior placements of the child was associated with placement stability concerns, both with a moderate effect size. Older carer age, lower carer satisfaction and higher education level were also associated with more placement related concerns, (rs > .30), but were not significant. Contrary to prediction, neither child externalising and sexualised behaviours, nor carer parenting style, were related to placement stability concerns.

Because the placement stability variable was so skewed, with the majority of participants reporting no concern, T-Tests were also conducted to explore whether the group who expressed concern differed from those who did not. There were no significant differences on parent characteristics and child characteristics, with the exception of child sexualised behaviours, $t(36)$

= -2.431, p = .02, with more child sexualised behaviours reported by carers with placement related concerns (M = 75.87, SD = 25.03), than carers with no concerns (M = 57.78, SD = 17.67).

T-Tests were also conducted to explore possible differences of support variables. There were no significant differences with respect to level of partner support. There was a significant group difference for overall level of psychological support, $t(36)$ = -.2.08, p = 0.5, with carers reporting placement related concerns also reporting more psychological support (M = 1.8, SD = .94), than carers reporting no such concerns (M = 1.00, SD = 1.28).

Next, a Chi-square analysis was conducted to test possible differences between carer age-group (dichotomised as either above or below the carer mean age of 49 years) and placement concern (concerns vs. no concerns). There were no significant differences.

Carer satisfaction. As predicted, carer attachment style (both higher Attachment Anxiety and higher Attachment Avoidance) were associated with lower carer satisfaction. In addition, lower partner support, higher number of other children in the home and higher number of prior placements of the child were associated with lower carer satisfaction (moderate - large effect sizes). Contrary to prediction, child externalising and sexualised behaviours and carer empathy were not related to carer satisfaction.

Table 5

Correlation Matrix, Means and Standard Deviations of Study Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1. Carer age in years																						
2. Education level	-.26																					
3. Amount of training	.08	.13																				
4 Experience as a carer	.04	-.12	-.02																			
5. Number of prior placements	.26	.09	.08	-.09																		
6. Time in prior placements	-.01	.25	-.06	-.19	.73**																	
7. Other children in home	-.41*	-.16	.04	.04	-.06	-.14																
8. Level of partner support	.03	-.04	-.06	-.17	.27	.37*	-.14															
9. Carer psychological support	-.09	.15	-.13	-.08	.27	.43**	-.01	-.20														
10. Parenting style	-.04	-.22	-.14	-.01	-.25	-.21	.34*	-.14	-.06													
11. Carer Perspective Taking	-.25	.03	.11	.29	-.01	-.09	.14	-.27	.02	-.35*												
12. Carer emotional compassion	-.04	-.01	.37*	.21	.13	.04	.21	-.09	.01	-.27	.52**											
13. Carer personal distress	.13	-.18	.01	.29	.15	.12	.09	.23	.03	.31	-.32*	.01										
14. Carer attachment anxiety	.31	.09	-.12	-.03	.10	.15	.17	-.19	.17	.28	-.39*	-.00	.34*									
15. Carer Attachment Avoidance	.13	.04	-.09	-.17	.32	.42**	.17	-.23	.48**	.10	-.30	-.07	-.09	.52*								
16. Child age (in years)	.19	-.12	.04	.32*	.12	.04	-.13	.33	.12	-.05	-.03	-.11	.32*	.11	-.20							
17. Child internalising	-.11	-.02	.05	-.13	.08	.06	-.05	-.06	.27	-.46**	.15	.22	-.28	-.16	-.08	.18						
18. Child externalising	-.18	.33	.05	-.06	.33*	.40*	.09	.07	.20	-.07	.15	.22	-.00	.03	.17	-.09	.36*					
19. Child sexualised	-.06	.15	.16	-.03	.25	.22	-.03	.15	.09	-.10	.32*	.38*	.05	.03	-.22	.40*	.55**	.49**				
20. Child psychological support	-.05	-.12	-.01	.01	.10	.21	-.05	-.20	.66**	-.23	.13	.12	-.11	-.05	.29	.03	.18	.05	-.01			
21. Carer satisfaction	.02	-.32	-.23	-.03	**-.33***	-.24	**-.38***	**.48****	-.34*	-.19	.06	-.16	-.09	**-.44****	**-.41***	-.02	-.04	-.24	-.14	-.06		
22. Placement stability	**.32~**	**.30~**	-.24	-.12	.22	**.33***	-.10	-.14	.27	-.00	**-.35***	-.22	-.03	.23	.24	.07	.15	.01	.04	.23	**-.31~**	

p<0.05; **p<0.01; ~p<0.10

Multivariate Analysis

Next, multivariate analyses (logistic regression, linear regression), were conducted to test study hypotheses and explore the strongest predictors of carer concerns about placement stability and carer satisfaction. Variables that were associated (or marginal, $rs \geq .30$) in bivariate analyses were included.

Placement stability concerns. Hypothesis 1 proposed that child factors (i.e. higher levels of externalising (aggressive) and problematic sexualised behaviours) would be associated with carer concerns about placement breakdown. A logistic regression was conducted with child factors regressed on placement stability concerns (concerns vs. no concerns). This was not a significant model. Then, cases where carers reported no concern for placement stability were excluded ($n = 15$). A simple linear regression was conducted and child externalising and sexualised behaviours were regressed on extent of concern for placement stability. This was not a significant model, so this hypothesis was not supported.

Hypothesis 2 proposed that carer factors (low empathy and problematic parenting style), would be associated with carer concerns about placement breakdown. Preliminary analyses indicated that Perspective Taking was associated at a bivariate level, but the other empathy factors and parenting style variables were not. In addition, other variables that were associated in the bivariate analysis (or marginal $r = .30$), time in prior placement, carer age, education and satisfaction, were next considered in a simple linear regression. This was a significant model ($F(5,10) = 4.26$, $p < .05$). The adjusted R^2 indicated that 53.8% of the variance in the placement stability scores could be explained by variance in these predictors. However, only carer age ($t = 3.19$, $p < .05$), was a unique significant predictor. That is, older carer age predicted higher concerns about placement stability. So this hypothesis was not supported.

Carer satisfaction. Hypothesis 3 proposed that child factors (higher externalising and sexualised behaviours) would be related to carer satisfaction. Bivariate analysis did not show an association; therefore this hypothesis was not supported

Hypothesis 4 proposed that carer factors (higher carer attachment and avoidance, and low empathy) would be associated with lower carer satisfaction. Preliminary analysis showed that attachment anxiety and avoidance, partner support, number of other children in the home and number of prior placements of the child were associated with carer satisfaction. These were regressed to determine the best predictors of carer satisfaction. This was a significant model, $F(5,34) = 4.56$, $p < .01$. The R^2 indicated that 38% of the variance in carer satisfaction scores could be explained by the variance in these predictors. However, only level of partner support ($t = 2.79$, $p < .01$) and number of prior placements ($t = -2.17$, $p < .05$) made significant unique contributions. Level of partner support ($\beta = .45$), was the most influential predictor. This model suggests that more partner support and fewer prior placements experienced by the foster child predicted higher carer satisfaction. These findings are presented in Table 6.

Table 6

Predictors of Placement Stability and Carer Satisfaction

		Placement Stability		
	B	SE *B*	*b*	95% CI
Constant	-3.40	5.97		
Perspective taking	-.09	.10	-.20	[-.33, .14]
Time in prior placements	-.15	.26	-.11	[-.73, .43]
Carer age	.18	.06	.79*	[.05, .31]
Carer satisfaction	-.04	.05	-.15	[-.15, .08]
Education	2.59	1.19	.49	[-.10, 5.3]
R^2	.70			
Adj R	.54			
F	4.27			
		Carer Satisfaction		
Constant	43.10	11.33		
Partner support	2.18	.78	.45**	[.57, 3.80]
Attachment Avoidant	-.22	2.91	-.01	[-6.22, 5.79]
Attachment Anxiety	-1.85	2.08	-.16	[-.61, 2.43]
Other children in home	-1.42	.96	-.25	[-3.40, .56]
Number of prior placements	-1.85	.86	-.33*	[-3.62, -.09]
R^2	.49			
Adj R	.38			
F	4.56			

*Note. *p< .05. **p< .01.*

Summary

The aim of this study was to examine the extent to which various child and carer characteristics were related to carer concerns that they would not be able to maintain a long term placement of a foster/ kinship child, and carer satisfaction. Thirty-nine foster and kin carers participated and reported on a range of indices (demographics, supports, parenting practices, attachment style and empathy) and their child's behaviour (internalising, externalising and

sexualised behaviours). The carers and the children reported on in this study were generally a homogenous group with respect to the key study variables and covariates. Many of the carers reported problematic scores for parenting variables and there were high rates of clinically significant behaviour problems in the children, many of whom had also been diagnosed with a psychiatric disorder.

The hypothesis that greater concerns about placement stability would be associated with child externalising and sexualised behaviours was not supported. This was despite the majority of children reportedly displaying clinically significant externalising and/or sexualised behaviours (68% and 41%, respectively). The hypothesis that placement stability would be associated with parenting style and empathy gained only partial support. While perspective taking was strongly associated at a bivariate level, it was not significant when carer age was included in the analysis. Older carer age predicted higher concerns about placement stability.

Carers who reported no concerns were compared with those who reported some concerns about placement stability. There were no differences between these groups across carer, child or support indices, with one exception; child sexualised behaviours were higher amongst carers with placement related concerns.

With regard to carer satisfaction, neither child behaviour problems nor carer characteristics (attachment style and empathy) were significant predictors. Rather, partner support and number of prior placements of the child were found to be significant predictors of carer satisfaction. That is, greater partner support and lower number of prior placements for the child were associated with greater satisfaction.

There were no differences between foster and kinship carers with respect to concerns for placement breakdown or carer satisfaction. Also, surprisingly, there was no

significant association between caregiver satisfaction and placement stability. Overall, findings suggest that caregiver context, rather than caregiver and child psychological characteristics, impact on the caregiver experience and placement stability, Specifically, findings strongly suggest that caregiver stressors in the context of ageing impact placement stability, while levels of partner support, and number of prior placements on behalf of the child, impact overall satisfaction. These results, in conjunction with information provided by caregiver comments (presented in Chapter 4), are further discussed in Chapter 7.

CHAPTER 3

STUDY 1: Carer Responses

In order to explore factors not previously identified within the literature, and those that may be unique to the current sample, four short open-ended questions were included in the participant survey. Participants were invited to add comments on the level of support they and their child received, the level of satisfaction they experienced in being a carer, and the reasons why they were, or were not, concerned about their ability to maintain a placement for their foster child.

Materials and Method

Thematic Analysis of Participant Feedback

All carer responses were written. Each transcript was analysed numerous times to identify key words, ideas and major themes. A second coder, with a Master's degree in Clinical Psychology, and over 10-years of experience in working with families at-risk, was utilised to check for subset agreement. Across each of the exploratory headings (*Supports, Satisfaction* and *Placement Stability*), a consistent additional theme arose, in relation to the nature and impact of the working relationship carers experienced with their foster care agency. A fourth category was therefore generated: *Working Alliance*. For simplicity, both statutory care agencies, such as Family and Community Services (FaCS), and the non-government foster care agencies, will be referred to as the 'foster care agency'. All carer and child names and potentially identifying information have been changed.

Placement stability. In addition to providing a rating (0–10) of their concerns regarding placement stability, carers were invited to provide an accompanying explanation. Comments from carers who rated little or no concern about placement breakdown (rating of 1-2 out of 10, *n*

= 24) were demarcated from those rating 3 and above (n = 14) and examples are presented below.

Carers who reported little or no concern for placement breakdown made comments which reflected a significant commitment to the child. It was noteworthy that all but one in this group expressed their commitment in past tense, indicating that they did not currently question the longevity of the placement and caring for the child. For example: *"We made a long term commitment that we are in this beyond even the stated care order. They (child and siblings) are part of our family, they belong"* (Stefan aged 41, foster carer of child aged 6), and "*(I) made a lifetime commitment to this child, the same as if she were my own. No matter how hard things can and do get, I would never change my mind about that"* (Racquel aged 48, foster carer of child aged 9).

Several carers with low placement concerns also noted the importance of receiving ongoing support from, and acceptance of, the child, by the carer's own children and extended family network. In these cases, the fostered child appeared to be strongly integrated and accepted. *"We are fortunate that we have the full support of our own children and their families"* (Sean aged 59, foster carer of child aged 9), and "*When she goes for respite (every 6 weeks) we have at times, not every time, asked our (birth) children how they thought things were going, what were their views etc. The last time we did this our eldest (age 14) said, 'I don't want you to ask us that because you don't need to, she's part of our family.' That really said it all"*, (Evette aged 45, foster carer of child aged 8).

Some contrasted this with the support received from the agencies. "*There have been times when I've thought I couldn't continue and felt let down by the agency for support but I'm a good mum and have proof in my sons and grandchildren and see how far Mike (child) has come with*

glimmers of hope, I'm not about to lose faith now" (Gloria, aged 60, foster carer of child aged 12).

A number of carers, in response to the question about concerns, described joy in caring for their child, while others also looked positively to the future in their relationship with their child. "*I enjoy it"* (Benn aged 58, foster carer of child aged 10), "*I love being a foster parent"* (Hannah aged 39, kin carer of child aged 7), and "*we feel very lucky to have her in our lives. We hope once our daughter turns 18 she will continue to live with us"* (Joelene aged 55, foster carer of child aged 11). One carer also indicated her intention to move from foster carer to legal parent: "*I have no concerns about looking after my foster daughter. Looking forward to an adoption plan"* (Wikitoria aged 54, foster carer of child aged 6).

Concerns about placement breakdown. Carers who rated moderate or significant concerns for placement breakdown (scores of 3 and above out of 10), described a variety of issues relating to caring. A strong theme that emerged among kin carers, consistent with the quantitative results, was concern related to carers' age and compromised physical and health capacity to parent. Donald, aged 71 and a kin carer to a child aged 11 years, cited 'health' problems as a key concern impacting his capacity to care for his child into adulthood.

These concerns were echoed by other carers, illustrating a particular issue faced by mature carers of young children. "*My age and my health"* (Charmaine aged 45, kin carer of child aged 8), "*My wife is getting ill/older, it is tacksing (sic) for her"* (Trent aged 63, kin carer of child aged 7), and *"At 68 years of age with some health problems, I hope I will be able to look after (my child) until he is an adult"* (Fiona aged 68, kin carer to child aged 11).

For some, the concerns were financial, but these were also directly or indirectly linked to carer age. *"Financially the payments are sufficient to cover the child's needs, but they do not*

make up for the long term financial cost to our family – i.e. what it costs us to maintain a larger household – the sacrifice of our retirement years spent raising children" (Darlene aged 52, foster carer of child aged 9), and "*Health issues may force early retirement so won't financially be able to support child at same level as we do now – always out of pocket. Trying to save for retirement but children also have needs that need to be financially support(ed) that are not covered (by the agency)"* (Doris aged 52, kin carer of child aged 11).

Only two carers in this subgroup made comments focused primarily on child behaviour problems. The combination however, of carer age and child behaviour, in this subgroup, was noted by several, including concerns about caring for others and being able to manage the child's significant behavioural problems into the future, as they age. Again, these seemed particularly pertinent to kin carers. These comments were so striking they are summarised in Table 7.

Table 7

Themes and Example Quotes Illustrating Age-Related Concerns About Placement Instability

Themes	***Exemplary Quotes***
Impact of ageing on parenting capacity	*"Getting older and tire more easily, don't feel capable of keeping up as well as we did when we were younger"* (Doris aged 52, kin carer of child aged 11). *"Not sure long term if I will be able to manage the behaviour*" (Hillary aged 43, kin carer of child aged 8). *"I will be 70 years by the time he (foster child) is 18. H*e *is becoming increasingly more violent and aggressive towards me and my possessions, and I don't feel I have the ability or support to assist me through his teenage years if this behaviour continues"* (Anka aged 70, kin carer to child aged 8). *"This child targets me with his behaviours and at times is violent. As well, my husband is sick and if he gets sicker as expected I don't know whether I will have the strength to keep going" (Violet aged 51,* foster carer of child aged 12).
Impact on parenting of own children	*"This child is physically aggressive and sometimes I am concerned for my safety. As committed as we are, I will not put my biological children at risk"* (Sybil aged 47, foster carer of child aged 12). *"Pressure from birth children, who want equal time and $(sic) spent with them. Resentment from birth children"* (Doris aged 52, kin carer of child aged 11).

Carer satisfaction. Several sources of satisfaction were identified, including feeling as though the child were one of their own, observing developmental changes in the child over time, and developing a warm reciprocal attachment relationship. Beverly, Angela and Sean's comments illustrate the experience of the foster child as being part of their 'own' family:

> *"When we were told there was a little boy for us to meet seven years ago it was like being told by my doctor I was pregnant, my heart skipped a beat, my husband, son & I couldn't wait to meet this boy who was waiting to meet us. (I) am in love with this boy as much as my natural son & my two other foster children"* (Beverly, aged 39, foster carer of child aged 7);
>
> *"I love her as my child for life. She is part of my family for ever, no matter what, and I make sure I regularly tell her that"* (Angela aged 39, foster carer of child aged 12); and
>
> "*From my own perspective, having (a) foster child is an extension of my own family"* (Sean aged 59, foster carer of child aged 9).

Veronique and Charmaine describe the pleasures of observing developmental and emotional improvements in their children's lives. "*I have seen this child flourish under our care from feeling worthless to feeling valued"* (Veronique aged 47, foster care of child aged 11); "*It is very challenging but very rewarding … to see a child so unhappy become happy"* (Charmaine aged 45, kin carer to child aged 8).

The comments below from Georgia, Fiona and Raelene emphasise the rewards of a reciprocal attachment relationship. "*I am deeply bonded to this child, and she is securely attached to me. Caring for this child since she was 2-days old has totally changed the way I see myself as a person."* (Georgia, aged 53, kin carer of child aged 8); "*Knowing he is loved, safe*

and happy is of great importance to our family" (Fiona, 68yrs, kin carer of child aged 11) and "*After having this child in our care for a year I do feel we are starting to build a relationship. He (child) says things like 'She (carer) always tells the truth' or 'she always does what she says she will'. Well he knows I will always try very hard"* (Raelene aged 65, foster carer of child aged 9).

A few carers reported negative experiences around birth family related issues and fears of restoration that reduced carer satisfaction. Doris and Sybil describe the strain that caring for a child with complex needs has on the carer and extended family:

> *"Feelings vary from month to month and sometimes day to day. Sometimes, it is easy to see the changes and growth in the child then it is extremely rewarding and satisfying. Sometimes when the child is disruptive and appearing to pull the whole family apart, you do have regrets and doubts on whether this was the right decision for our family"* (Doris aged 52, foster carer of child aged 11);
>
> *"I'm glad this child is in my care, but that does not stop me reflecting on how life was before she came (how easy), and sometimes I wish it would go back to being that easy!*" (Sybil aged 47, foster carer of child aged 12).

Finella and Karen's comments highlight the ongoing anxiety experienced by some carers in relation to birth family contact: "*sending them to access even though you know it is a bad move as a parent"* (Finella, aged 50, kin carer of child aged 8); "*I am worried that given the push to restore children from NSW government, if the mother shows ANY improvement the children will be sent back to save the government money"* (Karen aged 48, foster carer of child aged 11).

Carers' views on agency support. Carers identified both positive and negative experiences in terms of the support they received. Those who spoke positively about the level of support they, or their child received, described a high level of timely therapeutic and case management within a collaborative team-based approach. Many identified the benefits of their child receiving multi-modal care and emphasised that carers needed direct therapeutic support in addition to that which the child received: *"A lot of high quality therapy and training"* (Hillary aged 42, foster carer to child aged 8), and

> "*I am part of (a) Program that provides extra financial support to help with not working to be [so that I can be at] home for the child to provide a therapeutic environment. I also have a worker from (an NGO agency) to provide counselling to my child and for myself when required. Also, monthly meetings with my (foster care agency) and also monthly care team meetings with (foster care agency) social worker and (second NGO agency) workers with myself to provide a team approach supporting accessing services and supporting the school and myself"* (Angela aged 39, foster carer of child aged 12); also *"Fortnightly visits from the caseworker, about 1-2 e-mails a week, about 1 extra phone call a week. In the past I have had to call the agency and have had my queries answered immediately. Play therapist has visited about every 3 months for individual discussions and support. Case Conference every 6 months"* (Evette aged 45, foster care of child aged 8).

Others, however, reported inadequate support, therapeutically and financially, in meeting the range of complex needs of their foster child. Veronique, aged 47 and a foster carer of a child aged 11, reported that the only support received was that of *"self-funded family counselling"*.

Other carers reported similar problems with the level of support and/or frustration with the length of time they had to wait for services to be organised for their child:

> *"We are regularly researching methods to help the child and ourselves, in order to assist him in his development and our own. Unfortunately, the NGOs offer lip service only to these efforts, whilst offering very little by way of assisting development of carers themselves"* (Sean aged 59, foster carer of child aged 9); and
>
> *"Support, financial or otherwise, is minimal in regard to assessments, specialists around diagnosing and therefore accessing appropriate support for this child. Support for us in coping with the complex issues around this child is negligible"* (Famke aged 52, foster carer of child aged 12); and
>
> "*It takes a long time to get any testing and action taken because of the funding, many levels of care involved, permission required"* (Doris aged 52, kin carer to child aged 11); and
>
> *"It took almost 12 months for my concerns to be recognised and some support/training to be arranged"* (Darlene aged 52, foster carer of child aged 9). Finally;
>
> *"Generally, the time it takes the foster care agency to give us permission to travel with our foster child, getting a passport (it took 4 years!!) the amount of paper work needed to get extra tuition etc. and never speaking to the same person, is all very time consuming and frustrating"* (Joelene aged 55, foster carer of child aged 11).

Carers also described services provided as unhelpful or misdirected. "*Repetitive remarks like – 'you're doing a good job' and 'look after yourself' become meaningless. Need advice on how to look after self"* (Doris aged 52, kin carer to child aged 11); "*We also have a foster care*

agency psychologist who focuses on behavioural issues and not the underlying problem, which is attachment related" (Anika aged 42, foster carer of child aged 6); and

> *"Our child has 'play therapy' which we have found to be inconvenient and disruptive. I believe the child attends 'play therapy' so the Department can be seen to be 'ticking a box' – the usefulness of the therapy has never been raised with us.… It would be much more useful to have a hotline for foster parents to call to receive advice, assistance as "parents", as well as counselling for the child when appropriate and useful"* (Olive aged 41, foster carer of child aged 6).

As previously mentioned, problems with the working relationship between carers and their agency emerged as an ongoing theme in relation to supports and are outlined below.

Working alliance. The quality of support that carers received from their supervising agency, whether it be a government or a non-government foster care agency, and the impact of this on their fostering experience and perceptions of placement stability, was a pervasive theme in the comments provided by carers within this sample. Some carers identified that their relationship with their agency was the key stressor in their caregiving experience:

> *"I love being a foster mum but the system can sometimes make you feel that you shouldn't love the children as your own. In fact, when I speak to other foster carers we all agree that most agencies use the threat of removing children as the FIRST option not the last"* (Karen aged 48, foster carer of child aged 11);
>
> *"I know in so many ways, the reality of the effect on my life – the complete and sheer exhaustion of dealing with an abusive system. … I know these experiences have been profoundly damaging for my health and well-being, and often I feel I will not be able to*

prevail against a fundamentally destructive system" (Sula aged 30, foster carer of child aged 11); and

"Dealing with the department is incredibly difficult. I would never recommend anyone become a foster carer ONLY because of the department" (Olive aged 41, foster carer of child aged 6).

Many carers described a lack of pre-placement preparedness regarding the child's specific needs and/or deficits in the current level of support the child was receiving from agencies and professionals, to address these complex needs. Permeating these comments was a sense that carers had to continually 'fight' against their foster care agency to secure assistance for their child's and their own needs. A number of carers talked about an ongoing sense of inequality and powerlessness in their relationship with their agency, a sense of being criticised and of feeling powerless. Table 8 illustrates comments relating to these themes.

Table 8

Themes and Example Quotes Illustrating Problems with the Working Alliance Between Carers and Key Care Agency

Themes	***Exemplary Quotes***
Lack of pre-placement preparedness/ support	*"In my opinion, when children come into care they should have access to a full developmental assessment so that therapy, strategies can be accessed asap and also that carers are better informed of what to expect and able to decide from the start if they are willing to take these issues on long term – this may help secure long term placements if carers feel supported"* (Famke aged 52, foster carer of child aged 12). *"It's not the child's fault, but the problems are real, the problems were not identified prior to taking the child and along with nothing but criticism from the foster agency and very little support, we often feel we are 'at sea'"* (Darlene aged 52, foster carer of child aged 9). *"It was also noted in his profile that he had been diagnosed with PTSD (Post-Traumatic Stress), ODD (Oppositional Defiance Disorder), and RAD (Reactive Attachment Disorder) but apart from Ritalin no therapies had been provided"* (Sean aged 59, foster carer of child aged 9).
Insufficient support/ having to 'fight' for supports	*"Through our insistence, our child now receives counselling, occupational therapy and we are happy to provide this for his long term prospects"* (Sean aged 59, foster carer of child aged 9). *"He has 12 hours a week of SSO (Student support services) as well as OT (occupational therapy) and a psychologist. I have to fight (foster care agency) constantly for this support"* (Helen aged 51, foster carer of child aged 7). *"Support, financial or otherwise, is minimal in regard to assessments, specialists around diagnosing & therefore accessing appropriate support for this child. Support for us in coping with the complex issues around this child is negligible"* (Famke aged 52, foster carer of child aged 12).

Untimely support/ process problems	*"… time it takes DoCS to give us permission to travel with our foster child, getting a passport took 4 years!!! the amount of paperwork needed to get extra tuition etc. and never speaking to the same person is all very time consuming and frustrating"* (Joelene aged 55, foster carer of child aged 11). *"The red tape is a killer"* (Finella aged 51, kin carer to child aged 8).
Misdirected support/ lack of collaboration	*"I really don't think the caseworker 'gets' this child at all"* (Raelene aged 65, foster care of child aged 9). *"We try our best, the foster agency does not allow us to discipline in ways that we know work (we have raised 4 children). When we ask for help they want us to modify our behaviour not the child's. We are concerned that when this child goes through puberty that the placement will break down and us persevering will be in vain"* (Darlene aged 52, kin carer of child aged 9).
Feeling criticised by agency	*"I used to feel the agency supported us and highly praised them until recent events where my foster son was removed from our care for approx.7 weeks and returned only after ombudsman intervention. During this time I was made to feel worthless and doubted my parenting skills except for my family, friends, neighbours and public school teachers" (Gloria aged 60, foster carer of child aged 12).*
Powerlessness/ inequality	*"… the one & only reason I wonder whether we did the right thing in having this child is that the foster care system is fundamentally abusive of carers and children, because it embodies a structure where one party (foster care agency) has all the power, & another party (the day to day parent) does all the work"* (Sula aged 30, foster carer of child aged 11). *"Dealing with the department is incredibly difficult. I would never recommend anyone become a foster carer ONLY because of the department. I often say to friends that the kids are the easy part, but the department is inefficient, ineffective, intrusive and incompetent"* (Olive aged 41, foster carer of child aged 6).

Summary

Written responses were collated from participants of the study to identify unique experiences and perspectives not captured by the questionnaires. Four short open-ended questions were posed in relation to carer's reasons as to why they were, or were not, concerned about their ability to maintain the placement for their foster child, their level of caregiver satisfaction and regarding the supports they and their child received.

Carers who reported no or little concern for placement breakdown also reported a strong sense of commitment to the child long term, and support for and acceptance of the child in their care by their family network – including biological children, in spite of any child-related stressors they experienced. Carer age, and carer age in combination with carer health problems and child behaviour problems, underscored uncertainty about maintaining the child's placement into the future. These carers reported concerns that they might not be able to physically manage to care for the child as the child moved into adolescence, especially if the carer experienced current health problems. Child behaviour problems augmented this concern, when the carer's physical safety was compromised.

Carers who reported caregiver satisfaction also reported that they accepted the child as 'one of their own', and made references to strong integration and acceptance in their family system. Satisfied caregivers commented on the rewards of witnessing the child's recovery and development following maltreatment, as a result of their care. Carers reporting low satisfaction cited child behavioural problems and their impact on the extended family as a key issue. To a lesser degree, concerns about the negative impact of contact visit between their child and the

birth family, and of premature or unwarranted future restoration of the child to their birth parent(s) was reported as a source of dissatisfaction.

Carers who reported a good level of agency support described receiving a multi-modal, collaborative and team-based response that addressed the individual needs of both child and carer. Carers reporting problems with support cited a lack of collaboration with agencies regarding the actual needs of the child and carer, inadequate and/or untimely practical and therapeutic support, or training, to address the complex needs of the child in their care.

The quality of the relationship carers had with their agency, whether non-government or government, appeared to greatly impact carers caregiving experiences, their level of satisfaction as well as their concerns for placement longevity, even for those carers who reported low or no problems with their child. These carers reported having to continually advocate with their care agency for, or independently arrange, additional support for the child, while simultaneously feeling criticised by their care agency. Carers described being held responsible for parenting without legal and decision-making powers, which impacted their day to day experiences and which left them feeling powerless.

The results of study one and their implications for the ongoing assessment and measurement of child well-being and placement stability, are further discussed in Chapter 7.

Chapter 4

The Assessment of Psychosocial Safety and Stability for Children in Out-Of-Home-Care

As discussed in Chapter 1, child maltreatment and safety are best understood in the context of the interplay of strengths and vulnerabilities that lie within the child, caregiver, family, environment and social-political contexts across time (Bowes et al., 2012; Bronfenbrenner and Ceci, 1994; WHO, 2014). The provision of assessment, intervention, and prevention of child maltreatment requires professionals to take account of multiple, interdependent factors and remains a complex and challenging task for child protection intervention services (Kojan & Lonne, 2012). In this chapter, assessment approaches and tools commonly used in the child protection field and their strengths and weaknesses are considered. The shortcomings of current tools are identified, with respect to informing the therapeutic assessment of child risk, safety and well-being, and in guiding therapy interventions post maltreatment. Then, key domains considered in the development of a clinician-rating assessment tool: the Multi-Systemic Assessment of Psychosocial Safety (MAPS) are outlined.

The public health model provides a theoretical and practical approach to the assessment and response to child maltreatment, and can be applied to the spectrum of services involved in working with children and families. Within this model, individual and systemic factors are considered and risk and protective factors are identified. Approaches to addressing problems are population- and evidence-based, multi-disciplined, and demarcated into primary, secondary and tertiary responses (Scott, Lonne, & Higgins, 2016). With respect to child maltreatment, primary interventions are universal services that aim to improve the health, well-being and support of families, and thereby also prevent harm. They may include universal maternal and child health

services, routine health screening and housing support. Secondary services target groups with an increased risk of child abuse occurring. Examples include the provision of respite care, routine screening for at-risk children, or parenting classes to address parent-child strain or child behaviour challenges. In ideal circumstances, early interventions are provided to prevent child maltreatment or reduce the likelihood of maltreatment reoccurrence. Finally, tertiary services tend to focus on identifying and responding to maltreatment and seek to ameliorate the effects of abuse and prevent reoccurrence. These include trauma-based therapies, access to shelters, forensic investigations and/or criminal proceedings, and mandatory reporting procedures (Scott et al., 2016). Overall, service responses cater to child and family needs, as well as attempting to address the social and environmental factors that construct and reinforce problems (Lonne, 2013).

Within Australia, current tertiary approaches to the assessment, intervention and prevention of child maltreatment are frequently criticised. Child protection agencies, often the initial responders following child maltreatment, have been accused of adopting a risk-dominated, forensic approach to assessment (a focus on tertiary responses), rather than supporting family well-being and underlying causal factors (primary approaches) (Kojan & Lonne, 2012; Lonne, 2013). Similarly, tertiary therapeutic services, specialised in child maltreatment intervention therapies, have been found to lack systematic and comprehensive tools to provide holistic assessment and adequately measure outcomes of intervention (Ager et al., 2012; Thomas, Ong, De Meryck, & Manson, 2011). This has resulted in services lacking specific knowledge about which interventions work, for whom, and in what circumstances, and the application of therapies without a clear evidence base (Lonne, 2013).

The Assessment of Children At-Risk Within Statutory Child Protection Services

To date, most of the research on assessment of risk of child maltreatment has occurred within statutory child protection services. Assessment for child protection caseworkers begins when a notification of risk of significant harm for a given child is reported. The initial task is to ascertain the presence of an immediate or imminent risk of harm to the child (Harris, 2012; Le Blanc, Regehr, Shlonksy, & Bongo, 2012). Accurate assessment is critical to avoid the unnecessary removal of children, while also preventing child abuse or fatal harm (Bolton & Lennings, 2010). It is well understood that these types of assessments can be extremely complex. The likely impact of abuse on a child or young person needs to be evaluated in the context of child age, developmental stage and existing special needs. In addition, exacerbating factors such as prior abuse, and possible mitigating factors, such as parental awareness, family support, and parental engagement with informal and formal supports that may reduce the impact of abuse and future maltreatment, should also be considered (Fallon, Trocme, & MacLaurin, 2011; McMahon & Camberis, 2016).

Historically, caseworkers have relied on unstructured assessments to aid decision-making. These predominantly comprise caseworker experience and situational judgment and have proven to be problematic. In a qualitative study, Munro (1999) used content analysis to comprehensively review 45 child abuse inquiry reports in Britain, over a 20-year period between 1973 and 1994. In reviewing cases where children later died, as a result of abuse or neglect, caseworkers were found to base assessments on a narrow range of evidence, be biased towards information readily available to them, and to overlook information considered important by other professionals. Caseworkers also tended to favour information that was more emotionally charged and to give greater weight to either the first or last aspect of information received, before making

decisions in relation to the safety of a child. Most importantly, caseworkers were slow to revise their judgments despite contrary evidence, such as when assuming that some positive change in family functioning ensured safety, even in the context of persistent or mounting risks.

Caseworkers' attitudes towards removing children from their birth family, and their confidence in the foster care system, also influence their assessment and judgment about child risk. Davidson-Arad and Benbenishty (2010) presented 236 child protection caseworkers with a clinical vignette describing a typical child at-risk situation, and asked caseworkers to indicate their recommendations for intervention. They were also provided with a questionnaire to gauge their attitudes towards child protection issues. Attitudes were found to significantly predict decision-making, with more positive attitudes towards removal contributing to more intrusive intervention recommendations.

Vicarious trauma has also been shown to influence child protection assessments. Regehr, Le Blanc, Shlonksy, and Bongo (2010), examined the association between caseworkers' prior exposure to critical incidents at work and their judgment of children at-risk. Ninety-six caseworkers were presented with two simulated clinical interviews, involving a parent of a child reported to be at-risk, and subsequently completed a standardised risk assessment measure. Workers were also asked about their level of prior exposure to critical incidents, such as threats of, or actual, assaults and/or the death of a child or adult client. Caseworkers in this study reported a high level of work related traumatic stress. As the extent of workers' prior exposure to trauma increased, their perceptions of child risk of abuse decreased. The authors concluded that judgment of risk was influenced by worker's prior exposure to workplace trauma and that, in addition to assessment tools, judgment and decision-making in child protection matters requires consultation with other professionals in the field.

Structured decision-making: consensus- and actuarial-based assessment tools.

Internationally, there has been increasing pressure to develop effective assessment of risk tools, relatively free from caseworker bias. This has resulted in a move away from the use of unstructured decision-making towards structured, standardised risk assessment instruments. Currently, two major standardised risk assessment approaches have been demarcated within the child protection field: consensus- and actuarial-based instruments (White & Walsh, 2006). At a basic level, they reflect opposing methods of reasoning; the former assessments based on intuitive judgment, informed by work experience and the latter based on statistical data and informed by research.

Consensus-based instruments allow expert clinical judgment to determine which individual and family characteristics or variables are important when assessing risk. Importantly, judgment should be informed by both clinical experience and knowledge of research literature (Shlonksy & Wagner, 2005). In using these tools, caseworkers are required to consider and judge the quality of factors in a child's and family's life, which may be most appropriately viewed on a continuum of human experience or capacity (Knoke & Trocme, 2005). The Strengths and Stressors Tracking Device (Berry, Cash, & Methiesen, 2003), is a well known example of a consensus-based tool within Australian child welfare. This tool was developed to assist clinicians to assess the level of child maltreatment or risk of out-of-home placement, and considers the family environment, level of social support, parenting skills, and child well-being. Workers rate the relative level of a pre-determined risk factor (e.g. *'pays rent or mortgage on time', 'prepares balanced, nutritious meals'*) as either a stressor or strength for a given family, across a 5-point Likert scale, between -2 (serious stressor) and +2 (clear strength). Within these parameters,

workers provide a subjective judgment regarding the parents' ability to care and provide for the child, as well as their support and the current well-being of the child.

Actuarial-based tools include assessment items relating to individual and family characteristics that have been identified through empirical research and shown to be statistically predictive of future maltreatment. The relative weight that each factor contributes to the overall risk rating is determined by a formula designed to maximise predictive accuracy (White & Walsh, 2006). The Minnesota Structured Decision Making Family Risk Assessment tool (FRA; Loman & Seigel, 2004) is an example of a commonly used actuarial assessment. This tool was developed to help assess the level of child abuse and neglect risk, and to aid caseworkers in allocating resources to those families with greatest needs and those who would require greater casework and/or more intensive support services. Within this 25-item tool, 13 items assess neglect risk and 12 reflect abuse risk, which together contribute to an overall final risk score. The FRA requires objective and subjective judgment, and scoring is divergent across items. Objectively clear items include age of carer, number of children in the home, and refer to child protection history such as *'number of prior assigned reports'*. With the latter, the scoring parameter ranges between 0, indicating no prior reports, and 3, indicating three or more historical reports of neglect. Other variables require subjective responses. For example, the statements *'lacks parenting skills'*, or '*apathetic or hopeless*', is assigned a yes/ no score, with 0 indicating that the statement is not applicable to the given parent, and 1, indicating that it applies. There is reference to historical and current domestic violence, current substance use problem, caregiver cooperation, and motivation. In this measure, there is only one reference to child characteristics, *'child in the home has a developmental disability or history of delinquency'*, scored as either yes/no.

Consensus- and actuarial-based assessment tools both have strengths and weaknesses. Research across disciplines have found actuarial-based assessments superior in their ability to predict future maltreatment (Johnson, 2006) and type of maltreatment (Price-Robertson & Bromfield, 2011). As items tend to be fixed, actuarial assessments also tend to elicit good inter-rater reliability (Price-Robertson & Bromfield, 2011). This strongly suggests that actuarial-based assessments are best-placed to determine immediate risk and risk of future maltreatment within child protection.

Actuarial-based assessments have been criticised, however, for their inability to capture the impact of change, fundamental to the accurate assessment of a family's current safety and need. Factors which are viewed as static are often open to change, for example the chronicity and severity of parental drug use and domestic violence, the stability of mental health and/or the co-occurrence of these over time (White & Walsh, 2006). For instance, a parent with a prior substance use problem may receive the same score endorsement as a parent with a current substance use problem, potentially leading to an erroneous prediction of harm (Bolton & Lennings, 2010). Additionally, actuarial-based assessments do not identify specific areas for intervention, and individual and family factors that may impede therapeutic progress. For example, whilst a parent may be identified as *'lacking parental skills'*, the actual skills deficit is not identified (e.g. appropriate discipline, understanding of developmental milestones, ability to adequately attune to child's emotional needs), nor are relevant contextual factors, such as family or social supports, which may moderate parenting capacity and increase or decrease the likelihood of abuse actually occurring (James, 2000). Additionally, critical factors, such as caregiver insight, cooperation, ability and motivation, greatly impact the likelihood of therapy

engagement, progress and risk, and should also be considered in ongoing assessment (Andrews, Bonta, & Hoge, 1990), but do not often feature in actuarial-based assessments

The key benefit of consensus-based instruments is that they allow for a wider and more flexible consideration of variables that might impact a family's functioning, and they are more sensitive to the influence of dynamic factors, which help develop, maintain or reduce risk. The evaluation and clinical observation required in these assessments relies more on subjectivity, however, and continues to pose challenges for rating consistency and reliability (White & Walsh, 2006; Wood, 1997). At the same time, while the Strengths and Stressors Tracking Device guides clinicians to assess a number of systemic issues, it does not consider the relative functioning and quality of critical mesosystems important for children who have experienced maltreatment, such as the support provided to foster parents, relationships with the birth family, caregiver relationships with the school, and the working relationship between the caregiver and their key child protection or foster care agency. Study 1 (Chapter 3) in this thesis sought to consider the impact of various systems on placement stability and results highlighted the importance of contextual support factors. The current study seeks to extend the assessment of child safety and well-being for agencies providing tertiary services to children and their families (birth, kin and foster), by considering a range of individual, family and social systems and supports.

There is some evidence to suggest that clinicians may prefer to assess families at-risk using a combined approach, whereby actuarial devices are complemented with clinical discretion regarding contextual factors. In an Australian study, Bolton and Lennings (2010) examined senior Court Clinic Assessors' opinions of the use of three structured approaches (actuarial, a contextual/dynamic tool, and a combined actuarial and contextual tool). In this study, five senior clinicians were directed to use each tool to clinically assess and form recommendations

regarding the restoration of children to birth families, as outlined in a set of clinical vignettes. Clinicians reported each of these approaches to be useful in identifying relevant risk factors and issues to consider in relation to restoration and in overall decision-making. They favoured the Contextual/ Dynamic and Combined approaches, because of their ability to help identify specific areas for interventions. Overall, the Combined approach was perceived most favourably, followed by the Contextual/Dynamic approach and lastly, the actuarial approach.

It may be more useful to consider assessment tools in relation to different stages of child protection intervention. Clearly, actuarial-based tools continue to be efficient at determining immediate or likely risk of harm to a child, and should thus continue to be relied upon for their original purpose – to assist caseworkers on the frontline, to determine which cases to investigate further, which children need to be removed, and which families require the most intensive interventions (Gillingham & Humphreys, 2010). Consensus tools that are informed by literature on key risk factors are likely to be suitable for tertiary services that assess ongoing child and family safety and risk. However, an extension to such a tool, with additional focus on factors identified in the literature that promote stability and recovery following child maltreatment, would enhance agency capacity for assessment and intervention planning. The development of a clinician-rating tool that assesses the well-being and therapeutic needs of children following maltreatment across multiple systemic domains was one of the key objectives of the current research and is discussed below.

The Multi-Systemic Assessment of Psychosocial Safety of Children Who Have Experienced Maltreatment

It is only relatively recently that researchers have begun to monitor the outcomes of children who have experienced significant maltreatment. Following abuse, careful assessment of safety and stability of placement for children appears necessary, for positive and subsequent social-emotional, behavioural and academic outcomes, whether they reside with family or are in alternate care (Andersen & Fallesen, 2015). Unfortunately, research shows that a portion of children continue to experience significant problems, even when safety and placement stability have been achieved (Jones, Laliberte, & Piescher, 2015). Correspondingly, the child protection field has widened the parameters of outcome goals for children following maltreatment, to include a range of 'well-being' indices. Although child well-being definitions vary, most include indicators that consider the whole child and span several domains, including child physical health, social-emotional and behavioural functioning, academic outcomes, as well as caregiving context (Jones et al., 2015).

The Multi-Systemic Assessment of Psychosocial Safety (MAPS; Markovic & Sedgmen, 2017, unpublished document), was developed by the author, in collaboration with child protection counselling specialists, to enhance the psychosocial assessment of children following maltreatment, and to provide a tool to measure indices of child safety and well-being over time. Two key theoretical frameworks: Bronfenbrenner's Social Ecology Model (1977, 1986; Bronfenbrenner & Ceci, 1994) and Morton and Salovitz's Model of Safety (2006), were chosen to guide the conceptual framework. The key premises underpinning these models, namely the systemic and interdependent nature of child risk, harm, protection and health promotion, are internationally supported (AIHW, 2012a). Given the existing consensus on theory relating to the

construct of psychosocial safety, a deductive strategy was employed at the initial stage of scale development (Hinkin, 1998, Slavec & Drnovsek, 2012). A review of the literature, in relation to the psychosocial safety of children following maltreatment, was undertaken to identify relevant domains and specific items of focus, and is detailed below. A copy of the MAPS, version 1, can be found in Chapter 4A.

The MAPS tool is comprised of eight scales that evaluate a wide range of factors associated with the psychosocial safety and well-being of children (aged 6-16 years). In brief, the first two domains (*Child Health and Psychosocial Functioning*; *Child Educational Engagement and Functioning*) focus on child factors including mental health, social engagement, self-confidence and school attendance, academic performance, and developmentally appropriate social interactions. The third domain (*Primary Caregiver Health and Psychosocial Functioning*) considers caregiver factors, including mental health, coping skills, parenting confidence, and self-care. Domains 4, 5, and 6 have a more contextual focus.

The fourth domain is divided into two categories, depending on the child's current caregiving context. The first category *(4A: Birth family security and safety)* is applicable to contexts where maltreated children are residing with the birth family, and the second *(4B: Alternate Placement Security and Safety)* applies when children are residing in either kinship or foster care. Domain 5 (*Relationship Safety and Security with Birth Family*) considers contexts where children who are in kinship or foster care have contact with their birth family.

Domain 6 (*Primary carer's engagement support and environment*) considers factors relating to caregivers' access to supports, for caregiver and child, management of existing socio-economic strains, and their demonstrated motivation to engage constructively with these services. The final domain (*Systemic Alliance and Support*), considers the key care agency's

capacity to address and meet the needs of the child and their family, including the agency's knowledge of the child's maltreatment history, the quality of communication between the agency and the caregiver (birth, kin or foster), and the working alliance established between the care agency and other agencies involved in implementing therapeutic interventions. Inclusion of these specific contexts, such as birth, kinship or foster family functioning, school and care agency, and the working alliance between some of these systems, is not provided in currently existing measures.

For each MAPS domain, clinicians are able to ascribe a range of functioning as follows: high risk (ratings 1 or 2), medium risk (3 or 4), or low risk/no risk (5 or 6). Medium risk ratings are further rated according to the duration of the problems: 3 (problems lasting 6 months or more) and 4 (less than six months). A range of 5 or 6 on any domain indicates that the child and/or their family and care systems are functioning at a high level (on that domain), with evident strengths. At this level, there is likely to be less of a focus on abuse prevention and more on health promotion.

The MAPS domains, and the individual items comprising them, were identified through research relating to child safety and well-being factors. For case management and clinical documentation purposes, the MAPS also includes a 3-page summary sheet, where the ratings for each domain are visually displayed and key therapeutic and case management decisions can be noted. This was added in response to clinical consultation and is further outlined later in this document. The accompanying clinical planning summary sheets were further developed and refined, following numerous consultations with child protection clinicians and agencies in NSW. This consultation process and outcomes are detailed in Chapter 5.

Pertinent research relating to child safety and well-being factors that informed the construction of the MAPS is discussed below. For consistency, welfare workers who provide specialist therapeutic interventions for children who have experienced child abuse and neglect will be referred to collectively as counselling specialists. Statutory child protection agencies and foster care agencies will be referred to collectively as 'the care agency', and children and young people will be referred to as children henceforward.

Child Factors

MAPS Domain 1: Child Health and Personal Functioning. The literature on factors impacting children's mental health and functioning has been previously reviewed in Chapter 1. In addition, indices were included in line with global research, which highlight the effects of child maltreatment and important domains for intervention for trauma recovery and health promotion (Crawford, 2005; English et al., 2005; Higgins et al., 2001; RACP, 2006; Sawyer et al., 2001; Sawyer et al., 2007).

Health, emotional and social behaviour. This domain evaluates the child's current general physical and mental health functioning and management of any existing problems, developmentally appropriate self-care and safety behaviours (both towards self and others), engagement in peer and adult relationships, self-esteem and confidence and the child's engagement in developmentally appropriate responsibilities and activities.

MAPS Domain 2: Educational Engagement and Functioning. This domain evaluates children's school attendance, school engagement, relationships with peers and adults within the school setting, learning progress, caregiver support and the caregiver-school working alliance.

School attendance, engagement & performance. Educational indices have frequently been ignored by counsellors in the child protection field (Fernandez, 2008). Yet children in care

are known to experience a range of poor educational outcomes, including reduced attendance, social and behaviour problems, over-representation in suspension/ expulsion rates, and low completion rates (Clemens, Lalonde, & Phillips, 2016; Dinehart, Katz, Manfra, & Ullery, 2013; Vinnerljung, Lindbald, Hjern, Rassmussen, & Dalen, 2010; Zetlin, Wienberg, & Shea, 2005). Recent Australian longitudinal research highlights the prevalence of school disruption and adjustment problems for children in OOHC: more than half of the children aged 6-11years, and three quarters of children aged 12-17 years experienced one or more primary school changes, while approximately one fifth of all children had attended more than three. One-third of carers of children aged 6-11 years and over half of carers of children aged 12-17 years reported concerns about their child's academic functioning or other school-based problems. Furthermore, almost 10% of OOHC children aged 12-17 years are reported to not be attending school (AIHW, 2015). Children in care report lower aspirations for themselves, perceive their parents to have lower expectations for them, and report lower levels of parental support, than children not in care (Tilbury, Creed, Buys, Osmond, & Crawford, 2012).

Caregiver support and relationship with school. Parenting characteristics have been shown to influence educational participation and outcomes for children with maltreatment histories. In a recent longitudinal study, Maclean, Taylor, and O'Donnell (2016) examined the prevalence, risk, and protective factors for low educational achievement amongst children who had been the subject of notifications and/or placed in OOHC (n = 2,716), and those not involved in the child protection system (n = 44,122). As found in other studies, children with maltreatment histories had significantly lower reading achievement than the comparison group. However, children in OOHC had significantly higher school attendance and better reading achievement, compared to those children who had been the subject of abuse and neglect reports who were still

residing with birth families. Reading achievement was partially mediated by school attendance, which in turn was likely influenced by caregivers. Similarly, caregiver involvement, particularly academic support in the home and caregiver academic expectations, predicted academic success amongst 687 youths aged 10-15 years in OOHC (Cheung, Lwin, & Jenkins, 2012). Qualitative studies with young people in care attest that caregiver support strongly influences school engagement (Tilbury et al., 2012). Moreover, young people and adults previously in care suggest that caregiver enforcement of homework routines, educational advocacy and carer academic expectations assist children in care to later graduate and enrol in postsecondary education (Morton, 2015).

Parenting responses to their children's educational needs also influence educational outcomes. Henderson (2012) examined the relationship between parenting strategies and educational outcomes for 12,439 children aged 13-14 years and their parents, involved in the *Longitudinal Study of Young People in England* (2004-2006). Parent-child communication (i.e. how often the child and their parent talked about matters important to the child) and involvement (the degree to which parents were involved in their child's school life) were associated with teachers' positive perceptions of the child, whether the child liked school, child self-belief, and the likelihood of the child applying to university.

Taken together, these studies suggest a number of systemic factors important to the educational outcomes of children with maltreatment histories. In addition to school attendance, participation and performance, caregiver support of the child's academic needs and the nature of the carer-school relationship all appear to scaffold children's educational experiences and outcomes.

Caregiver Factors Important for Children's Long Term Well-being

MAPS Domain 3: Primary carer Health and Psychosocial Functioning. This domain evaluates caregiver's general physical and mental health, coping skills and demonstrated parenting ability, parenting confidence and engagement in positive social relationships, and self-care. Evidence for the importance of these with respect to child safety and well-being is outlined below.

Health, emotional and interpersonal indices. From a risk perspective, caregiver substance misuse, mental health problems and exposure to domestic violence are widely acknowledged as key risk factors for child abuse and neglect (Scott, 2013). In a review of the impact of caregiver substance misuse, mental illness and domestic violence on child risk, Bromfield, Lamont, Parker and Horsfall (2010) found that each risk factor impaired caregiving and risks frequently co-occurred. With regards to substance misuse, the associated intoxication, substance withdrawal and mood disturbances impair parental supervision, and the ability to attend to child needs, leading to inconsistent, reactive and harsh parenting responses. Mental health problems are heterogeneous and their consequences for parental functioning depend on illness type, severity and chronicity. Significant mental health problems likely to negatively impact parenting include depression, bipolar affective disorder, schizophrenia, post-traumatic stress disorder, borderline personality disorder, and antisocial personality disorder. In broad terms, the typical effects of these on parenting include caregiver dependence on the child or child 'parentification', parent-child attachment difficulties, child emotional stress and possible cognitive impairment due to neglect, and an increased risk of child neglect, physical and psychological abuse (Bromfield et al., 2010).

Domestic violence is the most frequently reported characteristic of at-risk families and commonly co-occurs with caregiver substance misuse and mental illness. In addition to the physical and/or psychological harm sustained by victims of domestic violence, associated problems include homelessness or housing instability, diminished ability to place the needs of the child first, and impaired parent-child relationships. Overall, children exposed directly or indirectly to parental substance use, mental health and/or domestic violence are at risk of long term profound psychological problems, as a result of chronic stress (Bromfield et al., 2010). As such, caregiver physical and mental health is fundamental to the assessment of child safety and well-being (Department of Health, 2010b).

Parent resources. Large scale studies have identified numerous parenting capacities and resources as protective, in that they are associated with a reduced incidence of child maltreatment. These include parental awareness and insight regarding children's developmental needs, coping skills, and access to familial and external practical supports (Lamont & Price-Roberston, 2013; White, 2005). Parental self-efficacy has also been consistently shown to positively influence parenting practices, behaviours and child adjustment (Enebrink et al., 2015; Jones & Prinz, 2005; Weaver, Shaw, Dishion, & Wilson, 2008), but needs also to be paired with a realistic understanding of children's developmental needs (Hess, Teti, & Hussey-Gardner, 2004). Furthermore, relationship happiness, self-care through community engagement, and social supports (e.g. use of recreation/ fitness/ community drop-in services) has been found to be protective against a range of child developmental delays (McDonald, Kehler, Bayrampour, Fraser-Lee, & Tough, 2016).

Importantly, children will typically require differing parenting behaviours in response to their maltreatment trauma, depending on whether they are in foster care, kin care or if their

relationship with birth parents is relegated to court ordered contact only. Additional parenting skills and capacities, sensitive to these needs, are further captured in MAPS Domains 4A, 4B and 5, and are discussed in the following section.

MAPS Domains 4A; 4B: Alternate Placement Security & Safety and Birth family Placement Security & Safety. The MAPS Domains 4A and 4B consider children's needs across different care contexts: 4A refers to contexts where children reside in either foster or kinship care and may be in temporary or long term placement; 4B refers to children residing with birth parents. In this context, children may have been previously taken into care and subsequently returned to their birth parent(s), and/or are the subject of a current supervision order[9]. The scales for both contexts are similar, with the exception of one focus item. Both evaluate the general quality of the child-carer or child-parent relationship, the carer's or parent's attempts to initiate and maintain a positive relationship with their child, employ positive parenting, and expressed commitment in maintaining care of their child. Both also consider the carer's or parent's insight into the developmental needs of the child and impact of trauma and placement history on the child. The last focus item differs. In 4A, where children reside with foster or kinship carers, the item evaluates the carer's willingness and attempts to support and maintain the child's birth family contact and links to culture. In 4B, where children reside with birth parents, specific consideration is given to their insight into their own role in child maltreatment (where relevant), and demonstrated change with respect to the parenting behaviours that led to maltreatment and/or child removal. Research indicating the importance of these caregiver attitudes and responses for children's outcomes is discussed below.

[9] Such as when parental capacity is being monitored and parents are engaged in court-ordered support or treatment services.

Parenting style and parenting alliance. The literature on parenting styles associated with positive outcomes for children has been reviewed in Chapter 1. A brief summary of additional parenting attitudes and responses, as it relates to Domains 4A and 4B, is provided below.

The need to provide sensitive, structured care for children following trauma, exceeds that of normative parenting (Murray et al., 2010), and appears important for both birth parents and foster or kinship carers. Accordingly, the assessment of caregiver strengths is important. Numerous large scale studies of children and their parents have demonstrated that an authoritative parenting style is optimal. Caregivers who are appropriately monitoring and demanding, emotionally available, impart clear expectations of, and consequences for, positive and negative behaviour, support their child's self-expression, and enforce discipline to support and educate, rather than punish, have children with fewer externalising and internalising problems and greater adaptive, self-regulatory skills in childhood and adolescence (Fuentes et al., 2014; Rinaldi & Howe, 2012; Tan et al., 2012).

Additionally, parental warmth, positive daily parent-child interactions (e.g. play, reading with younger children), and emotion coaching are well established correlates of positive child adjustment (Lansford et al., 2014; McDonald et al., 2016; Wilson, Havighurst, & Harley, 2014). Finally, children's outcomes are influenced by the quality of the relationship between co-parents. Poor parenting alliance is strongly associated with poor behaviour outcomes (Stallman & Ohan, 2016) and good alliance with positive behaviour functioning (Holland & McElwaine, 2013), and thus should be considered as part of the parenting rubric.

Placement security and caregiving environment. Placement instability is a common problem for a portion of children in OOHC and poses a significant risk to children's mental health outcomes (Delfabbro et al., 2010). The challenges and impacts of placement insecurity in

relation to foster and kinship placements has been reviewed in Chapter 1. In addition, commitment to maintaining the placement/ restoration would also appear important to consider with birth parents, especially if children have been restored following a period of time in care. Studies indicate a range of poor outcomes for children reunified with families following maltreatment, compared to those who remain in OOHC. These include greater behaviour problems, including engagement in destructive behaviours, substance use, poor school performance, school drop-out, and lower self-reported competence (Bellamy, 2009; Taussig, Clynman, & Landsverk, 2001). Bellamy (2009) found that reunification increased the likelihood that children were exposed to various stressors, including poor parental mental health, and noted significant problems readjusting to parenting.

Parents who have undergone restoration of children also identify numerous challenges they face, including children's challenging behaviours, concerns about being unsuccessful, and the future removal of the children, as well as concerns about ongoing supports (Fernandez, 2013). Overall, caregiver's willingness to maintain the placement appears important to assess in conjunction with understanding which factors may underscore concerns surrounding placement breakdown.

Caregiver responses to child trauma. Abuse and neglect sustained in childhood significantly impacts a child's development and is associated with long term mental health problems (Gaskill & Perry, 2012). Cognitive immaturity makes young children susceptible to the development of dysfunctional appraisals and maladaptive coping strategies, including avoidance and dissociation (Ehlers, Mayou, & Bryant, 2013). Without intervention, these strategies have been shown to maintain trauma symptoms and predict the development of PTSD months to years after the initial traumatic event (Ehlers et al., 2013; Kezelman & Stavropoulos, 2012). Notably,

poor caregiver-child interactions exacerbate trauma symptoms over time, even when the caregiver is not responsible for the trauma (Gil-Rivas & Kilmer, 2013). It is important, therefore, that caregivers are aware of the possible impacts of prior trauma experienced by children in their care and are skilled to adequately support their child through recovery. Yet data indicates that caregiver awareness of children's trauma-related symptoms is low (Meiser-Stedman, Smith, Glucksman, & Dagleish, 2007). A lack pf pre-placement awareness of child trauma and the implications of this on children's mental health, was also evidenced in carer responses outlined in Study 1, Chapter 3.

Caregiver responses to the trauma event and related child symptoms influence child outcomes. Scheeringa and Zeanah (2001) reviewed 17 studies that simultaneously assessed child and parental functioning following child trauma exposure. Trauma exposure included single and chronic events (e.g. dog attack, flood, fatal illness, child maltreatment). Parents included in the study were not perpetrators of the trauma. The authors found a consistent association between unhelpful caregiver responses and child mental health problems. Based on the data, the authors proposed a relational model of childhood PTSD which outlines three pathways by which caregiver responses can exacerbate child symptoms. Caregivers preoccupied with their own history of trauma may be less available to recognise and assist their child, particularly if they engage in withdrawal and avoidance strategies in response to their child's trauma symptoms. Caregivers preoccupied with the traumatic event itself may inhibit their child's participation in developmentally appropriate activities and can impede recovery by adopting an overprotective, restrictive parenting stance. Alternately, caregivers may exacerbate their child's trauma symptoms if, due to their own emotion regulation difficulties, they become preoccupied with trauma reminders, to the extent that they are unable to inhibit their own statements or responses

to intrusive reminders of the event when with their child, especially if these are expressed in unregulated ways.

The negative impact of ongoing parent dysregulation following child trauma has received some support in subsequent studies. Bockszczanin (2008) examined the role of family factors as predictors of post-traumatic stress symptoms among 533 children and adolescents following a natural disaster. Perceived lack of support from parents, greater levels of family conflict, and parental overprotectiveness, in particular, were associated with increased PTSD symptoms. In a qualitative study, Williamson and colleagues (2016) interviewed 20 parents whose children had attended an emergency department following a traumatic incident. They identified that parental beliefs about their child's vulnerabilities underscored their inhibiting of their child's resumption of pre-trauma routines.

There is growing consensus that whoever provides care for a child following maltreatment needs to appreciate the impacts of trauma on child functioning and development, and have the capacity to provide an appropriate narrative to the child about their trauma experiences. Central to these capacities are the caregiver's ability to anticipate the child's current and future needs '*in the context of their level of empathic response to the level of harm experienced by their child*' (Donald & Jureidin, 2004, p. 8). Overall, caregiver insight, willingness to develop an understanding of the impact of trauma, capacity to contextualise their child's needs and provide empathic and appropriate supports, and capacity to separate their own emotional needs from those of the child, appear crucial and should form part of a holistic assessment of the child's psychosocial well-being following trauma. While it is recognised that these can be taxing tasks for foster and kin carers (FaCS, 2016), they are likely to be especially challenging for birth families who may be directly or indirectly responsible for the maltreatment.

Supporting birth family contact and culture. A key difference between Domain 4A and 4B is the focus item included in 4A, which relates to foster and kin carer's support, or lack thereof, of their child's connection with their birth family and culture. Foster and kinship carers are legally obligated to recognise and support their child's relationships with their birth family, their cultural and religious identity, and to support these relationships in accordance with their child's care plans (Office of the Children's Guardian, 2013). A fundamental way to promote identity and familial ties for children in OOHC is the preservation of family contact, alongside the meaningful exposure to tangible family mementos and keepsakes. Family contact is wide ranging and can include parents, siblings, grandparents, cousins, extended family, and cultural members. Research indicates that well-planned and positive contact can maintain and build a sense of connectedness, support and belonging for children, as well as assist reunification with family (when this is the goal) (Department of Communities, Child Safety & Disability Services, 2012; Panozzo, Osborne, & Bromfield, 2007).

Children require their caregivers to actively support their family relationships and rituals. Survivors of childhood maltreatment and displacement attest to how caregiver insensitivity to family ties and loss can complicate the grief process (McDowell, 2013; Unrau, Seita, & Putney, 2008). As evidenced in chapter 2, a portion of carers were not aware of the cultural background of the child in their care. The reasons for this are unknown and were outside the scope of the study. Loss of such information however, may be due to the care agency not seeking, or receiving, adequate information from birth families, not passing information on to carers, carers not reinforcing cultural knowledge with their child or a combination of these. Regardless, qualitative research with children in care confirms a common desire to maintain family links, as well as highlighting children's reliance on carers to support them around issues of family

connection and to provide understanding and comfort if/ when contact is emotionally taxing (McDowall, 2015). An active knowledge of birth family culture and the ways connection are or were sought would likely assist carers in the process of maintaining children's links to family.

Parental responsibility and change. The key difference between Domains 4A and 4B, with respect to birth parents, is the focus item relating to parents' insight into their personal role in the substantiated child maltreatment (where relevant), and demonstrated change with respect to the parenting behaviours that led to maltreatment and/ or child removal. It is recognised that parents involved in child protection may exhibit problematic responses which inhibit progress, including false compliance, denial, and avoidance (Brandon et al., 2008b; Ward, Brown, & Westlake, 2012). It is also understood that fear, shame and stigma surrounding the child maltreatment, as well as a low confidence in one's ability to change, may underscore a parent's resistance to intervention (Ward, Brown, & Hyde-Dryden, 2014). Nonetheless, these authors point out that failure to consider parental responses and attitudes to child protection intervention has been implicated in large scale analyses of child deaths and serious injury through abuse and neglect. In addition to evaluating parental strengths, there is strong consensus that assessments of safety and well-being should also consider how the historical functioning of the family and current level of engagement may impact present day risks to children (Brandon et al., 2008b).

A review of parental protective factors identified key behaviours and attitudes that mitigate parental problems and reduce the likelihood of maltreatment recurrence. These include parental recognition of the problem that led to child protection intervention, the willingness to take responsibility for personal behaviour and change, and a willingness to engage with services that support the parent's efforts to change (Ward et al., 2014).

MAPS Domain 5: Relationship Safety & Security with Birth Family.

This domain considers the nature of the parent-child relationship in the circumstance where the child is residing in alternate care and has contact with his/ her parent(s). Notably, clinicians will use either MAPS Domain 4B, when the child resides with the birth family, *or* Domain 5, when the child resides in OOHC. Thus, Domain 5 replicates a number of items presented and discussed in 4B, namely the consideration of the parent-child relationship, the parent's attempts to initiate and develop the relationship, general parenting style during contact, and child responses to parent's overtures. Again, similar to the previous domain, consideration is given to the parent's ability or willingness to provide a developmentally appropriate narrative regarding past maltreatment and separation, including the parent's own role in the maltreatment (if applicable). As a point of difference, this domain also guides the clinician to consider the parent's ability to support the child's relationships with her or his foster or kinship family and, finally, the child's own understanding of past maltreatment and removal. The relevance of these to children's well-being are discussed below.

Supporting alternate attachments. For the parents of children removed from their birth family, grief is often disenfranchised; not able to be openly acknowledged or socially supported (Doka, 1989). The loss experienced is often overshadowed by blame for past abusive or neglectful parenting (Dumbrill, 2006; Hinton, 2013). Furthermore, following removal, the focus of therapeutic attention is typically redirected to foster and kin carers, often leaving birth parents isolated from the system and from decision-making (Forsberg & Poso, 2007). This reduced collaboration with birth parents is perhaps as much a reaction to the abuse as it is due to limited resources (Forsberg & Poso, 2007). However, evidence suggests that ongoing engagement and therapeutic assistance to birth parents further safeguards maltreated children. Poor birth parent-

child attachments are associated with higher levels of foster placement breakdown (McWey & Mullis, 2004), and qualitative research demonstrates that many children continue to endure negative or abusive parenting during contact visits (Durell & Hill, 2007; Forsberg & Poso, 2007).

Parents preoccupied with denying their actions and/ or with anger and blame towards other parties, are more likely to be focused on child restoration (Schofield et al., 2011), less emotionally available to their children, and less cooperative with carers and agencies supporting the child (Haigh, Mangelsdorf, Giorgio, Schoppe, & Szewczyk, 2002). These factors, in turn, influence child well-being. Children who have conflicting allegiances between birth and foster families display higher levels of emotional and behaviour disturbance (Leathers, 2003), whereas children of parents who accept and support the foster/kin placement, affirm the new carers in their role and have a cooperative relationship with services, exhibit better outcomes (Scott, O'Neill, & Minge, 2005).

Contextual Factors Important for Child and Family Long term Well-being

MAPS Domain 6: Primary Carer's Engagement, Support & Environment.

This domain focuses on the caregiver's demonstrated motivation and cognitive and emotional ability to understand the child's psychosocial needs and make necessary behaviour changes in response to those needs. The parenting context is often situated within a wider context of exclusion and disadvantage (e.g. low education, poverty, housing instability, neighbourhood disadvantage, and social isolation) (Bromfield et al., 2010). This domain thus also considers contextual factors which destabilise family functioning, such as the availability and accessibility of necessary support networks, the presence and management of any current socio-economic strains, and social and housing safety.

Motivation, reflective parenting and change. At a minimum, caregiver cooperation, motivation, and engagement with services is considered a necessary condition for meaningful parenting change to occur. While disguised or partial compliance can be difficult to assess, common signs include disrupted therapy attendance, avoidance of intervention focus, or a persistent redirection of focus by the parent, onto other family stressors or strains. These responses continue to pose a risk to child safety and well-being, as they thwart therapeutic attempts to attend to child needs and hold caregivers accountable for addressing those needs (Brandon et al., 2008b; DeRoma, Kessler, McDaniel, & Soto, 2008).

To date, there has been very little research investigating what differentiates caregivers who benefit from specialist counselling interventions from those that do not, especially with respect to multi-strained families (Barth, 2013). In an Australian study, Hilferty and colleagues (2010) evaluated the outcomes of an intensive intervention (*Brighter Futures*), developed for families identified at-risk by a government child protection agency. In this study, parents who were willing, able and motivated to assist their child, and who accessed the family supports offered, tended to make gains in parenting practices, child behaviour and connection to community resources and supports. There was also a significant reduction in risk of harm reports for participant families. Children of families who completed the program were also less likely to be placed in OOHC, compared to families who initially declined the program.

An additional caregiver quality considered crucial for behaviour change and child well-being is the caregivers' orientation to the child's mental states, often referred to as mentalisation or reflective capacity. Reflective parenting refers to a caregiver's ability to monitor, attend to, and consider their own thoughts and emotional responses, in response to, as well as separate from, those of their child, as well as an understanding of the ways in which mental states

influence behaviour (Brandon et al., 2008b; Fonagy, 2001; Fonagy et al., 1991). Recent research demonstrates links between high reflective functioning and the provision of adequate caregiving and secure parent-child attachment, while low reflective functioning has been associated with childhood anxiety, emotion regulation problems and externalising behaviour problems (Camoirano, 2017). This domain guides clinicians to consider the parent/ carers ability to self-reflect and apply learning to necessary behaviour change.

Access to services and psychosocial strains. Assessment of caregiver motivation, capacity and change should include the appraisal of the availability and accessibility of supports which enable change, as well as existing impediments to change. Analysis of national records in the US demonstrates that most families, where child abuse has been substantiated, are not provided with family preservation interventions, and there is a dearth of specialist services to address drug and alcohol and/ or domestic violence problems (Dakil, Cox, Lin, & Flores, 2011). Australian services experience similar problems in supporting families at-risk, as secondary and tertiary services are often not available to meet the complex needs of families engaged in the child protection system (Council of Australian Governments, 2010). Lastly, it is well recognised that environmental and social factors associated with child maltreatment include poverty, unemployment, housing problems/ neighbourhood conflict and crime (Camberis & McMahon, 2016; Chu, Pineda, DePrince, & Freyd, 2011; Lamont & Price-Robertson, 2013). As such, the relative strengths or problems in the caregiver's environment should be considered.

MAPS Domain 7: Systemic Alliance and Support. Domain 7 considers the key care agency's awareness of the child's maltreatment history and psychosocial needs, their ability to meet necessary case management responsibilities, maintain communication with the caregiver, and the quality of the working alliance between agencies and caregivers. Over the last decade,

the nature of the working relationship amongst families at-risk and agencies who work with them has been increasingly recognised as an important factor contributing to child safety and well-being outcomes, as highlighted and discussed in Study 1, Chapter 3.

Casework skill and responsiveness. Case management is a significant and unique aspect of the work directly provided within the child protection field. It is considered a dynamic process whereby workers collaboratively identify family needs and coordinate and monitor service provision, often alongside multi-disciplinary teams (FaCS, 2015). Effective case management requires cognitive, emotional and relational skills, so that the systematic assessment of, and response to, family needs is enacted within a respectful, sensitive relational context.

Research has identified specific casework skills and demeanour associated with client engagement. Gladstone and colleagues (2014) examined the association between casework skills and parental engagement with child protection services, with 131 worker-parent dyads from 11 child welfare agencies. Client engagement was higher when workers made and returned phone calls when arranged, located support services, listened to problems raised by the parent, and did not ask parents to do things the parent did not find helpful. For foster and kinship carers, caregiver strain has been linked to problems with casework, including the extent to which carers are provided with information about their child, the provision of additional support and the level of support received during critical times of strain (Thomson, McArthur, & Watt, 2016). Additionally, foster and kin carers identify a need for their care agency to help manage problematic dynamics with birth families around contact arrangements (Department of Communities, 2012).

Working Alliance. Research into the impact of the client-provider working alliance in child welfare is very limited. March and colleagues (2012) conducted a systematic review of

seven available studies. The quality of the working alliance was found to be a consistent predictor of client participation, but results were mixed with respect to predicting outcomes. Positive associations were found between the working alliance and client safety, with regards to improved parental discipline, emotional care, and reduction in violence in the home (Johnson & Ketring, 2006; Lee & Ayon, 2004). A good working alliance was also associated with improved child emotion and behaviour regulation, and reduction in family anxiety and depression (Johnson & Ketring, 2006; Johnson, Wright, & Ketring, 2002). However, in another study, while the working alliance assisted client engagement, it was not associated with increased parental attendance at family contact or reunification of children (Altman, 2008). These studies suggest that whilst the working alliance may not be a sufficient condition for change, it is crucial in influencing engagement and as a vehicle for clinically meaningful outcomes.

Qualitative evidence also supports the significance of a positive working relationship on client engagement and outcomes. Parents identify that negative caseworker attitudes exacerbate their own negative emotional states and sense of stigma, which impedes their willingness to engage (Lalayants, 2006). This dynamic was similarly illustrated in comments made by foster and kin carers, reported in Chapter 3. Conversely, parents of maltreated children who perceive their worker to be experienced, able to discuss problems, collaborate on goal formulation, listen to parent's emotional pain, and acknowledge parental strengths, tend to be more engaged with their caseworker. Together, these skills confirm the importance of caseworkers collaborating with clients. The benefits were reciprocal and led to a positive feedback loop. Caseworkers who act collaboratively, by including parents in planning and providing positive feedback to parents about their efforts, ideas, and achievements, felt more engaged with their clients (Gladstone et al., 2012, Dumbrill, Leslie, Koster, Young, & Ismaila, 2014).

The collaboration and alliance between different agencies involved with the family is also important to evaluate, when considering the level and quality of systemic support for children. Specifically, effective cross-system communication about children's needs, clear roles and responsibilities between agencies, and respect between professionals and service-users, have all been shown to influence outcomes for children (Cox, 2013; Gustavsson & MacEachron, 2013; Howarth & Morrison, 2011; Noonan et al., 2012).

Summary and Rationale for Study 2: Multi-Systemic and Psychosocial Safety (MAPS): Inter-rater Reliability & Clinical Utility

In sum, accurate assessment of child safety and well-being following maltreatment is critical to prevent further trauma, and to identify specific interventions that are likely to promote placement stability and facilitate health promotion. To date most tools for assessment of risk have been developed within statutory child protection agencies and have evolved to rely heavily on structured, actuarial-based assessments, shown to be superior to more intuitive flexible assessments with respect to inter-rater reliability and predicting future maltreatment (Price-Robertson & Bromfield, 2011). These tools fit the intended purpose of assessing the immediate risks of harm and the needs of families, however they typically do not evaluate a range of systemic factors relevant to ongoing child safety and well-being, or signify specific areas for intervention. Assessment of child safety and well-being following maltreatment within therapeutic child protection services requires further development. A holistic assessment from an ecological framework (Bronfenbrenner, 1977, 1986, 1994) needs to consider and synthesise a wide range of individual, family, and support system factors, as well as be able to assess critical changes over time (Ager et al., 2012; Department of Health, 2010a, 2010b; Gillingham, 2006).

Holistic assessment will also more likely provide appropriate outcomes data with which to judge the effectiveness of intervention in a complex field (Thomas et al., 2011).

The Multi-Systemic Assessment of Psychosocial Safety (MAPS) was developed by the author, to assist specialist counsellors to assess the psychosocial safety of children (aged 6-16 years) who have experienced maltreatment. The MAPS tool considers multiple child, family, and social systems, and aims to provide a snapshot of a child's current well-being, identify key risks and protective factors, and help identify individual areas for intervention. Used across time as a repeated assessment tool, it is expected to provide relevant outcome data. Chapter 5 outlines the aims, methodology and outcomes of an action research project, which culminated in the development of the MAPS tool. Chapter 6 summarises an empirical study investigating the inter-rater reliability and clinical utility of the MAPS tool. These two related studies sought consultation from specialist child protection counsellors, however the sample of counsellors were different across the studies. Some of the survey questions given to each sample across the studies were repeated, to capture a variety of views and/ or to consult regarding changes made to the early version of the MAPS, based on initial consultation.

Chapter 4a.

The Multi-Systemic Assessment of Psychosocial Safety (MAPS).

Health
Western Sydney
Local Health District

Multi-Systemic Assessment of Psychosocial Safety: MAPS.

MAPS Domain 1: Child Health & Psychosocial Functioning (6-16yrs)

Consider the child or young person's functioning in the last 6 months.

NSW GOVERNMENT Health Western Sydney Local Health District

1	2	3 4	5	6
Overall, physical & mental health problems are mismanaged & have led to harm to self or others. Significant problems with self-care or interpersonal behaviours Serious concerns for safety & well-being of CYP / others.	**Overall physical & mental health problems are inadequately managed AND present a clear risk to safety/ well-being of CYP or others. Problems significantly impact engagement in interests & activities.**	**Overall, physical & mental health problems are not adequately managed AND/OR are at risk of impacting CYP's safety or that of others. Problems impact engagement in interests & activities.** **Rank as 3 if problems > 6 months.**	**Overall CYP's physical & mental health problems are adequately managed. CYP generally displays adequate self-care, social skills, self-esteem & engages in developmentally appropriate interests & activities.**	**Overall, CYP presents with good or well-managed physical & mental health. CYP displays good self-care, social skills, self-esteem & engages in developmentally appropriate interests & activities.**
The child or young person (CYP):	The child or young person (CYP):	The child or young person (CYP):	The child or young person (CYP):	The child or young person (CYP):
☐ AND/OR Carer poorly understand or mismanages physical or mental health problems in ways that worsen problems, prevent developmentally-expected learning or recovery. CYP has caused harm to self or others (e.g. people /animals).	☐ Poorly understands & manages physical or mental health problems AND/ OR Carer inadequately supports needs. Problems present a significant risk to self or others.	☐ Insufficiently manages physical or mental problems (e.g. rejects help) OR Carer does not sufficiently access necessary supports OR problems are adequately managed but still present a risk to self or others.	☐ Has minor physical or mental health problems that are adequately understood, managed & supported by CYP & Carer (e.g. uses care strategies/ accesses medical/psychosocial supports). Problems do not cause risk to self or others.	☐ Has good physical & mental health OR minor problems are well understood, managed & supported by CYP & Carer (e.g. uses care strategies/accesses medical/ psychosocial supports). Problems do not significantly impact daily functioning.
☐ Displays self-care significantly below developmental expectations OR risk-taking behaviours/lacks self-preservation. Presents immediate & significant risk to self or others.	☐ Displays self-care significantly below developmental expectations OR risk taking behaviours OR a lack of basic protective behaviours AND problems presents significant risk to self or others.	☐ Has problems with developmentally appropriate self-care AND/OR limited protective behaviours that present some risk to self or others.	☐ More often than not displays developmentally appropriate self-care (hygiene/ coping skills) AND a sense of safety for self/ others.	☐ Displays developmentally appropriate self-care (e.g. hygiene, coping skills) AND a sense of safety for self & others.
☐ Lacks positive connection or attachments with peers or adults outside of school. Lacks developmentally expected empathy for others (people/animals) or respect of others' rights.	☐ Displays social or behavioural problems with peers AND/OR adults outside of school which significantly impacts involvement in extra-curricular activities AND/OR family outings.	☐ Displays social or behavioural problems with peers AND/OR adults outside of school & somewhat impacts involvement in extra-curricular activities AND/OR family outings.	☐ Has good relationships with peers & adults outside of school or problems do not impact participation in extra-curricular activities or family outings.	☐ Has numerous positive relationships with peers & adults outside of school, developmentally appropriate engagement with friends, interests or hobbies. Displays age-appropriate empathy for & awareness of other's rights.
☐ Has a negative, entitled sense of self/ lack of, or over-inflated confidence in abilities AND/OR rejects/ refuses many developmentally-appropriate tasks & responsibilities even with positive incentive, prompting or coaching.	☐ Has a negative sense of self AND/OR confidence & ability to perform many developmentally appropriate tasks & responsibilities even with positive prompting, coaching or incentives	☐ Lacks positive sense of self or confidence or ability to perform developmentally appropriate tasks & responsibilities without significant prompting/ supervision.	☐ More often than not has a positive sense of self, confidence & ability to perform developmentally appropriate tasks & responsibilities though may require intermittent coaching.	☐ Has a positive sense of self, confidence & ability to perform developmentally appropriate tasks and responsibilities.

MAPS Domain 2: Educational Engagement and Functioning

Consider the child or young person's functioning in the last 6 months

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1	2	3 4	5	6
Overall, school & social engagement is extremely poor seriously, affecting learning outcomes. Negative/ hostile School-Carer relationship.	**Overall, school and/or social engagement is significantly strained, significantly affecting learning. Poor School-carer alliance.**	**Overall, problems in school and/or social engagement are somewhat impacting learning. Strained School-Carer alliance.** Rank as 3 if problems > 6 months.	**Overall, minor strains at school do not significantly impact CYP's learning or engagement. School-Carer alliance is positive.**	**Overall, CYP is meeting or exceeding cognitive & developmental expectations. CYP & Carer's engagement with school is very positive.**
The child or young person:	The child or young person:	The child or young person:	The child or young person:	The child or young person:
☐ School refuses/ often absconds. Very poor school attendance.	☐ Has poor attendance AND/OR regularly absconds.	☐ Has had numerous absentee days (which has disrupted learning) OR has absconded numerous times.	☐ Willingly attends school OR absenteeism has been minimal.	☐ Willingly attends school & has very good attendance.
☐ Rejects or is hostile towards school. If in high school, has unrealistic or negative goals for future education career/job.	☐ Dislikes or has a negative view of school. If in high school, lacks developmentally appropriate goals, unrealistic goals for future education / career/job.	☐ Is ambivalent towards or poorly views school. If in high school, lacks a positive view or realistic goals for future education/ career/job.	☐ Generally enjoys school activities & looks forward to school events. If in high school, has positive view of future at school or realistic goals for future education/career/job.	☐ Enjoys most school activities, (home-work/ excursions) & looks forward to school events. If in high school, has positive view of future at school or developmentally appropriate realistic goals for future education /career/job.
☐ Has significant social problems (e.g. no friends/ victimises others or is violent) AND/OR problems with authority figures that HAS led to actual suspensions/ alternate school placement.	☐ Has significant social problems (e.g. no friends/is victimized or victimises) AND/ OR problems with authority figures that has led to numerous conflicts, disciplinary actions AND/ OR threatened suspensions.	☐ Has significant social problems with peers or teachers that has led to conflict, isolation, stress to child or disrupted learning.	☐ Has minor social problems (e.g. making/keeping friends, being accepted by peers OR difficulties with teachers) that do not cause significant stress or disruption to learning.	☐ Has developmentally appropriate number of stable friendships AND positive relationships with teachers.
☐ Is performing objectively below (3-4yrs) developmental & cognitive capacity across most or all school subjects.	☐ Is performing objectively below (3-4years) developmental & cognitive capacity in a number of school subjects.	☐ Is performing objectively below (at least 2yrs) developmental & cognitive capacity in a number of school subjects.	☐ Generally meets or approaches developmental & cognitive capacity in schoolwork. Any academic problems are being addressed & progress expected.	☐ Exceeds, meets or closely approaches developmental & cognitive capacity for most or all school subjects.
☐ There is a negative/ hostile School-Carer relationship (e.g. hostility, blaming, aggression, lack of insight & planning around CYP's needs) which maintains CYP's disengagement from school.	☐ There is poor School-Carer alliance (e.g. negative/blaming interactions or lack of communication, poor insight into & or planning to meet CYP's needs) significantly impacting problem resolution.	☐ The Carer & school have a strained alliance or inadequate communication however there is a willingness to collaborate & resolve issues.	☐ The Carer & school share adequate communication & working alliance that facilitates CYP needs.	☐ The Carer & school share a positive, collaborative relationship (e.g. good communication, insight into CYP's needs, effective strategies, and home-school alliance).

MAPS Domain 3: Primary Carer Health & Psychosocial Functioning

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Consider the Primary Caregiver's functioning in the last 6 months.

1	2	3 4	5	6
Overall, mental and/or physical health, interpersonal, coping or self-care problems significantly impact parenting, resulting in actual, immediate or significant risk of harm or neglect to CYP and/or self.	**Overall, mental and/or physical health, interpersonal, coping or self-care problems significantly impact parenting & there is a clear risk of harm to CYP or self.**	**Overall, mental and/or physical health, interpersonal, coping or self-care problems somewhat impact Carers ability to effectively parent, or access appropriate supports. This may present a risk to well-being to CYP or self.** **Rank as 3 if problems > 6 months.**	**Overall, where mental and/or physical health problems exist, they do not cause major disruption to parenting & do not pose risk to self or CYP's safety. Carer displays adequate interpersonal and coping skills.**	**Overall, Carer has good, or well-managed, mental and/or physical health problems, a positive sense of self & parenting confidence. Carer displays good coping & self-care skills.**
The Primary Carer:	The Primary Carer:	The Primary carer:	The Primary Carer:	The Primary Carer:
☐ Poorly manages physical and/or mental health problems or there is insufficient social/ medical support. Problems severely impact daily function or result in neglectful/ abusive parenting. Demonstrated risk to CYP or self.	☐ Inadequately manages physical and/or mental health problems or there is insufficient social/medical support. Problems significantly impact daily function or result in inappropriate/ negative parenting strategies. Presents a clear risk to welfare or well-being of CYP or self.	☐ Inadequately manages their physical and/or mental health problems or there is insufficient social/medical support. Problems regularly impact daily function or ability to maintain effective parenting. May present a risk to welfare/ well-being of CYP or self.	☐ Manages current physical and/or mental health problems. Problems do not cause major deterioration to parenting or risk to welfare/well-being of CYP or self.	☐ Has general good physical and mental health or problems are understood and well managed (e.g. Carer displays insight into problems/ accesses necessary & available medical/ psychosocial support/ has appropriate management plan for recurrent or severe problems). Generally, daily function and parenting capacity is good and stable.
☐ Demonstrates poor coping skills (e.g. avoidance, denial, substance use, gambling,) or persistently lacks foresight to plan for personal & parenting challenges AND does not access necessary social or professional help as needed.	☐ Demonstrates poor coping skills (e.g. avoidance, denial, substance use, gambling,) or shows limited foresight to plan for personal & parenting challenges and/or limited ability to access social or professional help when needed.	☐ Demonstrates limited coping skills and/or insight which results in difficulty anticipating & planning for challenges or access help when needed.	☐ Demonstrates some positive coping skills and insight but may have occasional difficulty anticipating/ planning for challenges or in accessing help when necessary or may lack a care plan for recurrent problems.	☐ Demonstrates good foresight in anticipating own & CYP needs and good coping skills (e.g. good self-care, plans for challenges & accesses supports as necessary).
☐ Displays negative, inflated or unrealistic sense of parenting ability and/or engages in risky relationships (e.g. conflict/ victimisation/ violation with family, friends, neighbourhood or services/ involvement in risky or illegal sub-culture).	☐ Has a negative, inflated or unrealistic sense of parenting ability and/or experiences interpersonal difficulties (e.g. conflict/ victimisation with family, friends, neighbourhood or services) that interfere with positive change or presents a risk to CYP/self.	☐ Lacks a positive sense of self or parenting confidence and/or may have difficulty maintaining healthy interpersonal relationships.	☐ Generally displays positive sense of self and parenting confidence and maintains generally positive & healthy interpersonal relationships.	☐ Displays a positive sense of self/ parenting confidence and maintains healthy interpersonal relationships.
☐ Engages in strategies that worsen physical/mental health and/or risky social networks.	☐ Displays very limited self-care strategies and/or lacks stable & appropriate social network and/or engagement in positive or healthy activities/ hobby.	☐ Displays limited self-care strategies and/or limited positive social network and/or engagement in positive or healthy activities/ hobby.	☐ Displays some self-care, strategies and maintains positive social network or ongoing engagement in activities/ hobby.	☐ Consistently displays range of self-care strategies and maintains positive social network or regular engagement in activities/hobby.

MAPS Domain 4A: Alternate Placement Security & Safety

Consider the nature of the placement in the last 6 months.

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1	2	3 4	5	6
Overall, serious concerns for placement appropriateness and Carer's parenting style or capacity that present immediate or significant risks to CYP's physical or emotional safety & well being. The Carer:	**Overall, significant concerns for placement appropriateness/ stability or Carer's insight & parenting support for CYP that may present a clear risk to CYP's physical or emotional well-being.** The Carer:	**Overall, some concerns exist for placement stability or Carer's current level of insight & parenting support for CYP that may present a risk to CYP's well-being.** Rank as 3 if problems > 6 months. The Carer:	**Overall, placement is secure. Minor strains with Carer-child relationship, parenting or insight into CYP's emotional, behavioural & developmental needs do not negatively impact CYP.** The Carer:	**Overall, placement is secure. Carer-child relationship is positive. Carer displays positive parenting & good insight into CYP's emotional, behavioural & developmental needs.** The Carer:
☐ Demonstrates negative relationship with CYP.	☐ Demonstrates major relationship strain with CYP.	☐ Has a strained relationship with CYP.	☐ And CYP generally share a mutually positive relationship.	☐ And CYP share a mutually positive relationship.
☐ Has significant difficulty interacting with CYP (e.g. dismisses, demeans, overt frustration/anger towards CYP) or in understanding CYP needs (persistently rejects/cannot assume CYP's perspective).	☐ Has significant difficulty interacting with CYP (e.g. lacks warmth, patience) and/ or in understanding or responding to CYP's feelings & behaviour (e.g. dismisses, belittles, is overwhelmed by).	☐ Has some difficulty initiating attachment forming & reinforcing behaviours and/or in helping CYP understand & organise their day-to-day experiences & feelings.	☐ Regularly displays attachment behaviours (e.g. verbal/ physical affection, play, emotion coaching), regardless of CYP responses.	☐ Often displays attachment forming & reinforcing behaviours (e.g. verbal/ physical affection, play, emotion coaching).
☐ Displays significant negative or harmful parenting (e.g. aggression, inadequate supervision, physical discipline, neglect) AND/OR domestic violence is evident, that present a clear & significant risk to CYP's well-being.	☐ Displays negative parenting responses (e.g. dismissive, over-reactive, passive) and/or couple conflict which impact CYP's emotional-behavioural development, exacerbates problems OR presents a clear risk to their well-being.	☐ Displays inconsistent, reactive or passive parenting and/or inadequate parenting alliance (couples), which impacts the CYP's emotional regulation/ problem-solving skills, maintains problems OR presents a risk to CYP's well-being over time.	☐ Experiences some parenting stress but generally maintains authoritative parenting AND Carer couples display adequate parenting alliance.	☐ Flexibly responds to CYP's needs AND displays warm & authoritative parenting most of the time AND Carer couples display good parenting alliance.
☐ Is often overwhelmed by CYP AND Carer OR clinician has serious concerns regarding placement appropriateness or safety for CYP.	☐ States or indicates placement instability OR clinician has significant concerns regarding placement appropriateness/ stability.	☐ States or indicates strains to placement stability (e.g. behavioural/concerns for foster/birth siblings in placement, financial, Carer health) OR Clinician has concerns for Carer(s) capacity to maintain placement.	☐ Is committed to maintaining placement (BOTH Carers in the instance of couples). Strains (e.g. behavioural, sibling conflict, financial, Carer health), do not threaten placement stability.	☐ Is happy with & committed to the placement (BOTH Carers in the instance of couples). No threats to placement stability on behalf of Carer.
☐ Rejects or inflates impact of trauma/ placement history and/or cannot distinguish CYP's trauma experiences & needs from own in ways which impede or prevent CYP's therapy or recovery.	☐ Dismisses or inflates impact of trau-ma/ placement history on CYP and/or has difficulty differentiating CYP's trauma experiences/needs from own OR impedes external supports to CYP.	☐ Lacks insight into CYP's developmental needs and/or impact of trauma/ placement history on CYP AND/OR is resistant to developing insight/ skills.	☐ Has adequate insight into CYP's developmental needs, impact of trauma/ placement history or how to develop or support an appropriate narrative for the CYP OR is willing to develop skills.	☐ Displays good insight into the developmental needs of CYP & impact of trauma/placement history AND are able to provide or reinforce an age-appropriate, positive narrative to CYP regarding being in care.
☐ Rejects, undermines or demeans CYP's birth family & cultural identity.	☐ Dismisses or undermines connections to birth family & cultural identity despite service intervention on matter.	☐ Inadequately supports or minimises CYP's connections to birth family/ cultural identity, despite service intervention on matter.	☐ Lacks knowledge on how to support CYP's connection to birth family & cultural identity but willing to.	☐ Actively supports CYP's connection to birth family & cultural identity (e.g. supports contact, displays family photos/keepsakes, engages with CYP around birth family stories).

MAPS Domain 4B: Birth Family Placement Security & Safety

Consider the nature of the placement in the last 6 months.

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1	2	3 4	5	6
Overall, serious concerns for placement appropriateness, parenting style & capacity & lack of adequate supports for CYP that present immediate or significant risks to CYP's physical or emotional safety.	**Overall, significant concerns for placement appropriateness/ stability, parenting style, lack of behaviour change, insight responsibility, & parenting support for CYP that present a clear risk to CYP's well-being.**	**Overall, some concerns exist for placement stability, parenting style, level of behaviour change, insight, responsibility or support for CYP that may present a risk to CYP's well-emotional being.** Rank as 3 if problems > 6 months.	**Overall, placement is secure. Minor strains with Parent & CYP relationship, parenting style or insight into CYP's emotional, behavioural & developmental needs do not negatively impact CYP. Parent demonstrates adequate behaviour change, responsibility & support for CYP.**	**Overall, placement is secure. Parent-child relationship is positive. Parent demonstrates positive parenting, insight into CYP's emotional, behavioural & developmental needs. Parent takes responsibility for maltreatment of & support for CYP.**
The Parent:	The Parent:	The Parent:	The Parent:	The Parent:
☐ Demonstrates negative relationship with CYP.	☐ Demonstrates major relationship strain with CYP.	☐ Has a strained relationship with CYP.	☐ AND CYP generally share a mutually positive relationship.	☐ AND CYP share a mutually positive relationship most of time.
☐ Has significant difficulty interacting with CYP (e.g. dismisses, demeans, overt frustration/anger towards CYP) AND in understanding CYP needs (persistently rejects/cannot assume CYP's perspective).	☐ Has significant difficulty interacting with CYP (e.g. lacks warmth, patience) or in understanding or responding to CYP's feelings & behaviour (e.g. dismisses, belittles).	☐ Has some difficulty initiating attachment forming & reinforcing behaviours and/or in helping CYP understand & organise their day-to-day experiences & feelings.	☐ Regularly displays attachment behaviours (e.g. verbal/ physical affection, play, emotion coaching), regardless of CYP responses.	☐ Often displays attachment forming & reinforcing behaviours (e.g. verbal/ physical affection, play, emotion coaching).
☐ Displays significant negative or harmful parenting (e.g. aggression, inadequate supervision, physical discipline, neglect) and/or domestic violence evident that present a clear & significant risk to CYP's well-being.	☐ Displays significant negative parenting responses (e.g. dismissive, over-reactive/passive) and/or couple conflict that likely prevents CYP's emotional and behaviour development and presents a clear risk to their well-being.	☐ Displays inconsistent, reactive or passive parenting and/or inadequate parenting alliance (couples), which impacts the CYP's emotional regulation/problem-solving skills, maintains problems OR presents a risk to CYP's well-being over time.	☐ Experiences some parenting stress but generally maintains authoritative parenting AND couples display adequate parenting alliance.	☐ Flexibly responds to CYP's needs AND displays warm & authoritative parenting most of the time AND couples display good parenting alliance.
☐ Is often overwhelmed by CYP and/ or Parent OR clinicians have serious concerns regarding placement appropriateness or CYP's safety in placement.	☐ States or indicates placement instability OR clinician has significant concerns regarding placement appropriateness/ stability.	☐ States or indicates strains to placement stability (e.g. behavioural/concerns for foster/birth siblings in placement, financial, parent health) OR Clinician has concerns for parent(s) capacity to maintain placement.	☐ Is committed to ongoing care of CYP. Strains (e.g. behavioural, sibling conflict/ financial), do not threaten placement stability.	☐ Is committed to ongoing care of CYP (both parents in the case of couples).
☐ Rejects or inflates impact of trauma/ placement history and/or cannot distinguish CYP's trauma experiences & needs from own in ways which impede/prevent CYP's therapy or recovery.	☐ Dismisses or inflates impact of trauma/ placement history and/or has difficulty differentiating CYP's trauma experiences & needs from own OR impedes external supports to CYP.	☐ Lacks adequate insight into developmental needs of CYP & impact of trauma/placement history AND is resistant to developing insight or skills to support CYP.	☐ Has adequate insight into CYP's developmental needs & impact of trauma/ placement history OR willing to develop skills & support CYP.	☐ Displays good insight into developmental needs of CYP AND impact of trauma/ placement history on these AND takes responsibility to support trauma recovery.
☐ Denies, rejects or shifts responsibility for maltreatment and/or demonstrates little or no behaviour change AND clinician has significant, concerns for CYP's immediate safety & well-being.	☐ Dismisses or denies responsibility for maltreatment and/or demonstrates little or inadequate behaviour change necessary to maintain safety & well-being for CYP.	☐ Lacks adequate responsibility for role in maltreatment and/or does not demonstrate adequate behaviour change in areas that resulted in maltreatment.	☐ Has adequate insight into & takes responsibility for role in maltreatment AND demonstrates some behaviour change in areas that resulted in maltreatment.	☐ Displays good insight into & takes responsibility for role in maltreatment, AND demonstrates significant behaviour change in areas that resulted in maltreatment.

MAPS Domain 5: Relationship Safety & Security with Birth Family

Consider family dynamics during contact in the last 6 months.

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1	2	3 4	5	6
Overall, significant concerns for Parent(s)/kin interactions with CYP during contact and/or CYP's beliefs about past maltreatment. Problems with parenting style, Parent(s)/kin attitudes & behaviours towards CYP, Carers or Services present a clear & significant risk to CYP physical or emotional safety & well-being.	**Overall, significant concerns for Parent(s)/kin interactions with CYP during contact and/or CYP's beliefs about past maltreatment. Problems with parenting style, Parent(s)/kin attitudes & behaviours towards CYP, Carers or Services present a clear risk to CYP physical or emotional well-being.**	**Overall, some concerns for Parent(s)/ kin interactions with CYP during contact. Parenting style, responsibility for maltreatment or support for CYP relationship with alternate Carers is inadequate & may present risk to CYP's well-being.** **Rank as 3 if problems > 6 months.**	**Overall, CYP relationships & contact with birth family is generally positive. Parenting style, responsibility for maltreatment, support for CYP to understand removal/ alternate placement is adequate & Parent(s)/kin support CYP relationship with alternate Carers. Nil risk to CYP's emotional well-being.**	**Overall, CYP's relationships & contact with birth family are very positive. Parent(s)/kin provide positive parenting, appropriate narrative to CYP about removal/ alternate care & support CYP's relationship with foster/kin Carers. CYP has appropriate understanding of removal/ alternate care. Nil risk to CYP well-being.**
Parent(s)/ Kin:	Parent(s)/ Kin:	Parent(s)/ Kin:	Parent(s)/ Kin:	Parent(s)/ Kin:
☐ Display significantly concerning interactions with CYP during contact (e.g. aggression/ threats to CYP, family or staff/sibling aggression OR CYP is distressed /acts out in ways that harm self, others or property).	☐ Display significantly concerning interactions with CYP during contact (e.g. inappropriate/ destabilising messages given to CYP, family aggression, OR CYP acts out aggressively/sexually but does not cause harm to self, others or property). Problems likely impact CYP's well-being.	☐ Display concerning interactions with CYP during contact (e.g. unhelpful messages given to CYP, family conflict) but do not likely cause significant risk to CYP.	☐ Generally share a positive relationship with CYP during contact.	☐ Share a mutually & mostly positive relationship with CYP during contact.
☐ Display harmful parenting (e.g. inadequate supervision, aggression, physical discipline, verbal abuse to CYP, family or services, medical neglect) in ways that would be expected to cause emotional or physical harm to CYP.	☐ Display negative/ harmful parenting (e.g. inadequate supervision, overt frustration, belittling).	☐ Have difficulties providing adequate attention, supervision, limit setting etc. to CYP during contact AND CYP not regularly supported by other adult kin or contact staff at these times.	☐ Display adequate parenting (e.g. supervision, limit setting) during contact periods OR CYP supported by other adult kin or contact staff at these times.	☐ Display positive parenting (e.g. warmth, limit setting, play) during contact periods.
☐ Express blame for removal on CYP, the system, or others directly to CYP.	☐ Provide detrimental explanation of removal/ reasons they are in care (e.g. inappropriately blame service/ deny responsibility, pressure CYP to return home).	☐ Are unable to provide CYP with adequate/ realistic narrative regarding removal/alternate placement, or take responsibility for maltreatment AND minimise /dismiss narrative provided to CYP by services.	☐ Provide adequate narrative to CYP regarding removal/ alternate placement, take adequate responsibility for own role in maltreatment AND/OR support agencies providing narrative to CYP.	☐ Provide suitable, developmentally-appropriate narrative to CYP regarding removal/ alternate placement AND take responsibility for own role in maltreatment.
☐ Regularly initiate discussion of & deny past maltreatment OR impact directly to CYP or services at contact.	☐ Openly dismiss/ deny impact of maltreatment on CYP to CYP or services at contact.	☐ Have inadequate insight into impact of maltreatment on CYP, but do not discuss at contact.	☐ Display adequate insight into impact of maltreatment on CYP.	☐ Display good insight into impact of maltreatment on CYP.
☐ Demean/ are indirectly or directly hostile towards/ openly challenge Carers in front of CYP or CYP pressured to leave placement.	☐ Undermine CYP relationship with alternate Carers (e.g. hostility towards/ challenging of Carer's parenting/rules openly with CYP).	☐ Do not adequately support or dismiss CYP's relationship with alternate Carers.	☐ Generally support CYP's connections to alternate Carers OR do not dismiss or undermine these.	☐ Support CYP's connections to alternate carers (e.g. can positively discuss CYP's Carers & CYP's activities with them).
☐ CYP has an unrealistic understanding of reasons for removal/ alternate placement (e.g. blames self, defends parents, blames services AND rejects/ is angry or hostile towards child protection agency workers.	☐ The CYP has an unrealistic understanding of removal/ alternate placement (e.g. blames self/ defends parents/ blames services).	☐ The CYP lacks understanding of reasons for removal/alternate placement and/or takes some responsibility for events.	☐ The CYP has some understanding of reasons for removal/ alternate placement AND generally understands adults as responsible (e.g. does not blame self/ siblings).	☐ The CYP has a developmentally-appropriate understanding of reasons for removal/ alternate placement (e.g. does not blame self/ siblings or defend parents).

MAPS Domain 6: Primary Carer's Engagement, Support & Environment

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Consider Primary Carer's demonstrated behaviours & support context during contact in the last 6 months.

1	2	3 4	5	6
Overall, Primary Carer demonstrates significant limits in capacity to change or protect & support CYP. Significant problems with supports, strains & management of these present actual, immediate or significant risk of harm/ neglect to CYP.	**Overall, Primary Carer demonstrates limits in capacity to change or protect & support CYP. Problems with supports, strains & management of these present a clear risk to well being of CYP.**	**Overall, Primary Carer demonstrates some limits in motivation, insight, capacity or behaviour to effectively meet needs of CYP. Problems with supports, strains or management of these may present risk to CYP's well being.** **Rank as 3 if problems > 6 months.**	**Overall, Primary Carer demonstrates adequate motivation, insight, capacity & behaviour to meet needs of CYP. Supports are available & accessed & strains are minor or well managed.**	**Overall, Primary Carer demonstrates good motivation, insight, capacity & ability to meet needs of CYP. Supports are available, accessed & strains are low or well managed.**
Primary Carer:	Primary Carer:	Primary Carer:	Primary Carer:	Primary Carer:
☐ Lacks adequate motivation AND sufficient responsibility or willingness to understand, prioritise & sufficiently manage CYP's needs which impacts OR presents a significant risk to, CYP's safety.	☐ Lacks adequate motivation and/or responsibility to understand, prioritise or sufficiently addressing CYP's needs which likely impacts CYP's well being.	☐ Demonstrates limited motivation and/ or responsibility to understand, prioritise or manage CYP's needs in a timely way.	☐ Demonstrates good motivation to understand CYP's needs AND generally prioritises & manages important needs in an effective & timely way.	☐ Demonstrates high motivation to understand CYP's needs AND consistently prioritises & manages those needs in an effective & timely way.
☐ Lacks cognitive or emotional capacity to self-reflect AND implement learning to change parenting behaviour.	☐ Lacks adequate cognitive or emotional capacity to effectively self-reflect and/ or apply learning to make change parenting behaviour.	☐ Demonstrates limits to cognitive or emotional capacity to self-reflect and/ or apply learning to make necessary behaviour change.	☐ Demonstrates good cognitive & emotional capacity to self-reflect, apply learning AND is able to make necessary behaviour change.	☐ Demonstrates high cognitive & emotional capacity to self-reflect and/or apply learning to make necessary behaviour change.
☐ Rejects or avoids or denies need for services to address key needs of CYP and/or often is negative /hostile to services, which prevents necessary help to CYP.	☐ Rejects or does not adequately access services to address key needs of CYP and/or regularly develops negative relationships with services.	☐ Does not adequately access services to address key needs of CYP and/or Primary Carer has difficulty developing effective working alliance with services.	☐ Accesses services to address key needs of CYP AND develops an adequate working alliance with services.	☐ Accesses available services to address needs of CYP AND develops a good working alliance with services.
☐ Has significantly limited supports (e.g. family, friends, religious or interest groups) AND does not access available services which likely impairs parenting.	☐ Has significantly limited supports (e.g. family, friends, religious or interest groups) OR does not access available services which likely impairs parenting.	☐ Has limited social supports OR doesn't access available services which likely increase parenting stress.	☐ Has an adequate support network (e.g. services, family, friends, religious or interest groups) AND accesses these when strained.	☐ Has a good support network available (e.g. services, family, friends, religious or interest groups) AND anticipates own needs & accesses supports ahead of time or as needed.
☐ Also: Nil/limited services available/ accessible to meet CYP's significant medical & developmental needs & significantly impacts CYP's safety.	☐ Also: Nil / limited services available/ accessible to meet CYP's significant medical & developmental needs & significantly impacts CYP's daily functioning.	☐ Also: Limited services are available/accessible to meet CYP's significant medical & developmental needs.	☐ Also: Adequate services are available/accessible to meet CYP's significant medical & developmental needs.	☐ Also: Services are available/accessible to meet CYP's significant medical & developmental needs.
☐ Significant psychosocial strains (e.g. housing/ finances/ legal/ neighbourhood conflict) are exacerbated by Primary Carer AND impact parenting & present a demonstrated risk to CYP safety.	☐ Significant psychosocial strains (e.g. housing/ finances/ legal/ neighbourhood conflict) are, in part, exacerbated by Primary Carer AND/OR impact parenting & present a clear risk to CYP safety, well being.	☐ Significant socio-economic strains (e.g. housing/ finances/ legal/ neighbourhood conflict) AND impact parenting OR are poorly managed/ exacerbated by Primary Carer.	☐ Some socio-economic strains (e.g. housing/finances/legal/neighbourhood conflict) but do not impact parenting & are managed well by Primary Carer.	☐ No or low socio-economic strains (e.g. housing/finances/legal/neighbourhood conflict) OR low strains are well managed by Primary Carer.

MAPS Domain 7: Systemic Alliance & Support

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Consider case management/ interagency relationship with supervising care agency in the last 6 months.

1	2	3 4	5	6
Overall, the Care agency lacks knowledge of CYP & family needs to the degree that stymies adequate case planning. Risks of harm to CYP are not adequately addressed resulting in exacerbation of risk to safety, welfare & wellbeing of CYP.	**Overall, the Care agency has a limited knowledge of CYP & family needs. inadequate case planning may lead to increased risk to safety, welfare & wellbeing of CYP. There are problems to interagency working alliance and communication.**	**Overall, the Care agency has an adequate knowledge of CYP & family needs. Case management minimises the escalation of risk to safety, welfare & wellbeing of CYP. Working alliance & communication between Care agency, services & family is adequate.** **Rank as 3 if problems >6 months.**	**Overall, the Care agency has a good knowledge of CYP & family needs & adequately facilitates the safety, welfare & wellbeing of CYP. Working alliance & communication between Care agency, services & family is generally positive.**	**Overall, the Care agency has a comprehensive knowledge of the CYP & family needs & optimises the safety, welfare & wellbeing of CYP. Working alliance & communication between Care agency, services and the family is effective.**
The Care Agency:	The Care Agency:	The Care Agency:	The Care agency:	The Care agency:
☐ Lacks capacity to meet case management responsibilities; e.g. Necessary meetings/ reviews not held, case unallocated to degree that risks are not addressed and may be exacerbated.	☐ Has limited capacity to meet case management responsibilities; e.g. attend meetings, case allocation, develop case plans so that risks to safety, welfare & wellbeing of CYP (including in relation to contact) are unresolved AND/OR continue to escalate.	☐ Generally meets the necessary case management responsibilities; e.g. attends meetings, allocates worker to family so that case plans address risks to CYP in a timely manner, including issues relating to contact.	☐ Meets case management responsibilities; e.g. attends & manages meetings, allocates worker to family so that clear case plans are achieved.	☐ Meets case management responsibilities to a high degree; e.g. attends & manages meetings, allocates worker to family so that relevant & clear case plans are achieved
☐ Demonstrates difficulties responding to issues impacting safety or well-being of CYP AND which has resulted in significant risk of harm to CYP.	☐ Demonstrates difficulties responding to issues impacting safety or well-being of CYP in a timely manner which leads to ongoing concern/ exposure to problems and increased risk of harm to CYP.	☐ Addresses basic issues which may impact CYP's safety and well-being or delays in responding do not cause significant risk to child.	☐ Addresses issues of CYP's safety & well-being generally within adequate time-frames, including organising & responding to contact needs.	☐ Addresses issues of CYP's safety & well-being in a timely manner, including organising and responding to contact needs.
☐ Lacks adequate knowledge of CYP's child protection history & psychosocial needs.	☐ Has limited knowledge of CYP's history OR understanding of CYP psychosocial needs.	☐ Has adequate knowledge of CYP's child protection history & psychosocial needs.	☐ Has good knowledge of CYP's child protection history & psychosocial needs.	☐ Has comprehensive knowledge of CYP's child protection history & CYP's psychosocial needs.
☐ Withholds basic communication with parents & cares to the degree that impacts working relationship.	☐ Does not maintain sufficient communication with parents & carers AND/OR attempt to resolve communication problems.	☐ Maintains necessary & timely communication with parents & carers. Attempts to resolve communication problems.	☐ Maintains generally clear & timely communication with parents & carers.	☐ Maintains very clear & timely communication with parents & carers.
☐ There is an ineffectual working alliance between key agencies, which impacts appropriate communication and effective case planning/ interventions	☐ There is a poor working alliance between key agencies (e.g. role confusion/ poor communication) which may effect case planning.	☐ There is an adequate working alliance between key agencies. Interagency issues; e.g. role confusion/responsibilities are adequately resolved).	☐ There is a good, respectful working alliance between Carer agency & key support services.	☐ There is a very positive respectful working alliance between Care agency & other key support services.

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MAPS Profile and Clinical Planning Tool.

1. Child Well-being	☐	☐	☐	☐	☐	☐
2. Educational functioning	☐	☐	☐	☐	☐	☐
3. Caregiver Well-being	☐	☐	☐	☐	☐	☐
4A. Placement safety OR	☐	☐	☐	☐	☐	☐
4B. Birth Family safety	☐	☐	☐	☐	☐	☐
5. Family Relationship	☐	☐	☐	☐	☐	☐
6. Caregiver Engagement	☐	☐	☐	☐	☐	☐
7. Systemic Support	☐	☐	☐	☐	☐	☐
	Immediate Risk	Significant Risk	Moderate Risk >3 mths	Moderate Risk	Low Risk	Strengths/ Low Risk

Any domains within the Immediate or Significant Risk category:

- Is a child-at-risk report required? Consult Mandatory Reporter Guide; MRG and Clinical Senior/ Lead or Service Manager.
- Ensure concerns are raised with the family or document why you have not done so. E.g. Will this place child at risk?
- Ensure concerns are communicated to FaCS or relevant Foster Care Agency? Consider Case Review Meeting or Worker's Meeting.
- Is greater interagency collaboration required to resolve problems identified? Is there interagency disagreement/ role confusion. Consider a Worker's Meeting.
- Is a review of the CPCS assessment, formulation and counselling plan to date required? Has family made adequate changes to ensure safety of children? Is there adequate safety for therapeutic intervention? Are key psychosocial needs met e.g. housing, access to health care, sufficient mental health treatment, neighbourhood safety? Are parents/ carers motivated/ engaged in change process?

Any domains within the Moderate (> 3 months) or Moderate Risk category:

- Discuss further with Clinical Senior/ Lead or Service Manager if family is not adequately addressing safety issues after 3 months CPCS intervention.
- Consider need to review family participation and engagement with counselling. Has the family been given an opportunity to provide feedback on counselling process/ ideas of progress? Are goals clear and agreed upon? Have barriers to change been sufficiently identified and considered in the counselling plan?
- Discuss concerns with FaCS or Foster Care Agency.
- Consider a review of the CPCS assessment, formulation and counselling plan to date.

Domains within the Low Risk category:

- Ensure that key changes, strengths and protective factors within family are explicitly identified with family, FaCS and Foster Care Agency.
- Focus on promoting child and family strengths into the future (i.e. Are there services, educational plans, activities, respite plans that could be put in place now to maintain support and promote family strengths post CPCS closure)?
- Ensure a clear counselling closure plan is developed with the family and key agencies.

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MAPS Counselling & Case Management Planning Sheet

Dated: _____ Counsellor(s): _____

Case Manager: _____

Specific strengths and risks identified	Key Goals (In consultation with family)	Key Interventions
Parents/ Caregiver(s) (list separately as needed):		

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Specific strengths and risks identified	Key Goals (In consultation with family)	Key Interventions
Child/ Young Person (list separately as needed):		

Chapter 5

Action Research: Clinician Responses to the Multi-Systemic Assessment of Psychosocial Safety (MAPS)

Background

The current version of the Multi-Systemic Assessment of Psychosocial Safety (MAPS), was developed and refined over a number of stages. This chapter outlines the initial consultations regarding the face validity and perceived clinical utility of the MAPS. Numerous factors have likely contributed to the difficulty in developing assessment tools that are acceptable across specialist services. In addition to the complex nature of risk and safety assessment, multi-disciplinary teams often hold divergent philosophies and related practices. Different clinical training, perceived marginalisation of roles amongst team members, or conflicting values, including in the adherence to medical versus social models of care, can hamper integrated assessment processes (Cameron, Lart, Bostick, & Coomber, 2013; Carpenter, 2003). Consequently, consultation regarding the clinical utility of assessment tools should be considered alongside investigations of validity with clinicians in the field. The investigation of face validity and perceived clinical utility of the MAPS domains and items was conducted in two stages and is presented below.

Method

Procedure

Phase 1[10]**.** During this phase, verbal feedback was sought on the initial version of the MAPS across a 10-month period. The initial draft (then six domains), was presented for peer review to a pool of approximately 25 experienced and predominantly senior NSW specialist child

[10] Phase 1 and 2 of this study were supported by the Integrated Violence, Prevention & Response Services (Western Sydney Local Health District). Theses initial phases were considered as quality improvement initiatives by the WSLHD and did not require ethics approval.

protection counsellors, working exclusively with children with maltreatment histories, including those in OOHC. A focus group of five specialist counsellors, representing three of the services, met three times to provide feedback from their teams and discuss the construct. Secondly, feedback from these teams was presented at a statewide meeting for specialist counsellors, where the MAPS was further discussed with respect to the key domains. At this consultation stage, all domains and items were endorsed as having face validity. There was majority consensus, however, that an additional domain be added to the MAPS that considered the working relationship between key agencies and the family. A further literature review was undertaken and the seventh domain, *Systemic Alliance & Support*, was developed. The majority of clinicians during this consultation phase also recommended changes to formatting of the tool (portrait to landscape orientation), the development of a short accompanying manual for clinicians, and a clinical summary sheet to aid case planning and management. All recommendations were implemented. A second, more in-depth evaluation of face validity and clinical utility was then undertaken and is presented below.

Phase 2. During this phase, written feedback was sought on the amended MAPS and accompanying user guide and clinical planning tool. Fifteen specialist counsellors and educators, working within three NSW tertiary health services, were invited to participate in the current study. Participation was voluntary. Participants were chosen on the basis of their current work (i.e. exclusively with children in care and/ or children with maltreatment histories), with at least one year's experience in the provision of therapeutic interventions to at-risk families and/ or trauma victims (domestic violence/ sexual assault). None of the participants had been involved in the phase 1 consultation. Participants were able to complete the surveys provided in their own time and send them back to the researcher. This process took six months.

Participants

Of the 15 invitees, 11 participated. Professional designations included social workers (*n* = 9), clinical psychologist (*n* = 1), and art therapist (*n* =1). Participants primarily worked in child protection counselling services (*n* = 7), or with at-risk families in another tertiary service (*n* = 2), court clinic assessment (*n* = 1), and child protection/ domestic violence/ sexual assault education and training (*n* = 1). Experience in working directly with families at-risk varied between 2.5 and 33 years, with a mean of 16.5 years (*SD* = 10.72).

Materials

MAPS User Guide and Clinical Planning Sheet. Participants were provided with a package which included a copy of the MAPS, the user guide, and a summary and clinical planning sheet. The user guide provides a description of the MAPS tool and practical application. The summary and clinical planning sheet is an additional and optional tool, providing space for counsellors to note and summarise key child and family strengths and risks identified during the assessment, to aid intervention planning and management. See Appendix E. for a copy of the materials.

Participant Survey. A printed survey was provided to participants. The survey ascertained clinical designation, place of work, years of experience working in child protection or with at-risk families, as well as total years of experience in providing therapy to children and families. For each MAPS domain, participants were asked four questions:

i) Regarding content validity of each domain, participants were asked to indicate and comment on *how relevant the areas of each MAPS domain are to a child or young person affected by abuse and neglect issues,* and to also comment on *any issues that they thought should be added to the specific domains.*

ii) Regarding clinical applicability, participants were asked for each domain if the assessment areas were ones that they thought *were important for clinicians to directly work on with children and/ or their families within child protection – and –* to comment on *how relevant the areas are for therapeutic intervention within child protection work.*

iii) To evaluate the clarity and sensitivity of each descriptor pertaining to risk and safety ratings, participants were asked if the specifier for each domain adequately summarised *the level of relative risk and/ or safety.* To help determine the usefulness of the tool's ability to monitor changes to individual and family functioning over time, participants were also asked their views on *whether they thought each domain would be able to capture relevant changes in individual and/ or family functioning over a six-month period.* Participants were also asked their views on the clarity of the user guide, the MAPS format, ease of use, clinical utility of the planning sheet, and how experienced they considered a worker would need to be to use the MAPS tool.

iv) Lastly, participants were asked if there were any aspects of the tool which they opposed or any that they felt were inconsistent with their professional values.

Given the exploratory nature of this stage of consultation, the survey utilised open-ended questions. The written feedback was reviewed and themes identified. A second coder, with a Master's degree in Clinical Psychology and >10 years experience in working with families at-risk reviewed responses and cross checked summary data. Key themes identified from participants' comments were confirmed by the second coder.

Results

A summary of participant responses for each survey question is provided below. Participants made a number of suggestions to enhance relevance and overall utility of the tool and these are discussed in a later section.

Content Validity

Relevance of items to children who have experienced maltreatment. The 11 participants were asked about the relevancy of each of the seven domains. Out of a possible 88 responses, 71 (81%) stated the items were relevant. Another 11 (12%) responses were either left blank or had a tick next to the question, indicating likely support for relevancy. There were no responses indicating the domains or items were not relevant. Written feedback was similarly positive. Some examples include: *"Extremely relevant, I think this domain has been treated with great thoroughness"* (Participant 3, Domain 4A: Placement Security and Safety); *"Relevant ... helping to establish positive supports, increasing carer self-efficacy and self-reflection"* (Participant 5, Domain 6: Caregiver Engagement, Support & Environment).

Clinical Utility

Relevance of items to assessment and treatment focus in the field. Participants were asked how relevant the items were with respect to assessment and counselling intervention they provide to children and their families in the child protection system. Many comments suggested that the MAPS captured child, family and systems issues directly relevant to their assessment and interventions. Examples include: *"Captured all areas of the scope of what child protection counselling services do, very comprehensive"* (Participant 1, Domain 1: Child Health and Psychosocial Functioning); *"Core business of* [specialist counsellors] *is to support the carer to support the placement"* (Participant 7, Domain 3: Primary Carer Health and Psychosocial Functioning); *"All issues are worked on directly by child protection counselling services"* (Participant 11, Domain 4A).

Two participants commented on the relevance of assessing issues outlined in Domain 5: Relationship Safety & Security with Birth Family. Participant 4 queried the relevance of assessing birth parent attitudes and parenting behaviours during contact, when the child was placed in

OOHC. In addition, Participant 2 did not consider the items referring to caregiver responses, in this domain, as relevant to child protection intervention: *"there is an overemphasis on attitudinal factors … I am not aware of any research that links parental expression of 'remorse' with increased safety – it is behaviour not words alone that is important."* In contrast, most participants found items on this domain critical to assessment and intervention. Participant 3 commented: "*Parent's capacity to understand the reason for child protection systems intervention is vital, since their level of understanding and motivation to change will be* [an] *important predictor for future behaviour around parenting"* and Participant 11: *"Pertinent … substandard/ harmful contact can undermine any therapeutic work undertaken. Development of meaningful and safe new attachments is hindered when security with birth family is not present".*

Participants expressed the most uncertainty in relation to Domain 7: Systemic Alliance and Support. While endorsing this domain as a relevant issue for children and their families (noted above), concerns were raised regarding whether the items captured poor alliance, the problem of subjectivity, and whether this domain needed to be included in considering intervention. For example, Participant 2 commented: *"I think the areas underplay the significance of conflicting viewpoints, , that is, you can have a caseworker and meeting attendance but still have no alliance".* Participant 10 commented: *"No – not necessarily as can be worker to worker strain – and confusion about roles and responsibilities which get managed outside of the family unit".* However, this participant also considered that lack of changes to family functioning over time may *"further highlight systemic issues and lack of interagency collaboration".*

Sensitivity to levels of risk and safety. In the initial MAPS version, the risk ratings provided ranged from 1 (indicating poor functioning and high risk) to 10 (indicating strengths, protective factors and low risks). Above key risk levels on each domain, a brief summary of risk is provided that aims to guide clinicians in their risk rating. For each domain, participants were

asked to comment on whether the specifiers for each level of risk rating sufficiently summarised key risk or safety elements and if they were clear enough to assist clinicians in discriminating between the levels of risk or relative safety.

The majority of participants reported the specifiers to be clear and, in most cases, likely to facilitate their ability to distinguish between risk levels. For example, Participant 8: "*Summary is very comprehensive",* and Participant 11: "*Very clear, the* [specifiers] *capture high functioning, through to current and actual abuse and neglect and/ or risk".*

Sensitivity to change in child, family and systemic function. Participants were asked whether, based on their clinical experience, they considered the MAPS sensitive enough to track child and family change over a six-month period. Across all domains, almost all responses were a direct *'yes'*. Notably, during this consultation, participants were instructed to consider the child, family and system functioning over the preceding six months. Some participants, however, expressed confusion over the time frame they should consider, indicating that further prompting on time frames should be provided when using the MAPS.

Experience required to use tool. Participants varied in the length of clinical experience they considered counsellors needed in order to use the tool effectively. While three participants considered '*over 1 year'*, two others considered less time was needed, as long as the counsellor engaged in clinical supervision and/ or regular input from professional peers. The majority considered that counsellors needed specific skills, as opposed to quantity of experience, in order to be able to differentiate risks appropriately when using the tool. Participant 7: *"[requires] having thorough knowledge of family rather than experience in child protection field".* Additionally, Participant 3: "C*an't measure* [experience] *in years ... need a solid knowledge of child development, attachment, trauma and child protection, and working with issues around parenting capacity".*

Ease of use. The majority of participants reported that the tool was relatively easy to use. One participant qualified this, by commenting that it was time consuming, while two participants suggested that greater use and familiarity with the tool would make it easier to use.

Usefulness in clinical and case management planning. All participants reported the summary and clinical planning sheets to be useful in their ability to summarise key child and family risks and strengths, e.g. Participant 5: "V*ery useful and makes [MAPS] more clinically relevant and helpful to clinician".*

Adherence to professional values. Seven of the 11 participants indicated no dissonance in using the tool with respect to their own professional values. Of note, some participants did raise concerns. These appeared to pertain to the impact that assessment measures have on a counsellor's ability to provide intervention and to the overall meaning implied in measurement. For example, Participant 5: "*I think measuring outcomes can be useful so long as it does not take over from therapeutic intervention, particularly in child protection as children/ families are waiting so long for therapeutic input",* and Participant 8: "*I am not a fan of ranking clients. I have a concern that we are 'psychometricising' our clients".*

Amendments to MAPS Based on Consultations

Participants made a number of suggestions regarding item amendments or in the practical application of the tool. These suggestions and the amendments made in response, as well as the rationale for not making certain amendments, are summarised below.

For Domain 1: Child Health & Personal Functioning, Participant 3 raised the concern that children's mental or physical health needs may not be appropriately understood by the care system in general, which may then place undue expectations on, and discriminate against, the carer: *"… there is an underlying assumption that the child's health issues will be adequately*

understood by the health system, which may not be the case, i.e. a child's medical issues may not be well managed, but this may not just be an issue of carer management".

This domain however, evaluates the carer's response to an identified medical or psychological need. Practically, this would mean supporting the child to access treatment and/or services or providing parenting responses to manage issues, as would likely be recommended at the time by specialist services involved (e.g. provision of prescribed medications, taking child to rehabilitative therapy), within the means available to them. There is recognition in this domain that a child may experience physical and/ or mental health problems, which may continue to present a risk to themselves or others, but which are being managed adequately by the carer. A rating of 3-4 would be given in this instance, to signify that a problem of concern exists, which would likely be a focus of intervention – but which also acknowledges that the causes or maintaining factors for the problems are not necessarily due to caregiver action or inaction. No amendments to the MAPS were made in respect to this participant response.

Also for this domain, Participant 6, suggested that the relevance of this domain, with respect to the child's current interpersonal behaviours, could be enhanced by including an item to refer to the child's *"empathy and awareness of others' rights".* The impact of attenuated empathy and indifference to others' rights, associated with callous-unemotional traits, has received increased clinical and research attention over the last decade. Causal pathways to developing these traits are considered different from those of children exhibiting less serious conduct problems (Frick, Ray, Thornton, & Kahn, 2014). Given the importance of these childhood behavioural and cognitive expressions, an item within the MAPS was amended to include consideration of the child or young person's empathy and awareness of others' (including animal) rights.

For Domain 2: Educational Engagement and Functioning, suggestions were made to include items which captured problematic caregiver-school interactions and homework strains. Participant 6 suggested: *"possibly including hostility/ blaming or negative relationship* [between caregiver and school]*";* Participant 2 commented: *"Where would you address homework and home reading? Homework is a significant source of stress for children, especially those who are failing at school".* As poor caregiver attitude is implicated in school attendance and absconding (Dalziel & Henthorne, 2005), an amendment to include this was made. The provision of homework tasks is not homogenous across school environments. As outlined in Chapter 4, other factors included in the MAPS, such as school attendance, caregiver attitudes and expectations towards education, and their relationship with the school were associated with better outcomes, as opposed to homework completion per se. No amendment was made in response to this latter suggestion.

For Domain 3: Primary Caregiver Health and Psychosocial Functioning, Participant 3 suggested the replacement of the word *"insight"* to *"foresight"*, when referring to the caregiver's ability to anticipate and plan for their child's needs. This amendment was made, as the suggested term more appropriately described the caregiver capacity under consideration.

A concern raised by one participant was that this domain did not adequately distinguish between prior parent risk history and current functioning. Participant 2 commented: *"if there is a history of domestic violence in two past relationships, but since the children were removed the parent has gained insight about the danger posed by those relationships … same with substance abuse – maladaptive coping – how much weight should be put on the recent past?"* The MAPS does not assess *current* risk based on prior harm, rather a caregiver's recent behaviours and responses to child needs. Indeed, assessing risk on past behaviour alone is a weakness identified in some existing measures (see Chapter 4). A parent who engaged in drug use historically, is not

seen to necessarily present a risk to a child in the present. The MAPS does aim to consider a wide range of vulnerabilities, capacities and skills, namely those evident in the *preceding six months*. If caregivers demonstrated good functioning in some areas (e.g. accessed support, engaged in hobbies/ interests for personal respite, maintained a good working relationship with the child's school), yet also displayed maladaptive coping skills (i.e. drug use), both strengths and risks would be evaluated. The multiple domains aim to capture vulnerabilities that may continue to exist or re-emerge within a substantial time frame.

Participant 2 also queried whether housing and/ or financial issues were adequately considered within the MAPS. Poverty, unemployment, housing problems, neighbourhood conflict and crime are recognised to be strains associated with child maltreatment (Chu et al., 2011; Lamont & Price-Robertson, 2013). Similarly, access to specialist services for families at-risk may be hampered by geographical distance, low service resources and long wait lists (COAG, 2010). To better account for the presence of strains and issues of service accessibility, items were added in the revised version of the MAPS Domain 6: Primary Caregivers' Engagement, Support & Environment.

Domains 4A (Alternate Placement Security and Safety) and 4B (Birth Family Placement Security and Safety) are similar in that they consider placement related issues for children residing in foster/ kin or birth family care respectively. Participants 3 and 10 suggested additions to Domain 4A (where child resides in kinship or foster care), to include the quality of the relationship between the foster child and the carer's biological children. Research on the impact of foster and kinship care on carer's biological children, family functioning and placement stability is very limited. Small, qualitative studies indicate that biological children of carers can experience significant strain with the placement of non-biological children, which in turn impacts their

relationship with parents (Hojer, Sebba, & Luke, 2013). Given this, and the theoretical link to placement strain, items in this domain were added to consider sibling relationships.

For Domain 5: Relationship Safety and Security with the Birth Family, Participant 4 queried the relevance of assessing the child and birth parent(s) relationship, when the child was placed in foster or kinship care: *"Maybe not as important depending on amount of contact between child and birth family"*. However, this was inconsistent with other participant views that expressed strong clinical applicability of this domain. Parental attitudes towards child maltreatment, including taking responsibility for behaviour and change, is associated with reduced maltreatment reoccurrence (Ward et al., 2014). Consequently, no changes were made in relation to items referring to these caregiver factors.

Lastly, on Domain 7: Systemic Alliance and Support, a suggestion was made to include an item referring to caseworker turnover. Caseworker turnover is a frustrating, albeit common, occurrence in the field. However, turnover is not necessarily equated with poor case planning or carer-agency alliance. To better capture existing problems, the MAPS items were extended to consider current casework and alliance factors indicated important in the literature, such as agency communication with the carer, follow through on carer/ child needs and the ability to respond in a timely manner to child protection concerns (as outlined in Chapter 4).

Two participants queried the clinical applicability of including Domain 7: Systemic Alliance and Support in an assessment of child and family needs. This domain was retained, due to the strong majority support participants expressed across both consultation phases, concerning the impact of poor systemic alliance on carer engagement, child safety and well-being, and the general view that poor systemic functioning could be a focus of intervention.

Three concerns were raised in relation to the tool's sensitivity to change in family functioning over time. The first concern related to the difficulty in assigning a risk rating in a

given domain, when strengths were also present. The forced categorisation of risk – when risk is present on any given domain, is deliberate. The acknowledgment of strengths and risks aims to assist with developing appropriate interventions. The authors did not perceive it clinically meaningful to discount risks, when strengths were present – a clinical error which leads to further child harm (Munro, 1999). However, the initial MAPS version did not allow participants to visually mark strengths or risks. To assist appropriate identification of both for case review and planning, amendments were made to include tick boxes and for ratings to be summarised on a clinical planning sheet.

Second, a number of participants requested reduction of risk levels. Participant 4 suggested: *"Could* [the risk levels] *be 1-5 to eliminate further debate/ confusion?".* In line with suggestions, risk levels of 1-10 were collapsed to 1-6 to more clearly distinguish *high risk* (ratings 1-2), *medium risk* (3-4), *and low/ no risk* (5-6). Third, some participants suggested that the MAPS could be used as part of their current case management with co-workers and/ or case managers, to assist objectivity. For example, Participant 5: "*(a supportive review process) if a clinician has not seen any changes across domains after six months. A case meeting with counselling team or supervision with senior or external supervisor"* and, Participant 6: "*needs to be good supervision, team discussion using examples routinely in case reviews".* Applying the MAPS as part of case management would support good clinical practice, in line with current specialist child protection counselling services (Department of Health, 2010b). The recommendation to use the MAPS with co-therapists and/ or case managers during routine clinical consultation was made in the amended version.

Additional comments provided by the participants were in regards to general terminology used across the domains. Two participants made similar suggestions to change wording of 'mental health' to 'psychological' or 'cognitive' functioning or 'emotional health'. For example,

Participant 3: *"I'd like to raise the issue of using 'mental health'. It is unclear whether the emotional/ psychological problems are encompassed by this term or if it refers to a more narrow* (sic) *definition. What about behavioural problems which might indicate emotional & psychological difficulties? If mental health is a term that will be retained then an explanation of the term in this tool is needed to indicate".* Dissonance experienced by two participants with the use of the term 'mental health' reflect ongoing discussion within multi-disciplinary teams and which, in part, may be due to different nomenclature to which counsellors are exposed to in their training. The term 'mental health' was retained, as it was endorsed by the majority of participants and is common to NSW Health training packages, publications and policy directives[11].

Participants also made a number of useful suggestions to differentiate between risk and safety levels, which influenced further amendments to the initial version. One such example was ensuring that the term 'developmentally appropriate' was used in lieu of 'age-appropriate', when suitable, and to account for children and young people with delays and disabilities. Another participant expressed confusion over the meaning of 'self-care' and 'risk-taking behaviours', and suggested that an explanation of such terms was provided to clinicians prior to using the MAPS. Lastly, one participant recommended simplification of language throughout the MAPS. Requests for clarity around terms 'self-care' and 'risk-taking' have attempted to be addressed for future users, by providing explanations in the user guide. Amendments were made to simplify language across the MAPS domains.

[11] The term 'mental health' is used to refer to aspects of a child or young person's thinking, emotional and behaviour functioning. As a spectrum, it includes a range of problems and some common to children in care (e.g. Depression, Anxiety, Post Traumatic Stress Disorder). The decision to retain the term in the MAPS was made to include not only formal diagnoses but also capture experiences of confidence and self-esteem, either iterated by the child or observed by the care system. The umbrella term 'emotional health' does not adequately cover formal diagnoses. The term 'cognitive functioning' may be easily confused with cognitive testing and was also not considered appropriate to the meaning inherent in the construct.

Finally, in response to participant suggestions, amendments were made to the clinical summary sheet and planning tools, to clarify who was responsible for clinical interventions and/ or case management tasks identified.

Summary

Eleven specialist counsellors provided written evaluative feedback with respect to the face validity of the MAPS domains and items, and the clinical utility of the tool in assessment and intervention planning with families where child maltreatment has occurred. Participants were also asked to provide feedback on the ease of use of the tool and any concerns about use of the tool in the context of their professional values.

All participants supported the face validity of the domains and agreed that they reflected common problems in need of intervention for children with maltreatment histories. Participants provided recommendations to augment the relevancy of the MAPS domains, which included adding items referring to child, caregiver and systemic factors. Additional child-related factors included reference to child empathy and awareness of others' rights. Caregiver factors included the caregiver-school relationship and alliance. Systemic factors included considering the impact of sibling relationships on placement stability and the impact of environmental and social strains, namely housing and financial problems. Amendments to the MAPS based on these suggestions were made. Other recommendations were made with respect to terminology used in the MAPS, which resulted in language being simplified or altered. Also, participants indicated some difficulty differentiating between risk levels, especially across the wide rating system used (i.e. 1-10). The MAPS was revised to include a collapsed scale (1-6), to more easily determine low, medium, and high risk. Participants perceived that the MAPS could be used to assess child and family functioning over time, and reviews, in consultation with peers and/or in supervision were recommended.

While participants considered the tool as relatively easy to use, some indicated that the application of it would enable better familiarisation and evaluation. The application of the tool to clinical vignettes, inter-rater reliability and clinical utility were examined in a subsequent study and are outlined in the following chapter.

This consultation stage helped to highlight some existing discord with the use of assessment measures in multi-disciplinary teams. While all participants found the MAPS highly relevant, with respect to the assessment and intervention they promote in their professional practice, some identified dissonance in the use of assessment measures with their professional values. The implications of these are further discussed in Chapter 7.

Chapter 6

Inter-Rater Reliability & Clinical Utility of the Multi-Systemic Assessment of Psychosocial Safety (MAPS)

Background

The previous chapter outlined an action research project undertaken in the development and refinement of the Multi-Systemic Assessment of Psychosocial Safety (MAPS). This chapter presents results of a study investigating the inter-rater reliability and clinical utility of the MAPS tool. The child protection specialist counsellors who participated in the current study were not involved in the prior consultations. This study had three key objectives: 1) to explore the general agreement among different participating clinicians' ratings using the MAPS, 2) to investigate the inter-rater reliability (agreement) of ratings between individual clinicians and the master ratings, and 3) to explore the perceived clinical utility of the tool for use in the child protection counselling field.

Method

Procedure

Specialist counsellors from three NSW Health Child Protection Counselling Services (CPCS), across three local health districts (Central Coast, Nepean/ Blue Mountains and Western Sydney), participated in the current study. CPCS receive their referrals from Family and Community Services (FaCS), who typically continue to provide a supervisory role to the family for the duration of CPS intervention. CPCS provide therapeutic interventions for children, young people and their families, where there has been substantiated abuse and/or neglect. Key aspects of this role are to assess the impact of abuse and neglect on the child's functioning as well as to assess the level of psychosocial safety and well-being during the process of therapy. Given the high level of dependence children, it is expected that assessment and intervention extend to carers be

they birth, foster or kinship carers. Additionally, CPCS clincians provide regular and formal feedback to the referring FaCS agency with regards to therapeutic progress and the presence, or any escalation of, safety concerns. This feedback, along with the views of the family, is typically provided at case reviews which are attended by FaCS, CPCS and the family (Department of Health, 2010b). As such, assessment within CPCS services informs therapeutic intervention, as well as aids to inform statutory services about current or emerging safety and risk factors within the child and their family environment.

Each study day required approximately 3.5 hours of participant time, and was undertaken over a six-month period[12]. Participants were provided with the MAPS user guide and received one hour of face-to-face group training in the use of the MAPS tool to rate a fictional clinical vignette. During this training stage, participants could openly discuss queries and consider the relative risk and protective factors and discuss the overall risk rating that was most appropriate. Participants were then provided with three clinical vignettes and rated the various domains on their own, using the MAPS. Finally, participants were provided with a survey to complete, inviting open ended comments and all documents were provided to the author. Ethics approval for this study was provided by Macquarie University, and site specific approvals were granted across three health districts: Central Coast, Nepean/ Blue Mountains and Western Sydney. See Appendix E. for copy of participant's survey & study vignettes.

Participants

Participants were nine specialist child protection counsellors; eight females and one male. Seven were social workers, one a counsellor and one an art psychotherapist. Participants held

[12] To use the MAPS tool with various clinical vignettes, a whole day participation was required and initially agreed to by services, however, at the time of the study services were not able to meet this request, due to resource strain and this reduced the number of vignettes tested using the MAPS.

undergraduate (n = 5) and postgraduate qualifications (n = 4). Seven of the participants had 3-5 years experience, and two had 1-3 years experience specific to child protection work. As such, all had significant experience in assessing children and families where there had been substantiated abuse and neglect of a child, in working with birth parents, kinship and foster carers, and in providing clinical services to this population.

Materials

Participants were provided with a copy of the MAPS user guide one week prior to the study day, which provided a description of the MAPS tool and practical application. On the study day, participants were provided with a booklet containing teaching and study clinical vignettes, as well as copies of the MAPS tool (MAPS scale, profile and clinical planning tool). In total, each participant assessed three vignettes, covering 14 domains. The vignettes presented described a range of care contexts, and families with a range of risks and strengths. Consequently, participants assessed risks and strengths evident in each vignette, using relevant MAPS domains. Given the restricted time frame with clinicians, it was not possible to apply all relevant domains to each vignette, but rather a choice was made to ensure all the domains were applied at least twice to different care contexts. The exception to this was Domains 4A and 4B, which were applied once each as they are almost identical but refer to either-or contexts; the child is living in an alternate placement (4A) or with birth family (4B).

Vignette one described a pre-adolescent girl residing with her birth mother, a placement that was under a supervision order. The child had externalising problems that had resulted in physical harm of others and poor school engagement, and her birth mother had mental health issues and a history of poor engagement with services. For this vignette, participants assessed risk and strengths using the MAPS Domains 1: Child Health and Personal Functioning, 2:

Educational Engagement and Functioning, 3: Primary Caregiver Health and Psychosocial Functioning, and 4B: Birth Family Placement Security and Safety. *Vignette two* described a young boy residing in kinship care. This vignette presented some birth family-related risks (i.e. parental aggression during contact visits), systemic risks (untimely response to contact problems), as well as carer strengths (e.g. proactive response to child's needs, positive interpersonal relationships and supports). For this vignette, participants assessed risks and strengths using the MAPS Domains 5: Relationship Safety and Security with Birth Family, 6: Primary Caregiver Engagement, Support and Environment, and 7: Systemic Alliance and Support. *Vignette three* described a young boy in foster care with numerous child-related strengths and risks (e.g. good relationship with carers/ internalising behaviours problems following contact with birth family), and carer-related strengths and risks (e.g. positive relationship with child, but current inability to discuss issues regarding birth family, placement history or prior trauma with child). For this vignette, participants applied all of the MAPS domains. This vignette was considered by the author to be the most complex as it presented moderate risk issues, less obvious, than those in the previous vignettes. A participant survey was provided at the end of the study tasks.

MAPS profile and clinical planning tool. A MAPS profile graph was provided for participants to note down their ratings of each domain for each vignette. The MAPS profile allows clinicians to plot the lowest rating on each domain, which yields a visual plot of the risks as well as strengths of child and family functioning (see Chapter 4a for copy). Importantly, within any given domain, the lowest assessment rating given (indicating high risk), is recorded on the profile as the final rating for that domain. The final ratings for a given domain range between 1 and 6. The ratings indicate *immediate or high risk* of harm to a child (scores 1-2),

moderate risk (3-4), and *low/ no risk with clear strengths (5-6).* Clinically, this 6-category demarcation allows clinicians to identify even small shifts and changes to an individual's or family's functioning over time. However, for the purposes of assessing agreement among clinicians and with master ratings, agreement in the categories (high, moderate and low/no) was deemed sufficient.

Participant Survey. The Participant Survey used was similar in parts to the survey used in the action research phase (Chapter 5). Different items on the current survey were added to gauge clinician views on new aspects of the MAPS, that were added as a result of this prior consultation. The survey ascertained participant's clinical designation, educational achievement and work experience with respect to child protection counselling, as well as with other work with families at-risk. For each domain, participants were asked how relevant they thought each domain was in identifying risks to children's psychosocial safety and well-being, and the extent to which the risk levels (i.e. 1-6 and accompanying explanations) represented the risks and strengths in the vignettes presented. Comments were encouraged.

Participants were also asked their views on the clinical utility of the MAPS, including the ease of use, utility in clinical and case management planning, and how sensitive they considered the MAPS could be in assessing change in individual and family functioning over a six-month period. The survey utilised 6-point Likert scales (*'not at all useful'* to *'highly useful'*), and open-ended questions to qualify responses on the Likert scales and to provide additional information on participant views. Lastly, participants were asked about any assessment measures they were using in their current professional role. See Appendix E. for copy of participant survey.

RESULTS

Preliminary Analyses

Prior experience in CPCS. Independent t-tests were undertaken to assess whether there were significant differences related to level of experience and ratings on the MAPS. Two groups were compared: those who had worked in CPCS for less than 1 year (n = 3) and those who had worked for more than one year (n = 6). The two groups of participants provided identical scores for 14 of the 21 vignettes. No statistically significant differences, related to level of clinical experience, were found for the remaining seven domains.

Concordance of ratings amongst clinicians. Next, agreement among the 9 clinicians was examined. This was important as substantial variability would suggest that either the MAPS domains were not sufficiently clear to produce consistent ratings, that training was insufficient to achieve reliable rating procedures, or that the clinical vignettes provided were not suitable for assessment using the MAPS.

The ratings for given domains were collapsed into three categories to signify immediate (1-2), moderate (3-4) and low/no risk (5-6). Table 9 presents the results.

Table 9

Frequencies of agreement for immediate, moderate and low risk ratings across 14 MAPS domains

Domain	High risk (1-2)	Moderate risk (3-4)	Low/ no risk (5-6)
Vignette 1:			
1. Child Health & Psychosocial Functioning	9	0	0
2. Educational Engagement & Functioning	9	0	0
3. Primary Carer Health & Psychosocial Functioning	9	0	0
4b. Birth Family Placement Security & Safety	9	0	0
Vignette 2:			
5. Relationship Safety & Security with Birth Family	9	0	0
6. Primary Carer Engagement, Support & Environment	0	0	9
7. Systemic Alliance & Support	8	1	0
Vignette 3:			
1. Child Health & Psychosocial Functioning	0	2	7
2. Educational Engagement & Functioning	0	6	3
3. Primary Carer Health & Psychosocial Functioning	0	0	9
4a. Alternate Placement Security & Safety	1	6	2
5. Relationship Safety & Security with Birth Family	0	8	1
6. Primary Carer Engagement, Support & Environment	0	6	3
7. Systemic Alliance & Support	1	8	0

Seven of the 14 domains rated using the MAPS yielded 100% concordance. On the remaining seven domains, three (Domain 7: Systemic alliance and support, in both vignette 2 and 3, and Domain 5: Relationship safety & security with birth family), had only one participant differ in his or her overall rating on that domain from all other participants and responses on these domains are not examined further. Importantly, all but one of the differences in ratings across the domains was between the immediate and moderate risk categories or the moderate and low risk categories. That is, participants were able to similarly identify risk levels when the presence of both risk factors *and* strengths were evident in the one domain. Ideally, however,

participants would demonstrate strong concordance in their ratings of immediate, moderate or low risk and the variability of ratings in some domains warrants further investigation. The third vignette, in particular, yielded substantial variability, resulting in disagreement between clinicians on ratings of high, moderate or low risk categories in three of the remaining domains. This variability in scores and concordance with master ratings is examined further below.

Inter-rater reliability compared with master ratings. An inter-rater reliability analysis, using Cohen's Kappa statistic (*k*), was performed to determine agreement (yes/ no) between each participant's ratings across the 14 domains assessed and ratings provided by the authors of the MAPS (*'master ratings'*). Table 10 displays the average inter-rater reliability figures and confidence intervals. Overall, there was moderate to very good agreement across the 14 domains; Cohen's Kappa ranged from .56 (95% CI, 0.23 to 0.90) to .89 (95% CI, 0.69 to 1.09), *p* values ranged from $p<0.005$, to $p<0.03$. Moderate agreement (i.e., between 0.55-0.56) was noted for three participating clinicians. While average *kappa* scores were generally acceptable, wide confidence intervals are acknowledged. As previously mentioned, there were no statistically significant differences between level of clinical experience and domain ratings. The three clinicians who showed only moderate agreement with master ratings shared similar clinical training with the rest of the participants and came from two of the study sites. This suggests that differences in applying the scale to the vignettes, rather than training or service culture may have influenced variability in ratings.

Given the variability noted earlier in vignette 3, Cohen's kappa statistic was performed separately on the responses provided for vignette 3. Inter-rater reliability for this vignette was, generally poor to fair and not significant. This suggests a number of possible problems; the use of

this particular vignette in testing inter-rater reliability for the MAPS, participant fatigue, the MAPS tool itself, or a combination of these.

Table 10

Inter-rater reliability with master ratings across 14 Domains

Participant	Average *k**	CI	Asymp. Std Err.	V 3[a] *k*	CI	Asymp. Std Err.[b]
1	0.78	(0.51 - 1.00)	0.14	0.41	(0.14 - 0.68)	0.35
2	0.56	(0.23 - 0.90)	0.17	-0.17	(-0.05 - 0.16)	0.37
3	0.89	(0.69 - 1.00)	0.10	0.67	(0.47 - 0.87)	0.27
4	0.78	(0.52 - 1.00)	0.13	0.36	(0.11 - 0.61)	0.29
5	0.56	(0.23 - 0.90)	0.17	-0.17	(-0.05 - 0.16)	0.37
6	0.54	(0.20 - 0.90)	0.17	0.34	(0.01 - 0.67)	0.28
7	0.78	(0.51 - 1.00)	0.14	0.42	(0.15 - 0.69)	0.35
8	0.67	(0.36 - 0.98)	0.16	-0.16	(-0.47 - 0.15)	0.36
9	0.67	(0.36 - 1.00)	0.16	0.42	(0.11 - 0.73)	0.35
	M = 0.70 (*SD* = 0.12)			*M* = 0.24 (*SD* = 0.32)		

** $p<0.03 – p<0.0005$*

Note. [a]Vignette 3.
Note. [b]Non-significant.

Each participant response sheet was examined to identify specific items within domains which may have resulted in the variable responses. In vignette three, Domain 1: Child Health and Psychosocial Functioning, two participants agreed with the master ratings indicating medium risk (2) to the child. Seven participants however, provided a low risk rating (3). Items in this domain relate to four key areas; child physical and mental health, developmentally appropriate self-care and safety behaviours, engagement in peer and adult relationships, and self-esteem/ confidence undertaking developmentally appropriate responsibilities. Participant responses to only the last item varied (i.e., self-esteem, confidence). Whilst some participants perceived the

child in the vignette to display anxiety and low confidence which impacted his ability to undertake developmentally appropriate tasks, the majority did not.

In Domain 2: Educational Engagement and Functioning, six participants provided a moderate risk rating and three provided a low risk rating (as did the master raters). Again, in this vignette, only one item was responsible for the variable responses. This item referred to the child's current academic functioning. The vignette described the child performing a grade below his age and developmental expectations in a number of learning areas, but noted that the carer and school were providing support and educational intervention. The MAPS guided clinicians to assign a moderate risk if the child or young person is performing objectively below cognitive and developmental expectations (*by at least 2 years*), on a number of subjects. Despite the vignette indicating the level of delay, not all participants assigned it correctly.

Domains 4A: Alternate Placement Security and Safety and 6: Primary Carers Engagement, Support & Environment yielded the greatest variability in ratings. Items where participants differed in Domain 4A included their ratings of the carer's relationship and behaviour towards the child in their care, the carer's level of insight into the child's developmental and trauma-related needs, their ability and willingness to help provide a narrative to the child about being in care, and the level at which the carer supported the child's relationship with the birth family. For Domain 6, participants were in complete agreement on three of the six items, which referred to the carer's level of social supports, access to necessary services to meet child's medical and developmental needs, and level of socio-economic strains (i.e. housing, financial, legal strains and/ or neighbourhood conflict). Ratings varied, however, for items relating to carer's level of motivation to understand and manage the child's needs, carer's demonstrated ability to self-reflect and make necessary behaviour change, their accessing of

available services to address the child's needs, and development of an adequate working relationship with services to achieve this. Similar to vignette 2, only one participant rated differently to the master ratings in Domain 7: Systemic Alliance & Support.

Clinician Feedback on the Clinical Utility of MAPS

Relevance of each domain in assessing children's psychosocial safety and well-being. Participants were asked how relevant they considered each domain to be in identifying risks to children's psychosocial safety and well-being, using a 6-point Likert scale (1 = *'not relevant at all'*, 6 = '*highly relevant'*). Overall, participants considered the domains to be highly relevant in identifying the risks to children's psychosocial safety and well-being. All but one participant rated each of the eight domains as a *'highly relevant - 6'*. One participant rated each domain at '5'.

The 'fit' of the risk and strength categories. Participants were asked how useful they judged the MAPS tool to be in assessing the overall risks and/ or strengths present in the child's and family's context, again utilising a 6-point Likert scale (1 = '*not at all useful*', 6 = '*highly useful*'). The majority of participants perceived each risk and strengths category to be useful to highly useful, with all respondents providing ratings between 4 and 6.

Ease of use. Participants were asked to rate their overall experience using the MAPS in assessing the risks and strengths in the case samples provided, using a 6-point Likert scale (1 = '*Very great difficulty'*, 6 = '*Straightforward'*). Overall, participants indicated the tool was relatively easy to use, providing ratings between 4 and 6. Despite ease of use, two participants indicated some challenge in using the tool, with the limited information provided by the vignettes and in the time needed to make a decision. For example, Participant 4 commented: *"Some criteria were hard to match to the information provided",* and Participant 2 noted: *"At*

times, spent considerable time choosing between two ratings". Participants who perceived the tool as easy to use commented that it became easier with each successive vignette. Participant 3 suggested that the tool would be easier to use with their own '*real life*' clinical cases, as they would have access to more information, whereas another participant suggested that it may be more challenging when applied to real world cases as they may not have all the information required.

Use of the MAPS to aid case management and counselling objectives. Ratings of the utility of the MAPS to identify both case management and counselling objectives were gathered, using the same 6-point Likert scale. In relation to case management objectives, the majority identified the tool as useful, rating it at *highly useful* 6 (n = 5), while two indicated it to be not useful, assigning a score of 3 (n = 1) or 2 (n = 1). Participants indicated the tool as useful in identifying counselling objectives, with ratings of 6 (n = 3), 5 (n = 2), '4-5' (n = 1), 4 (n = 1), and 2 (n = 1). One participant did not respond.

Perceived sensitivity to change within child and family contexts over six months.

Participants in the study were asked if they considered the MAPS domains sufficiently sensitive to capture changes over a six-month period. Responses were mixed. Three clinicians said 'yes', with participant 5 commenting: "*I imagine it would be, however, in some families perhaps 6-9 months is a more realistic time frame*". Three clinicians responded indicating they were unsure. Of these, participant 8 added:

> "*Sometimes issues remain the same but the way the child/ family/ caregiver responds changes, i.e. [family] contact may remain problematic, but carers may manage the fall out of this in more helpful ways that assist the child to manage their distress/ emotions they may experience in more helpful ways"*.

Participant 4 commented that recognition of change within families depended on "*information gathered by the counsellor*", and that change in some families is more likely to be detectable in their accessing of external supports "*seen in some of the resources*". Participant 1 was undecided and suggested that the MAPS tool should include a column on each domain, for clinicians to list changes witnessed within families over time, to help them assess how these have, in turn, influenced level of risk and protective factors.

Other types of measures used. Participants indicated that they did not use structured assessment tools on a regular basis within their services. One participant stated that they occasionally used a measure to assess adult depression and anxiety, and another indicted that they used a mix of child and adult measures, but only if co-working with a psychologist on the team.

Additional comments. Comments provided by participants indicated support for the overall use of the MAPS within CPCS: *"Really good tool – I think it will aid clinicians to think about cases more objectively and to id(entify) areas of concern for intervention",* Participant 4: *"I like the fields [domains] and the use of lowest score to determine final risk",* and Participant 6: *"Very keen to have something that paints such a holistic picture".* Only one reservation was expressed by Participant 1: "*My only concern is the time it takes to complete the MAPS, however, this may lessen over time".*

Summary

Nine specialist counsellors working in NSW Health CPCS participated in the current study, which assessed the inter-rater reliability and clinical utility of the MAPS tool. Participants were trained in the use of the tool before applying it to three clinical vignettes. Clinical experience, specifically to CPCS ranged from one to five years. No differences were found for

participants' ratings across 14 domains, with respect to prior child protection service experience. This suggests that one year's experience is likely sufficient to use the tool reliably.

Over half of the domains yielded 100% agreement with the master ratings for low/ no, moderate, or high risk categories. Only one participant differed in their response on three other domains and these differences were between ratings of moderate and low risk. Of note, the vignettes described a range of strength and risk factors pertinent to child, carer and/or systemic contexts. Recognising strengths, while not dismissing the presence of risk, is considered an especially challenging, but critical, skill in the assessment of children following maltreatment (Davidson-Arad, & Benbenishty, 2010; Munro, 1999). The agreement in ratings in this study suggests that, in using the MAPS, participants were able to delineate both risks and strengths within single family contexts.

There was, however, substantial disagreement between participants and master ratings in the third vignette. and inter-rater reliability was poor to fair and not significant. Analysis of individual participant responses revealed specific items where agreement was poor: disagreement in rating immediate, moderate or low risk categories in three areas; Domain 1: Child Health and Psychosocial Functioning, 4A: Alternate Placement Security and Safety, and 6: Primary Carer's Engagement, Support and Environment. In Domain 1: Child Health and Psychosocial Functioning, variations were found for only one item which referred to the child's sense of self and confidence to undertake developmentally appropriate tasks. Differences may be due to the less tangible and overt nature of internalising behaviours. Similarly, for both Domains 4A: Alternate Placement Security and Safety, and 6: Primary Carer's Engagement, Support and Environment, agreement regarding risk by clinicians was moderate to high for items that were more objective, such as assessing if there were support services available to the carer, but

differed for items referring to level of carer insight or carer's self-reflective capacity. Arguably, these items are complex and require clinicians to make inferences about internal states, processes and beliefs from client verbalisations or demonstrated behaviour. It is possible the information presented in the vignettes was not detailed enough to facilitate a comprehensive assessment of these more subtle risks. It is also possible, as noted by some participants, that assessment would be easier with real life families. The utility of the MAPS in assessing real families in the field is a next step.

Overall, inter-rater reliability, when compared with master ratings across the 14 domains, was moderate to very high and provides preliminary evidence that the MAPS has the potential to be a reliable assessment tool. Again, this needs to be confirmed with real families in the field.

Participants provided a range of feedback on the clinical utility of the tool, generally endorsing the domains as relevant, and the risk and strength ratings as useful. This also suggests that any inconsistency between raters and the authors are more likely due to disagreement with the interpretation of the threshold of risk, rather than with the overall definitions provided.

The uncertainty regarding the ability of the MAPS to detect changes in child and family contexts over a six-month period appeared to be predominantly due to participant concerns that multi-strained families require longer therapeutic engagement. Given the long term nature of child protection counselling work, typically up to 2 years (NSW Health, 2010b), six-monthly application of the MAPS would likely capture change across time.

Lastly, no participants reported using standardised assessment measures consistently in their professional practice. This may be, in part, due to the absence of measures that assess child and family needs in a holistic manner. In addition, it may reflect an ongoing reluctance to utilise quantitative measures more generally. Despite this, participants found the MAPS useful and

indicated a willingness to apply it to their work. The implications of these findings for the assessment of and interventions provided, to support children's psychosocial safety and well-being following maltreatment, is further discussed in Chapter 7.

Chapter 7

Discussion

The overarching aims of the two studies presented in this thesis were to contribute to the understanding of factors that influence the stability of care and satisfaction of carers looking after children in OOHC, and to improve the assessment of children who have experienced maltreatment and are involved in the child protection system. Study 1 investigated factors which support or compromise placement stability, while Study 2 outlined the development of a clinician-rating tool (MAPS), to enable holistic assessment of child safety and well-being following maltreatment in a range of care contexts. The two studies outlined in this thesis developed in parallel. Together, they reflect consultation with both carers and clinicians in the OOHC field. At times, the lived experiences, views and values expressed by carers in Study 1 converged with the working experiences, views and values of clinicians in Study 2. This chapter provides an integrative overview of the findings of the research and their clinical applications, whilst acknowledging study limitations, and then suggested directions for future research are considered.

Perceived Stability of the Placement

In Study 1, standardised quantitative measures were completed by 39 carers, and analysed regarding the impact of child and carer-related characteristics, demographic variables and perceived levels of support, on carer perceptions of placement stability and satisfaction. The small sample size is acknowledged and constrains conclusions that can be drawn from these measures. Carers also provided open-ended comments on what influenced their views of placement stability for a given child, their caregiving satisfaction and the support they were receiving. Based on prior research evidence, it was expected that child behaviour problems

(particularly externalising problems), insecure (anxious and avoidant) caregiver attachment styles, low caregiving empathy and problematic parenting styles would be associated with higher concern about placement breakdown. Contrary to predictions, it was contextual factors, rather than child or carer characteristics, that were most strongly associated with both expectations of placement stability and carer satisfaction. Moreover, carers' comments highlighted factors not directly investigated in Study 1, but which appeared important to the needs of children in OOHC and their carers.

Carer age was the strongest predictor of placement stability with older carers more concerned about their ability to continue to care for their child over time. In this small sample, carer age ranged from 28 to 71 years, with 20% of carers being between 56 and 71years. Thematic analysis of carers' comments is informative and provides a narrative around the specific challenges faced by older carers, who described concerns for their own health, their capacity to see their child into adulthood, the burden of other care duties, and financial strain. Older carers in this sample expressed particular concerns about their ability to manage significant child behaviour problems, including aggression, as both they and their child got older, for example: *"I will be 70 years old by the time he is 18. He is becoming more violent and aggressive towards me and my possessions, and I don't feel I have the ability or support to assist me through the teenage years if this behaviour continues"*.

While prior research regarding carer age and placement stability has yielded inconsistent findings, older age is generally viewed as protective (Rock, Michelson, Thomson, & Day, 2015). The reasons for this are unclear, although they have been inferred; older carers may be more tolerant, more able to set appropriate limits, more emotionally involved and more child-centred than younger carers (Rock et al., 2015). It may be that there is an optimal age at which

psychological maturity is protective to placement stability, before the drawbacks of ageing, such as ill-health as noted in this study, begin to compromise carers' abilities to meet care tasks. This appears especially so when carer ageing and ill-health are combined with financial strains, in the context of children with complex needs. For example,

> *"health issues may force early retirement so [we] won't financially be able to support [child name] at same level as we do now – always out of pocket. Trying to save for retirement but children also have needs to be financially supported that are not covered by (NGO or government agency)".*

Clinicians providing feedback on the MAPS in Study 2 also recognised a need to assess socio-economic issues of the caregiver, although they did not relate this specifically to carer age: *"Where do housing and financial issues go? ... it would be preferable if money, housing, employment was drawn out more clearly",* suggesting a growing awareness in workers of the socio-economic strains experienced by carers.

Although carers are provided with financial remuneration, research indicates that they may experience financial strain as a result of care obligations. While payment for foster and kinship carers has not reduced over the last few years, economic analysis indicates that the costs of caring have increased and are not adequately compensated for by care agencies (Australian Foster Care Association, 2017). Children in care have been estimated to require more expenditure than children not in care, with respect to housing needs, household and contents insurance, transport needs and access to specialist services (McHugh, 2002). Additionally, routine health screening for children entering care has highlighted the increasing complexity of child problems, their associated needs for intervention, and a likely additional financial outlay that carers may be meeting, independent of their care agency (Acil Allen Consulting, 2013).

The development of and access to universal services, such as routine health screening for children entering care, while beneficial for the children, also likely adds to the burden of care in some ways. In practice, carers attending child protection therapy services report they are also attending other medical and health-related appointments, and they may be directly involved in multiple forms of therapy for the child (e.g. speech or occupational therapy), for longer periods than in the past. Financial strains associated with transport to appointments and family contact, as well as time away from paid work, may go unrecognised. While the increased awareness of child needs and greater involvement of carers in the treatment of children are undoubtedly beneficial, the absence of adequate financial remuneration to carers may paradoxically add to the strain of care, in ways not previously foreseen. Lastly, older carers in this study indicated that they were currently, or would in future, be responsible for the care of other family members (also ageing) which might further impinge on their ability to continue caring for their child. For example: *"As well, my husband is sick and if he gets sicker as expected I don't know whether I will have the strength to keep going"*.

Prior research on carer health, financial security and multiple care commitments is limited and has tended to focus on kinship carers. It is becoming recognised, however, that these additional strains are common challenges for kin carers, especially grandparents (Boetto, 2010). The current study findings suggest that older foster carers share these challenges and that the accumulation of these strains, paired with ageing, makes them concerned about the future and their ability to cope with the evolving challenges, as children in their care enter adolescence.

Consideration of these carer-related factors, in addition to the unique needs of children entering placement, is needed. Pre-placement assessments, ideally, should ensure appropriate matching between child needs and carer capacity. Difficulties recruiting enough carers to cope

with the increasing number of children entering care (Delfabbro, King, & Barber, 2010) may mean, however, that placements are driven, at least in part, by availability rather than suitability (DoCS, 2007). Notwithstanding these challenges and concerns, older carers do substantially contribute to the stability of care for children (Rock et al., 2015). More attention to the unique challenges faced by older carers is important, if they are to continue to provide what is an essential social service. These contextual strains, related to carer health and well-being, socio-economic problems, and partner and social supports, are considered across a number of domains in the MAPS assessment. Results of Study 1, though, suggest further refinement of the tool is warranted, with more explicit reference to carer age and some age-related constraints on capacity to provide longer term care.

Thematic analysis of carers' comments pointed towards a number of factors which may promote placement stability and, thus, highlight important areas for therapeutic assessment and intervention. Carers who reported no concern for placement breakdown also reported a strong sense of commitment to the child for the long term, were grounded in support for, and acceptance of, the child in their care by their broader family network, including their biological children, as well as reporting a sense of enjoyment of the child. The importance of expressed commitment to long term care for placement stability has gained some empirical support in a cross-sectional study. Children of carers who had explicitly expressed a commitment to the long term placement of their child to their caseworker, were less likely to experience placement breakdown, compared to children whose caregivers did not express commitment (Koh et al., 2014). It is impossible to determine in the current study, if the 'commitment' to a child was made prior to the placement, or was one that developed alongside the formation of the parent-child relationship. The fact that placement breakdowns regularly occur in the context of long term

orders, presumably often in cases where carers have made an initial commitment in good faith, suggests that realising this commitment is dependent on context.

Arguably, the most legally binding commitment carers can make to a child in their care is adoption. Only one carer in Study 1 mentioned her intention to adopt her child. Given the relatively recent availability and accessibility of this option for children in OOHC, the intention to adopt was not explicitly explored in this study. It does raise empirical questions, however, as to whether this form of commitment might have a positive impact on carers' perception of placement stability. Previous qualitative research with foster mothers, attests that planned long term care (as opposed to short term) of children freed them to connect with and love their child more (Blythe, Halcomb, Wilkes, & Jackson, 2013). Future prospective studies on placement stability could consider the nature of the initial carer commitment and the impact on long term stability, and how this may differ for children on long term orders versus guardianship or adoption.

A striking finding from comments of carers in Study 1 was the positive influence of the acceptance of the child in care from the carer's biological children and extended family, and the support they could provide to the carer. Qualitative research with biological children of foster carers offer unique insights into the dynamics of foster care families. While some of these children report positive experiences of fostering, such as increased understanding of others' needs, satisfaction in helping another child, and having a peer to play with, they also report numerous challenges. These include an increase in caring responsibilities for children less able than themselves, a perception that their parent(s) provide greater allowances for their foster sibling's problem behaviours, and difficulties with sharing their parent(s) attention and love (Noble-Carr, Farnham, & Dean, 2014). A number of siblings of children in care also expressed

annoyance when their sibling was referred to as a foster child, indicating that they wanted professionals, as well as friends, to acknowledge the family as a united one. Notably, these children wanted foster support services to engage with them about their needs and to take a whole-of-family approach to care (Noble-Carr et al., 2014). The need to consider carers' biological or other foster children, with respect to placement stability, was also echoed by a number of clinicians who provided feedback on the MAPS domains in Study 2. Comments suggesting the importance of sibling and family relationships included: *"include the relationship between other children", "impact of relationship with child and extended family",* and *"relationship child has with carer's children could jeopardise the stability of placement"*.

Taken together, these findings suggest that the MAPS could be enhanced by further inclusion of factors relating to the sibling relationships among the foster/ kin child and their carers' biological children, as well as general family cohesion and acceptance of the child.

Carers who reported no concerns for placement breakdown also reported that they enjoyed their child. It seems common-sense that carers who enjoy their child will be more willing to maintain care of that child. An ongoing challenge for child protection intervention services, then, is how best to help carers cultivate their appreciation and positive experience of their child, in the face of emotional and behavioural challenges. As discussed in Chapter 1, foster and kin carers (who do not have a pre-existing relationship with their child) have the difficult task of forming relationships with children who have experienced interpersonal trauma. The onus of establishing and maintaining this relationship lies heavily with the carer (Dozier et al., 2009; McClean, 2016). Research into what is effective in the treatment of children presenting with complex trauma is surprisingly limited. Interventions which have gained a good evidence base (e.g. trauma-focused cognitive behaviour therapy, see California Evidence-Base Clearinghouse

for Child Welfare, 2017) aim to address trauma-related symptoms, but not the carer-child and family relationship. Given the high level of dependency of children on adult caregivers and supports, trauma-informed care requires integrated interventions across child, family, and care agencies (Wall, Higgins, & Hunter, 2016). The current study highlights the importance of addressing carer experiences of caregiving, and promoting positive relationships between the child and the carer, as well as the child and wider family system. These findings provide further support for the inclusion of systemic factors, such as carer commitment, carer view of and relationship with the child, and family strain, such as relationship problems between the child and carer children, in the current MAPS.

Carer Satisfaction

Contextual factors were also found to influence carer satisfaction. More support from partners and fewer prior placements experienced by the foster child were associated with higher carer satisfaction. The type and quality of partner support was not investigated in this study and it is unclear exactly what carers found most helpful with respect to their partners. No carer made specific comments on their relationship with their partner when discussing their satisfaction. However, for carers who reported higher satisfaction, partner support appeared to reflect an implicit alliance. These carers indicated a shared commitment to, and appreciation of, the child. For example: "*[this child] needed to trust and have stability and we worked hard together as a team to build that trust"*.

There is scant research on the impact of partner support on caregiver satisfaction with children in foster or kinship care. Research on partner support and parenting experiences in the general population indicate that partner support (social, financial and emotional) positively impacts parent's mental health (Davey-Rothwell, Stewart, Vadnais, Braxton, & Latkin, 2017),

while low partner support is associated with higher parenting stress and more problematic bonding with their child (de Cock et al., 2016). The nature and impact of partner relationships, associated with better outcomes for carers and the children in their care, warrants further investigation. Results from Study 1 suggest that this support, when effective, appears to incorporate a shared commitment and positive experience of the child. Assessing the co-parenting relationship, alliance, commitment, and both caregivers' experiences of the child would likely identify problems which may compromise the caregiving experience. Similarly, identifying and enhancing co-parenting strengths may prove protective of the parent-child relationship within the placement. The MAPS tool includes assessment of the caregiver alliance, caregivers' commitment to the placement, and caregiver support, and may assist clinicians to be mindful of these important factors, both in assessment and therapeutic work with families.

Fewer prior placements of the child were also associated with caregiver satisfaction in this study. As discussed in Chapter 1, children entering care often bring attachment-related difficulties, which appear to increase in severity with greater placement disruptions (van Ijzendoorn, & Juffer, 2006; Voria et al., 2006). In the current study, contrary to expectation, the severity of child behaviour problems (as assessed by the Eyberg Child Behaviour Inventory; Eyberg, 1990, and Child Sexual Behaviour Inventory; Freidrich, 1997), was not correlated with carer satisfaction for the participants overall (as measured by the satisfaction sub-scale on the Parent-Child Relationship Inventory; Gerard, 1994). Some comments suggested, however, that at least for some carers, child behaviour problems in the context of multiple placements were difficult to manage and greatly impacted their caregiver experiences. As one carer of a child with four prior placements commented: *"Feelings can vary ... week to week and sometimes day to day. Sometimes it is easy to see the changes and growth in [child] and then it is extremely*

rewarding and satisfying. Sometimes when [child] is disruptive and appearing to pull the whole family apart, you do have regrets and doubts". The level of child behaviour problems and the impact of these on other family members may also negatively impact on partner and broader family support over time. Larger samples and prospective designs would be required to assess these indirect effects of child behaviour difficulties. In addition, alternate measures, which tap into emotional and interpersonal behaviours particular to children in OOHC, may be more helpful and are discussed later.

A few carers commented that birth family contact was a source of stress that impacted their satisfaction. Carers expressed concerns about the potentially negative impact of contact between their child and the child's birth parents and/ or the premature or unwarranted future restoration of the child to their birth parent(s). For example:

> *"Another HUGE factor in this child doing so well is that he only has four birth family access visits per year. … access [is] the single most damaging factor for both our children, in disrupting their healing and re-traumatising them. … we always live with the threat of birth family taking the situation back to court".*

Clinicians in Study 2 also recognised the need to consider contact-related issues when assessing and supporting families: *"negative behavioural/ emotional reactions by child before and after contact … this is so frequently presented by carers as an issue"*, and "*Development of meaningful and safe new attachments is hindered when security with birth family is not present".*

The frequency, quality and carer perceptions of contact with the birth family were not investigated in this study, but it is likely that these impact the overall caregiving experience and warrant future research. As discussed in Chapter 4, the research literature indicates that birth family contact can be destabilising for children, when birth parents are preoccupied with denying

their actions and/ or focused on child restoration (Haigh et al., 2002; Leathers, 2003). Problematic contact may well play a particularly harmful role when children have not had the opportunity to form a secure relationship with their alternate primary carers and extended family. Moreover, this may be especially so when children have experienced multiple prior placements and unsuccessful attempts to develop a stable relationship with a primary caregiver. Additionally, the fear of children being returned and/ or the consequences of their child's allegiance to the birth family may heighten carer's dissatisfaction, when there are ongoing strains evident in the placement.

The MAPS currently includes a number of items relating to birth family contact, including family attitudes towards child, child protection intervention, and whether or not they support the child's relationship with the carer. Consultation with carers, however, would ensure that the items sufficiently cover key problem areas and also any possible benefits that may be associated with birth family contact.

Satisfied caregivers reported that they accepted the child as "*one of their own*". Similar to earlier comments made by carers when reflecting on placement stability, carers indicated that their child's integration into, and acceptance by, their family system influenced their satisfaction. Additionally, these carers commented on the rewards of witnessing their child's recovery and development, as a result of their care. In this sense, the perceived bond with their child, and the child's signs of recovery and positive development in response to their efforts, bolstered caregiving satisfaction. Achieving developmental improvements in the child and carer ability to develop a positive relationship with the child, may be (relatively) less difficult when the child has not experienced multiple disrupted attachments. For example, two carers, both of children with no prior placements, commented: *"I have seen this child flourish under our care, from*

feeling worthless to feeling valued" and *"I love her as my child for life. She is part of my family for ever, no matter what"*. How effective a carer perceives him or herself to be and the carer's perceptions of the quality of the carer-child relationship were not directly investigated in this study. It may be that one or both helps buoy a carer, in the face of ongoing challenges and this could be a useful area of future research.

In Study 1, as in previous studies (e.g. Crum, 2010), caregiver satisfaction was not related to perceptions of placement stability. However, caregiver satisfaction appears to contribute to the overall experience of caregiving. The results in Study 1 provided insight into how the MAPS could be further refined to account for caregiver experience. First, MAPS items could be refined to more explicitly consider partner support, that is, level, quality, parenting alliance, or the presence of alternate supports when carers are not partnered. With respect to children's prior placements, the MAPS already considers a range of behaviours presented by children (emotional, behavioural, response to carers), but this could be refined through consultation with carers themselves. The MAPS also considers problems which may occur during contact with birth families, however again, the tool could be enhanced to consider the carer perceptions of contact, the child's allegiances or concerns for restoration, or of the child self-placing.

Carer responses from Study 1 also highlighted other factors important to consider in the study of placement stability, as well as with respect to assessment and support of families. These are discussed below.

Support from Agencies

The impact of systemic support of carers and children was a striking and pervasive theme in the spontaneous comments of caregivers. Some carers who viewed their supports positively indicated they were receiving, and appreciated, a multi-modal, collaborative and team-based

response that addressed the individual needs of both the child and carer. For example: *"I find the care team meetings very helpful … providing great help to follow through and implement ideas for support for my daughter and myself"*.

Problems with agency support were expressed, however, even by carers who reported very few difficulties with their child. These problems included a lack of pre-placement preparedness and access to appropriate therapeutic assessment and interventions:

> *"In my opinion, when children come into care they should have access to a full child development assessment so that therapy, strategies can be assessed asap (sic) and also so that carers are better informed of what to expect and able to decide from the start if they are willing to take these issues on long term; this may secure long term placements, if carers feel supported"*.

This lack of preparedness may be particularly problematic for kin carers. In this study, there were no differences in the amount of service contact and psychological support received by foster and kin carers following child placement. However, kin carers did not receive the same level of education and training that foster carers did prior to placement. In some cases they received none. As such, kin carers may not have been able to benefit from information on the impacts of trauma on child development, trauma-informed care, and carer expectations.

A lack of health assessment and therapeutic support was also concerning. Indeed, one quarter of carers reported receiving no direct therapeutic support, despite over half of the children having one to three psychiatric diagnoses, and the majority having clinically significant emotional and behavioural problems. Those carers who did report receiving at least one form of therapeutic support for their child and themselves, considered the support inadequate to meet the family needs. Some described having to organise and find supports of their own: *"he* [child] *had*

been diagnosed with PTSD, ODD, RAD, but apart from being placed on [Ritalin]*, no other therapies had been provided. Through our insistence our child now receives counselling, occupational therapy, speech therapy which we are happy to provide for his long term prospects".*

Moreover, some carers perceived their care agency to be oblivious or unresponsive to the needs of their child. These carers reported having to continually advocate with their care agency for, or independently arrange, additional support for the child, while simultaneously feeling criticised by the agency. For example, one carer commented: *"It took 12 months for my concerns to be recognised and some training/ support to be arranged",* and another carer: *"we are unable to thus far access formal assessments for a range of disabilities which may be at play and meet with opposition when we source our own professionals".*

In addition to problems with level of support, carers described a poor working alliance; perceiving a lack of collaboration and antagonism from their key care agency, which left them feeling frustrated and powerless. For example, one carer reported that her child received significant support at school, as well as occupational and psychological therapy, but commented: *"I have to fight constantly with [agency] for this support"*, and another carer commented that their 6-year-old child received play therapy that they were not included in and commented that the *"usefulness of which had never been raised with us"*. One other carer noted: *"It's not the child's fault, the problems are real, the problems were not identified prior to taking the child, and with nothing but criticism from the [agency] and very little support, we often feel we are 'at sea'".*

Recent research demonstrates ongoing problems with access to assessment and treatment processes following entry into care. In an Australian study, Chambers and colleagues (2010)

reported on a joint health and welfare project which provided comprehensive physical, developmental and mental health assessments to a cohort of children (4 months – 12 years), entering long term OOHC in Western Sydney. Similar to previous findings, children in the study were reported to have high levels of emotional, behavioural and developmental difficulties (e.g. hearing, vision, dental, speech delays and deficits). At a 6-12 month follow up, approximately 40% of recommendations made for children at the time of the assessment had not been initiated. While recommendations around family contact, medical need and child protection concerns were more likely to be acted upon, recommendations for further speech and language assessments or interventions, carer respite and caregiver support were not followed up by care agencies. The authors proposed that care agencies may have perceived carer-focused recommendations as less central to children's needs. While Chambers and colleagues considered that waitlists and funding issues may, in part, explain the inability of care agencies to follow through with more recommendations, it was unclear why agencies in that study did not *initiate* referrals for child developmental deficits, such as speech and language assessments. Future research could aim to assess whether these barriers are indeed related to accessibility issues, agency caseload, and/or caseworker understanding of the importance and impact of developmental deficits on overall child well-being and family functioning.

Of note, carer reluctance to engage in psychological interventions was also apparent in the study by Chambers et al. (2010). A substantial portion of carers missed appointments, failed to complete psychological measures, and did not involve all members of the household in the assessment process as requested by the assessment team. The authors suggested that carer strain, as well as perceptions that they may 'stand outside' the problems (and thus the remedies), for the children they care for, inhibited compliance. As agency perspectives were not included in the

current research, it is not known whether more supports had been offered to carers in the study and/ or what the rate of uptake and compliance was. Future research should gather the perspectives of both agencies and carers regarding child and carer needs, and analyse these in the context of service availability. This would help to more clearly determine the actual impediments to a positive working alliance and carer access to supports, be they related to service availability and/ or to the beliefs, values or concerns of care agencies or carers.

The working alliance. As discussed in Chapter 3, the quality of the working relationship carers reported with their care agency appeared to impact their sense of support, view of placement stability and their satisfaction. In the field of child protection, research on the working alliance has tended to focus on the relationship between birth parents and caseworkers, and strongly indicates that children's outcomes are influenced by, if not dependent upon, the nature of that relationship. Parents of maltreated children, who perceive their worker to be experienced, open to discussing problems, collaborative regarding goal formulation, and able to listen to parent's emotional pain and focus on parental strengths, tend to be more engaged in working with their caseworker (Thomson et al., 2016). Carers in the current study reported higher engagement when their caseworkers did not ignore problems they presented, when workers did not ask carers to do things that they considered unhelpful, and when workers were predictably reliable in making or returning pre-arranged calls. Together, these skills signified the importance of workers genuinely collaborating with and providing a secure base for clients. Not surprisingly, research suggests that workers who act collaboratively (i.e. include parents in planning, demonstrate care and support, provide positive feedback to parents about their efforts, ideas and achievements), feel more engaged with their clients as well (Gladstone et al., 2012, 2014).

Numerous factors may interfere with the development of a working alliance between carers and their care agency. With respect to birth parents who have engaged in abusive behaviour, workers may fear that a positive alliance may diminish or minimise the safety and needs of the child (Department for Child Protection, 2011). This worry could arguably be extended to carers, if agencies become concerned about child well-being or placement security. Additionally, there are unique challenges compared with other care-based working relationships. Unlike many other therapeutic relationships, the one entered into between a child protection/ care agency caseworker and carer may not be completely voluntary in nature. Carers are obligated to fulfil the expectations and rules dictated to them by agencies, yet they may choose not to disclose their views about, or difficulties meeting, these to caseworkers for fear of removal of the child in their care (Chambers et al., 2010). An attachment perspective, with an emphasis on the importance of parallel caregiving processes, may help explain some of the relationship dynamics that can undermine a working alliance. Foster and kin carers are responsible for parenting some of the most vulnerable and at-risk population. It is recognised that a child in need activates a caregiving response, as many carers attested to in this study. When under duress, however, a caregiver's own needs to be cared for may also be activated. Due to their dual concerns about coping with the child and potentially losing the child, carers may defensively avoid, dismiss or otherwise miscue caseworkers about their needs. This may be especially so if they perceive their caseworker, (their own 'caregiver'), as hostile, indifferent or overwhelmed. This is highlighted by comments from two carers, with very different experiences, when they needed help from their agency. One carer, who reported high concerns about placement breakdown, reported significant difficulties in working with her care agency:

"I could never regret having him [child], and I don't. But at the same time, I know that in so many ways, the reality of the effect on my life – the complete and sheer exhaustion of dealing with an abusive system … that are incapable of putting children first – I know that these experiences have been profoundly damaging for my health and well-being, and often I feel I will not be able to prevail against a fundamentally destructive system. … I would never take on another child within this system".

In contrast, a carer who reported no concerns about placement breakdown reported experiencing the agency as a secure base:

"After a short time he[child] came to live with us. We noticed some odd things about him. He.. wouldn't make eye contact, didn't cry if he hurt himself, we were told he may have a disability & if so would we still be willing to be his carers. I told our case worker it wasn't what we signed up for, but as long as we had help & support … We have had years of therapy support …. any time I've seen a problem or needed help I have gotten it … & many kind ears to listen to us through tough times. We have never regretted or been unhappy with our choice. I am blessed".

As discussed in Study 2, the majority of clinicians involved in the consultation process endorsed the inclusion of a MAPS domain specific to the working alliance with the carer, and the systemic support the carer experienced with their care agency. Only a few clinicians were uncertain as to the relevance of including this relationship as part of an assessment on the psychosocial safety and well-being of children following maltreatment. This may reflect, in part, clinicians' views that they may stand outside of the problems that carers and children face and/ or minimise the direct impact of the working relationship on child and family outcomes.

A working alliance in the child protection field may require extra attention and sensitivity on the behalf of caseworkers. As Gladstone and colleagues (2012) suggest, caseworkers who understand parents' apprehensions and can contextualise parents' responses as a defensive strategy rather than a personal attack, will more readily consider their own responses as influential to the progression and nature of the working alliance. Similarly, Howe (2010) advocates that "*the more recognized, acknowledged and contained the parent feels, the more the worker can help the parent keep the child in mind"* (p. 332). The current study suggests that caseworker and agency attention to the nature of the working alliance, in parallel with attention to the direct needs of the child, may prove protective for the caregiver experience, and the subsequent placement security and well-being of the child.

Although the quality of the carer-agency working alliance and placement stability were not explicitly investigated in this study, comments from participants suggest that foster and kin carers alike benefit from a positive working alliance with their caseworker and/ or agency, and that a poor relationship may significantly impact a carer's sense of satisfaction, support and intention to maintain a placement. For example: *"The one and only reason I wonder whether I did the right thing in having this child is that the foster care system … is fundamentally abusive of carers and children, because it embodies a power structure where one party [care agency] has all the power, and another party – the day to day parent, does all the work"*.

The two current studies revealed convergent views on the importance of the working relationship between agencies and carers, for carer well-being, carer experience, and subsequent outcomes for children across placement and contact contexts. Both the lived experience of carers and clinician feedback suggest that the MAPS assessment of working alliance can be further refined. This domain, in particular, would benefit from consultation with carers about what

constitutes an effective collaborative alliance. Moreover, while child protection caseworkers can provide an assessment of alliance, the inclusion of carers' perspectives when completing the MAPS would likely provide a more comprehensive assessment, and highlight areas where relationship repair is warranted.

Null Findings: Child and Carer Factors and Placement Stability

Contrary to prediction, the child factors investigated in this study (i.e. severity of externalising and sexualised behaviours) and carer factors (parenting style, empathy), were not significantly associated with carer views of placement stability, nor with carer satisfaction when contextual factors were considered. This contrasts with prior research. Several factors may have contributed to the null findings. First the very small sample size limited statistical power and variability in the data, and results should thus be interpreted with caution. It is noteworthy, though, that the majority of children in this study were rated as having clinically significant externalising, internalising and/ or sexualised behaviours, and this may have produced a ceiling effect. That is, the experience of problematic child behaviour was so common among carers studied that it did not discriminate individual differences in carer perceptions. It may also be the case that the carer-related measures used in this study were not sufficiently sensitive for this population, or that other child characteristics that were not studied may have been important.

Whilst the child measures included in this study were chosen for their ability to clearly distinguish factors identified in prior research as important (i.e. externalising and sexualised behaviours), and they had good psychometric properties and established use with the OOHC population, other measures may tap into interpersonal factors alluded to by carers in the study that were not captured by these measures. For example, in the current study, carers indicated the importance of reciprocity, particularly child responsiveness as contributing to the relationship.

One carer-report measure that taps into child emotional and behavioural issues common to the OOHC population, as well as capturing attachment-related strategies (e.g. non-reciprocal and indiscriminate reciprocal behaviours), is the Assessment Checklist for Children (Tarren-Sweeney, 2007). This measure may be more sensitive to specific child interpersonal strategies that could impact the quality of the caregiving experience and/ or their commitment to ongoing care.

Also, contrary to prediction, carer characteristics were not uniquely associated with placement stability or carer satisfaction. While carer empathy (i.e. perspective taking) was associated with placement stability at the bivariate level, it was no longer significant when contextual factors, such as carer age, were considered in regression analysis. Parenting style was also not associated with placement stability, contrary to prediction. Carer Attachment Anxiety and Avoidance were negatively associated with carer satisfaction at the bivariate level, but also not significant when contextual factors, such as partner support, were considered. Carer empathy was not associated with carer satisfaction, contrary to prediction.

There are several possible explanations for these findings. First, measurement issues should be considered. Both the measures of parenting style (Parenting Scale, Arnold et al., 1993) and empathy (Interpersonal Reactivity Index, Davis, 1980, 1983) appear appropriate at face value. They have been widely used and found to discriminate problematic responses to parenting (Irvine et al., 1999), and/ or potential risk to children (McElroy & Rodriguez, 2008; Rodriguez, 2013). The current study indicates, however, that factors which likely impact the child and carer relationship formation (i.e. higher prior child placements) more strongly impact satisfaction, and that other concerns (e.g. getting older) outweigh individual caregiver characteristics.

While the Attachment Style Questionnaire (Feeney et al., 1994), is a widely used measure of attachment style, surprisingly the respondents in this study had lower (more optimal) mean scores than previously published norms. Positive self-reporting (defensive responding by carers) may be one possible reason for this difference. There is much evidence to suggest that self-report measures of attachment reflect socially observable personal attributes evident in interactions (Mikulincer & Shaver, 2007). Criticisms of self-report measures centre on their assessment of c*onscious* attitudes and behaviours and, thus, potential failure to detect when attachment defences may distort responses. An associated concern is that they fail to account for differences in the way attachment systems and beliefs about self and others are activated in different contexts (i.e. parent vs. romantic partner vs. child) (Ravitz, Maunder, Sthankiya, & Lancee, 2010). Projective attachment instruments (e.g. the Adult Attachment Projective, George & West, 2001), which aim to activate the thoughts and feelings linked to attachment experiences, may be more effective.

Additionally, the ASQ does not discriminate between groups of foster carers and their actual carer performance, as rated by caseworkers (Thorpe & Caltabiano, 2005). It may be that the ASQ is not sensitive enough for this population, and/ or that measures tapping into specific carer-child relationship representations (e.g. the Parent Development Interview, Aber, Belsky, Slade, & Crnic, 1999) would be more relevant and informative, and enable a better evaluation of the impact of attachment representations on placement stability and carer satisfaction. Indeed, it is possible that attachment style, as assessed with the ASQ, may be more relevant in understanding the caregiver/agency relationship.

Carer parenting practices. While parenting practices assessed by the Parenting Scale did not relate uniquely to the study outcomes variables (perceived stability and satisfaction),

responses to this questionnaire are worthy of comment. Fifteen percent of foster and kin carers reported an over-reactive parenting style, characterised by anger, meanness, irritation or frustration, and parental use of threats or physical punishment (e.g. *'raise my voice or yell'*, to be *'picky and on my child's back'* and to *'get so frustrated or angry that my child can see I'm upset')*. There was a statistically significant difference for the total scores on the parenting scale, with foster carers having an overall higher (more problematic) mean score than kin carers. Both foster and kin carers, however, indicated different problematic parenting strategies, which may reflect divergent challenges in their relationship with their child.

Unlike kin carers, foster carers do not have the benefit of a pre-existing relationship with the child, and both child and caregiver have to navigate a new relationship in the context of attachment trauma. Pearce and Pezzot-Pearce (2001) offer an explanation as to how children's interpersonal responses in the new relationship may impact caregiver experiences and responses over time. Couched in attachment theory, they suggest that children's internal working models of caregivers, based on early maltreatment, may continue to be applied to subsequent carers, even in the presence of nurturing, consistent caregiving. Children may tend to interpret new care experiences to fit their pre-existing model of parenting (assimilation), rather than change their model to fit their current experience (accommodation). Over time, and if unchecked, carers may feel increasingly inadequate, powerless and frustrated. The use of over-reactive behaviours in the foster care relationship may be a consequence of this frustration and/ or an attempt to get 'through' to the child. These strategies, however, may reinforce children's representations of their carer as untrustworthy or dangerous, and of themselves as unlovable – exacerbating negative carer-child interactions.

Kin carers mean scores for Verbosity (parental reliance on lengthy, verbal responses to misbehaviour), were within the clinical range in the current study. These results suggest that kin carers may struggle with setting clear verbal limits for their children and in providing consistent follow through with appropriate behavioural supports. That kin carers reported fewer over-reactive responses to the child in their care may be due to their pre-existing relationship. Kin carers frequently report an established bond with their child and a strong commitment to caring for them, because of the shared 'bloodline' (Oakley, Cuddeback, Buehler, & Cox, 2007). An established bond may lessen the likelihood of caregiver aggression and frustration towards the child. Research has identified that grandparents perceive themselves to be disconnected from contemporary social and parenting contexts (Mission Australia, 2007). Typically, grandparents have been absent from the direct parenting of young children and, as a result, may not have been exposed to and benefitted from parenting supports and modern-day strategies. The current study results suggest that a subset of foster and kin carers struggle to use optimal parenting responses with the children in their care. Again, this likely reflects a gap between the complex needs of children with emotional and behaviour problems, likely due to trauma history, and the enhanced skills required by carers to address these needs. Interventions which are attuned to the carer's own emotional triggers and needs, and provide trauma-informed parenting strategies in addition to specifically addressing the unique carer-child dynamics, could be beneficial for foster and kin carers alike.

In summary, Study 1 highlighted numerous contextual concerns as influential to placement stability and carer satisfaction. Although the small sample size limits generalizability, the quantitative results found older carer age was associated with higher concerns for placement stability. Qualitative feedback indicated that age-related factors, including health, financial strain

and multiple carer roles, also impacted perceived stability of placement. Carer feedback also suggested potential protective factors to placement stability, such as family acceptance of the child, including that of the carer's biological children, carer's expressed commitment to the placement, and carer's enjoyment of the child.

Quantitative results found partner support to be positively associated, and number of prior child placements negatively associated, with carer satisfaction. Carer feedback indicated that carer concerns for contact between their child and birth family negatively impacted carer satisfaction, and also suggested that family acceptance of, and carer's sense of efficacy or positive impact on their child, as protective.

The quantitative and qualitative results of Study 1 confirm the importance of multidimensional assessment of the needs of children following maltreatment. To best support children in their recovery and ongoing well-being, their individual difficulties, strengths and needs should be evaluated in the context of, and in conjunction with, those of their carer, families, and systemic support domains. It is to the development of the MAPS that we now turn.

Assessment of Child Safety and Security Following Maltreatment: Multi-Systemic Assessment of Psychosocial Safety (MAPS)

Study 2 involved the development of the MAPS, through consultation with clinicians and inter-reliability testing. This process indicated good support for this clinician-rating tool. Participating clinicians, across the consultation stages, endorsed the tool as relevant and useful, in assisting them to holistically assess children's psychosocial safety and security across a number of domains and care contexts. They found the MAPS to be relatively easy to use, useful in identifying risk and protective factors within child and family contexts, and helpful in setting intervention objectives. Inter-rater reliability was generally good. In particular, full agreement

was reached amongst participants with respect to risk ratings for the initial vignettes presented. Increasing variability between participants and master raters was noted, as the vignettes became increasingly complex, and across the study day. It may be that participant fatigue, due to the requirement to assess multiple vignettes across a sustained period, impacted later ratings. The MAPS, like assessment measures in general, is designed to be used in practice by clinicians, with measured reflection during periodical assessment, rather than applied to multiple families in one sitting. In addition, clinicians indicated that they would likely use the tool as part of the standard counselling review, undertaken in work-based supervision with a clinical supervisor, as well as with their service co-therapist peers if relevant. Using the MAPS tool within supervision or with co-therapists would enable clinicians to discuss ambiguities, and may result in more accurate ratings.

Importantly, clinicians using the MAPS were able to identify and delineate risks and strengths within single family contexts. The ability to identify and process disparate information within child and family contexts is critical, as clinicians are vulnerable to dismissing or minimising risk factors when families present with protective factors or positive change (Munro, 1999).

Detailed analysis of items where participants varied in their risk ratings helped to highlight items which required clarification. Modifications to the MAPS, based on these analyses and qualitative feedback both from clinicians and from participants in Study 1, is expected to enhance the relevance and utility of the tool. An amended version of the MAPS, based on the current study has been developed and is attached in Chapter 7a. This version will form the basis for further consultation and research.

The importance of carer experience. As mentioned previously, there was a convergence of views regarding ways to improve the MAPS, suggested by clinicians in Study 2, and carers in Study 1. Similar to carers in Study 1, clinicians in Study 2 suggested more explicit recognition of contextual factors that impact caregiving capacity and experience. Three key areas recommended for amendment included socio-economic strains, strains within the carer's own family (namely the contribution of biological children with regard to placement stability), and the working alliance between the carer and their care agency and support provided. Each of these factors, in addition to others mentioned throughout this paper, will be refined in the next iteration of the MAPS. Moreover, further formal consultation with carers regarding the domains and specific items will be undertaken.

Clinician experience in child protection. Across consultations, clinicians were divided as to how much experience might be needed to effectively use the MAPS with families within a child protection context. Participating clinicians who had worked for less than one year were largely in agreement with more experienced participants. Those who did not have as much experience working therapeutically with families, where child maltreatment had occurred, generally had prior experience working either within child protection in a case management role or therapeutically with families. Prior research has also attested that workers of variable experience and different professional backgrounds can nevertheless provide similar assessments and intervention recommendations for families at-risk (Darlington, Healy, & Feeney, 2009) and, if a tool is to be widely implemented, this needs to be the case. The current study indicates that some experience in working with families, even if not 'at-risk', is sufficient alongside an understanding of key indicators of abuse and neglect, for using the MAPS assessment tool.

Although the majority of clinicians supported the use of the MAPS in practice, some raised concerns about using assessment measures in principle. Given the historical lack of standardised assessment processes and tools within specialist child protection therapy services (Thomas et al., 2011), these concerns warrant attention. The issues raised by clinicians included the view that formal assessment was separate from client experience and that the assessment process may divert attention away from, and delay, actual intervention: "*I have a concern that we are 'psychometricising' our clients",* and "*I think measuring outcomes can be useful so long as it does not take over from therapeutic intervention, particularly in child protection as children/ families are waiting so long for therapeutic input".* Understanding how these views have developed and what experiences may underlie them was beyond the scope of this study. The capacity to respond to these concerns is thus limited.

Child protection specialist counselling services are mandated to implement an assessment prior to intervention. Basic aims of this assessment are to identify the effects of child maltreatment and barriers to engagement and behaviour change, in order to set focused therapeutic goals, provide appropriate interventions, and monitor ongoing safety (Department of Health, 2010). In this regard, assessment in child protection, at least in part, is directive and is guided by pre-determined ideas and values (i.e. child protection history). It is true that such assessments may divert or delay intervention in child protection counselling, but this is not necessarily a problem if it ensures a more appropriately targeted intervention, including abuse prevention. For instance, assessment may result in closure (and thus incomplete intervention) when the family or members are unwilling or unable to make progress towards the agreed to goals, if children are removed, or the child protection risks escalate to the degree that they cannot be managed or addressed by counselling services (Coates & Howe, 2016). Arguably, clinicians

who choose not to use structured assessment protocols and/ or standardised measures are still making judgments about client problems and potential solutions, prior to engaging in intervention. Assessment in this case is implicit and less open to discussion and scrutiny. Conversely, assessment using the MAPS is explicit, as it outlines what information is being privileged and is thus open to critical evaluation and analysis by peers and supervisors.

Carer responses in Study 1 provided insight into their unique experiences with agency staff and highlight the importance of also acknowledging their voices in both research and assessment. Carers identified factors pertinent to their caregiving experience and ability to maintain placements which are not always considered in research on placement stability. These findings suggest that the MAPS tool could be further refined, by more direct consultation with carers and parents, specifically around assessment areas important to child and family well-being.

Summary and Clinical Implications

Foster and kin carers help protect children at-risk from further harm and, in the best of circumstances, develop a loving, secure and lifelong relationship with the child in their care. Carers also carry a significant social burden, in that they bear witness to and directly support children in their recovery from wide ranging socio-emotional, behavioural and physical impacts of interpersonal trauma.

Age, burgeoning health problems, disability and multiple care roles are realities for some carers, over and above their responsibilities for children with complex needs, and these contextual realities have significant implications on their perceived ability to maintain care of children placed with them. Partner and family support enhances the caregiver experience, while a poor working alliance with the care agency appears to negatively impact carer satisfaction and

willingness to maintain caregiving. Importantly, Study 1 highlights the need to continue to include child, carer, and contextual factors in future studies of placement stability. Furthermore, Study 1 suggests that measures assessing both child and carer attachment representations, and reciprocal interpersonal behaviours, would enable closer examination of the dynamics which may serve to strengthen or undermine placement security.

These findings have clinical implications for clinicians working in the OOHC and child protection field. While optimal matching between child needs and carer capacity is ideal, it is not always achievable. Given the importance of placement stability for children following maltreatment, attention to reducing strain and increasing supports is essential. For carers who identify age and/ or health-related problems, this may mean accessing home care services to alleviate some of the daily home duties, which increase carer strain and hinder their ability to 'keep up' with children in their care. Services and programs that provide respite, such as extra-curricular programs, camps or formalised respite care, should be a standard option, especially for carers with identified age and health-related problems. Mentoring programs for children and young people can also help alleviate some carer strain, while ensuring benefits to the child. Physically aggressive child behaviours were a key concern for older carers in Study 1 and there may be a service gap between the clinical needs of children in care and their families, and what is actually being provided. Families of children in OOHC may simply need more intensive therapeutic intervention, additional therapies and/ or longer term interventions, than what might be expected of families of children without maltreatment backgrounds (Coates & Howe, 2016). There also appears to be a gap between children's need for, and carers ability to finance, specialist health and therapeutic services.

Also important is the quality of the working relationship and alliance between the carer and their care agency. Prior research has indicated that children want to feel secure, supported and accepted by their caregivers. In parallel, caregivers need to feel safe, cared for, heard, respected and validated by their caseworker. Services can better assist children by being aware of the potential consequence of their relationship with carers, and by committing to developing and enhancing positive, respectful and collaborative relationships with clients (Shulman, 2006).

It is widely accepted that transparency with families within the child protection field, with regards to assessment and judgements of safety and risk, are fundamental to fostering therapeutic engagement (Ivec, 2013). Unlike many child and family assessments which look at specific areas of functioning or well-being, the MAPS is not a measure to be directly administered to, or filled in by families. However, families' awareness of what is entailed in assessment and intervention, what factors of their individual, family or social functioning are considered important in the contribution to child maltreatment and/or safety would be expected to be iterated as part of a collaborative work practice (Ivec, 2013). In addition, the clinical judgements and formulations which arise from the tool should, as part of responsible practice, be clearly shared with, open to critical analysis and reviewed by families, regularly (Department of Health, 2010b). Thus, while families would not be directly exposed to MAPS tool, transparency in assessment and formulation would be expected to be maintained with families throughout the engagement process.

Therapeutic assessment and intervention of whole-of-family needs, especially in relation to partner support, parenting alliance, relationship formation and family cohesion, appear fundamental for children and their families in the child protection intervention field. Both research and assessment of carer and/ or child factors in isolation will likely miss problems and

solutions central to the long term well-being of children and young people following maltreatment.

The MAPS is a potentially useful tool to aid clinicians in undertaking a broad and holistic assessment of factors related to child and family well-being following maltreatment. It offers a structured assessment frame which can be readily implemented in current child protection counselling service processes and reviews, and is consistent with current health policy directives. Ways in which the tool could be further improved and evaluated are discussed below.

Strengths and Limitations

A key strength of Study 1 was the inclusion of both child- and carer-related and contextual factors in the investigation of placement stability and caregiver satisfaction. The use of standardised measures to assess child and carer-related factors is also a strength, as prior placement stability studies have often relied on non-standardised and/ or caseworker perceptions. Additionally, providing opportunities for more open-ended comments from carers provided a rich insight into factors, some not considered in the current or prior research, that may influence the stability of care and well-being for children.

There are however significant limitations. The sample in Study 1 was small and this limits the generalisability of findings to the foster and kinship carer population. Despite recruiting actively for over a year, with a range of co-operating agencies, only a small number of carers decided to participate. In consultation with a governing foster care body, an online survey format was utilised, to allow carers to participate in their own time. Also, as recommended by a governing foster care body, a financial incentive was offered by way of entry into a draw for a gift voucher. Carer recruitment to research is often difficult (Jackson, Gabrielli, Tunno, &

Hambrick, 2012). Given the financial and time pressures faced by carers, the provision of financial remuneration to all participants may encourage carer engagement. Additionally, in negotiating the procedure for the study, it was recommended by a governing foster care body that foster care agencies contact carers about the study, through newsletters and e-mail. Although confidentiality about the study was explicit in information provided, it may be that some carers, who were not happy with their agency, were concerned about what access the agency had to their data. Prior research indicates that a face-to-face contact approach with carers, at the point of recruitment, is more successful (Jackson et al., 2012). A larger sample would provide a greater representation of carers and their care experiences. The small sample size was also limiting with respect to variability among some of the independent variables of interest – particularly child externalising behaviour problems.

The measure developed for the study of carer perception of their ability to maintain the care of a given child was used as the outcome indicator of placement stability. In practice, carer perception of placement instability is a key risk factor, warranting timely service response. However, it is unclear if carer doubts about the placement would necessarily lead to breakdown and/ or within what time frame. The reliance on exclusively self-report measures is a major limitation. Carers may potentially positively report, and research indicates that assessment of parenting styles is more reliably achieved through observation (Arney, 2004).

A third major limitation is the cross-sectional design of the study. A longitudinal design would help elucidate the relationship between carer perceptions of likely breakdown and actual breakdown. Moreover, longitudinal analysis would better assess the likely complex interplay (direct and indirect relationships) among child, carer and contextual factors over time, and their separate and cumulative impact on placement stability.

A key strength of Study 2 was the use of action research in the development of a tool for clinicians. This is likely to add to the clinical validity of the tool. Limitations include the small number of participants and the use of vignettes to assess reliability. Both these shortfalls were due to difficulties in engaging specialist services in a formal study of an assessment tool. The commonly cited problem for each specialist workplace approached was the lack of time available. Work place pressure also led services to shorten the previously allocated amount of time (full day to half a day), which resulted in fewer vignettes being assessed and, therefore, less inter-rater data. This problem, however, may in part reflect a general tension between the 'assessing' and 'doing' part of therapeutic intervention within a child protection context (Thomas et al., 2011). An additional shortcoming was the lack of direct carer consultation in the initial development of the tool. Although this is a clinician-rating tool, Study 1 highlights the importance of including carer perspectives in the construction of knowledge of child and family needs in the OOHC system. Similarly, children and young people were not included in either study. Their views on factors influencing placement stability and what might be important in assessment are important, but absent in the current research.

Future Research

Ideally, a longitudinal design with a large sample of both carers, children and young people would greatly enhance the ability to assess factors associated with placement stability over time. Consideration of child, carer and contextual factors (including family and system supports and strains) is essential. The MAPS requires further research to aid development. Following refinement, further inter-rater reliability study, on the application of the MAPS to the assessment of real life families, is warranted to establish validity. Inter-rater reliability could be assessed between therapy dyads, such as co-therapists for a given family and/ or between

clinicians and their clinical supervisors. Correspondingly, convergent validity could be assessed by comparing MAPS ratings with measures assessing similar discrete domains, such as those assessing child behaviour and social functioning, parenting behaviours, and indices of working alliance. Predictive validity could be assessed by comparing MAPS ratings with a variety of outcomes, including therapeutic engagement of caregivers, absence or recurrence of child maltreatment, school engagement/ performance/ attendance, child removal and/ or placement breakdown.

The inclusion of carers and children and young people in research, assessment and intervention is crucial. Whilst children are at the heart of the child protection system, they are much less likely to be included in research, or have their views on supports sought (McDowell, 2016). However, it would be illuminating to hear what children and young people say about what helps them to manage the impacts of trauma, to recover and enable them to experience the joys and tasks of childhood across their home, school and social contexts. Children and young people's views on what they think makes good family contact, or what turns a 'placement' into an experience of family where they feel loved, secure and belonging, should hold a firm place in future research.

Health
Western Sydney
Local Health District

Multi-Systemic Assessment of Psychosocial Safety: MAPS.

Terminology
CYP = Child or young person
Parent = birth parent
Carer = Foster or Kin carer
Primary Carer= Refers to who is responsible for day to day care of child (i.e. birth parent, foster or kin carer).
CYP = Child or young person
UK = Unknown

MAPS Domain 1: Child Health & Psychosocial Functioning (6-16yrs)

Consider the child or young person's functioning in the last 6 months.

	1	2	3	4	5	6	
	Problems with phsyical or mental health, self-care or interpersonal behaviours pose a serious risk to (2) or have caused harm (1) to child safety & well-being well-being.		**Problems with phsyical or mental health, self-care or interpersonal behaviours impact child's engagement in interests & activities. (Rank as 3 if problems > 6 months).**		**Phsyical or mental health problems are good or well-mananged (6), or adequately managed (5), and child displays adequate self-care & engagement in interests & activities.**		
Assessment Items	**The child or young person (CYP):**						**UK**
Health	☐ AND/OR Carer poorly understand or mismanage physical or mental health problems in ways that worsen problems, prevent developmentally- expected learning or recovery. CYP has caused harm to self or others (e.g. people / animals).	☐ Poorly understands & manages physical or mental health problems and/or Carer inadequately supports needs. Problems present a significant risk to self or others.	☐ Insufficiently manages physical or mental problems (e.g. rejects help) OR Carer does not sufficiently access necessary supports OR problems are adequately managed but still present a risk to self or others.	☐ Has minor physical or mental health problems that are adequately understood, managed & supported by Carer (e.g. uses relevant strategies/ accesses medical/psychosocial support). Problems do not cause risk to self or others.	☐ Has good physical & mental health OR minor problems are well understood, managed & supported by Carer (e.g. uses relevant strategies/accesses medical/ psychosocial supports). Problems do not significantly impact daily function.		☐
Self-Care	☐ Displays self-care significantly below developmental expectations OR risk-taking behaviours. Presents immediate risk to self or others.	☐ Displays self-care significantly below developmental expectations OR risk taking behaviours OR a lack of basic protective behaviours. Presents significant risk to self or others.	☐ Has problems with developmentally appropriate self-care and/or limited protective behaviours that present some risk to self or others.	☐ More often than not displays develop mentally appropriate self-care (hygiene/ coping skills) AND a sense of safety for self & others.	☐ Displays developmentally appropriate self-care (e.g. hygiene, coping skills) AND a sense of safety for self & others.		☐
Social	☐ Lacks positive connection or attachments with peers or adults outside of school. Lacks developmentally expected empathy for others (people/ animals) or respect of others' rights.	☐ Displays social or behaviour problems with peers AND/OR adults outside of school which significantly impacts involvement in extra-curricular activities AND/OR family outings.	☐ Displays social or behaviour problems with peers AND/OR adults outside of school & somewhat impacts involvement in extra-curricular activities AND/OR family outings.	☐ Has good relationships with peers & adults outside of school or problems do not impact participation in extra-curricular activities or family outings.	☐ Has numerous positive relationships with peers & adults outside of school, developmentally appropriate engagement with friends, interests or hobbies. Displays age-appropriate empathy for & awareness of other's rights.		☐
Sense of Self	☐ Has a negative, entitled sense of self/ lack of, or over-inflated confidence in abilities or rejects/ refuses many developmentally-appropriate tasks & responsibilities even with positive incentive, prompting or coaching.	☐ Has a negative sense of self or confidence & ability to perform many developmentally appropriate tasks & responsibilities even with positive prompting, coaching or incentives.	☐ Lacks positive sense of self or confidence & ability to perform many developmentally appropriate tasks & responsibilities without significant prompting/ supervision.	☐ More often than not has a positive sense of self, confidence & ability to perform developmentally appropriate tasks & responsibilities though may require intermittent coaching.	☐ Has a positive sense of self, confidence & ability to perform developmentally appropriate tasks and responsibilities.		☐

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MAPS Domain 2: Educational Engagement & Functioning

Consider the child or young person's functioning in the last 6 months

	1	2	3 4	5	6	
	Problems with school engagement, social behaviour and/or Carer-School alliance significantly impact learning outcomes (2) and/or or pose serious concerns for school placement (1).		**Problems with school engagement, social behaviour and/or Carer-School alliance evident. Overall, problems impact learning outcomes. (Rank as 3 if problems > 6 months).**	**Good school engagement, social behaviour and carer-school alliance (6), or minor problems (5) evident. Overall, child is meeting or exceeding developmental expectations.**		
Assessment Items	**The child or young person:**					**UK**
Attendance	☐ School refuses/ often absconds. Very poor school attendance..	☐ Has poor attendance and/or regularly absconds.	☐ Has had numerous absentee days (which has disrupted learning) OR has absconded numerous times.	☐ Willingly attends school OR absenteeism has been minimal.	☐ Willingly attends school & has good attendance.	☐
Attitude	☐ Rejects or is hostile towards school. If in high school, has unrealistic or negative goals for future education career/job.	☐ Dislikes or has a negative view of school. If in high school, lacks developmentally appropriate goals, unrealistic goals for future education / career/job.	☐ Is ambivalent towards or poorly views school. If in high school, lacks a positive view or realistic goals for future education/ career/job.	☐ Generally enjoys school activities & looks forward to school events. If in high school, has positive view of future at school or realistic goals for future education/career/job.	☐ Enjoys most school activities, (home work/ excursions) & looks forward to school events. If in high school, has positive view of future at school or developmentally appropriate realistic goals for future education /career/job.	☐
Social	☐ Has significant social problems (e.g. no friends/ victimises others or is violent) AND/OR problems with authority figures that HAS led to actual suspensions/ alternate school placement.	☐ Has significant social problems (e.g. no friends/is victimised or victimises) and/or problems with authority figures that has led to numerous conflicts, disciplinary actions and/or threatened suspensions.	☐ Has significant social problems with peers or teachers that has led to conflict, isolation, stress to child or disrupted learning.	☐ Has minor social problems (e.g. making/keeping friends, being accepted by peers OR difficulties with teachers) that do not cause significant stress or disruption to learning.	☐ Has developmentally appropriate number of stable friendships AND positive relationships with teachers.	☐
Performance	☐ Is performing objectively below (3-4yrs) developmental & cognitive capacity across most or all school subjects.	☐ Is performing objectively below (3-4years) developmental & cognitive capacity in a number of school subjects.	☐ Is performing objectively below (at least 2yrs) developmental & cognitive capacity in a number of school subjects.	☐ Generally meets or approaches developmental & cognitive capacity in school work. Any academic problems are being addressed & progress expected.	☐ Exceeds, meets or closely approaches developmental & cognitive capacity for most or all school subjects.	☐
Carer/ School Alliance	☐ There is a negative/ hostile School-Carer relationship (e.g. hostility, blaming, aggression, lack of insight & planning around CYP's needs) which maintains CYP's disengagement from school.	☐ There is poor School-Carer alliance (e.g. negative/blaming interactions or lack of communication, poor insight into & or planning to meet CYP's needs) significantly impacting problem resolution.	☐ The Carer & school have a strained alliance or inadequate communication however there is a willingness to collaborate & resolve issues.	☐ The Carer & school share adequate communication & working alliance that facilitates CYP needs.	☐ The Carer & school share a positive, collaborative relationship (e.g. good communication, insight into CYP's needs, effective strategies, and home-school alliance).	☐

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MAPS Domain 3: Primary Carer Health & Psychosocial Functioning

Consider the Primary Care giver's functioning in the last 6 months.

	1 2	3 4	5 6	
	Problems with physical or mental health, self-care or interpersonal behaviours pose a serious risk to (2) or <u>have</u> resulted in harm or significant neglect of CYP or harm to self (1).	**Problems with physical or mental health, self-care or interpersonal behaviours somewhat impact parenting and may present a risk to well-being to CYP or self. (Rank as 3 if problems > 6 months).**	**Physical, mental health, self-care or interpersonal behaviours are good or well-managed (6), or minor problems evident (5). Overall protective and proactive parenting skills are consistently evident.**	
Assessment Items	**The Primary Carer:**			**UK**
Health	☐ Poorly manages physical and/or mental health problems or there is insufficient social/ medical support. Problems severely impact daily function or result in neglectful/ abusive parenting Demonstrated risk to CYP or self. ☐ Inadequately manages physical and/ or mental health problems or there is insufficient social/medical support. Problems significantly impact daily function or result in inappropriate/ negative parenting strategies. Presents a clear risk to welfare or well-being of CYP or self.	☐ Inadequately manages their physical and/or mental health problems or there is insufficient social/medical support. Problems regularly impact daily function or ability to maintain effective parenting. May present a risk to welfare/ well-being of CYP or self.	☐ Manages current physical and/or mental health problems. Problems do not cause major deterioration to parenting or risk to welfare/well-being of CYP or self. ☐ Has good physical and mental health or problems are understood and well managed (e.g. Carer displays insight into problems/ accesses necessary & available medical/ psychosocial support/ has appropriate management plan for recurrent or severe problems). Parenting capacity is good and stable.	☐
Coping Skills	☐ Demonstrates poor coping skills (e.g. avoidance, denial, substance use, gambling,) or persistently lacks foresight to plan for personal & parenting challenges AND does not access necessary social or professional help as needed. ☐ Demonstrates poor coping skills (e.g. avoidance, denial, substance use, gambling,) or shows limited foresight to plan for personal & parenting challenges and/or limited ability to access social or professional help when needed.	☐ Demonstrates limited coping skills and/ or insight which results in difficulty anticipating & planning for challenges or access help when needed.	☐ Demonstrates some positive coping skills and insight but may have occasional difficulty anticipating/ planning for challenges or in accessing help when necessary or may lack a care plan for recurrent problems. ☐ Demonstrates good foresight in anticipating own & CYP needs and good coping skills (e.g. good self-care, plans for challenges & accesses supports as necessary).	☐
Sense of Self	☐ Displays negative, inflated or unrealistic sense of parenting ability and/or engages in risky relationships (e.g. conflict/ victimisation/ violation with family, friends, neighbourhood or services/ involvement in risky or illegal sub-culture). ☐ Has a negative, inflated or unrealistic sense of parenting ability and/or experiences interpersonal difficulties (e.g. conflict/ victimisation with family, friends, neighbourhood or services) that interfere with positive change or presents a risk to CYP/self.	☐ Lacks a positive sense of self or parenting confidence and/or may have difficulty maintaining healthy interpersonal relationships.	☐ Generally displays positive sense of self and parenting confidence and maintains generally positive & healthy interpersonal relationships. ☐ Displays a positive sense of self/ parenting confidence and maintains healthy interpersonal relationships.	☐
Self-Care	☐ Engages in strategies that worsen physical/mental health and/or risky social networks incentive, prompting or coaching. ☐ Displays very limited self-care strategies and/or lacks stable & appropriate social network and/or engagement in positive or healthy activities/ hobby.	☐ Displays limited self-care strategies and/or limited positive social network and/or engagement in positive or healthy activities/ hobby.	☐ Displays some self-care, strategies and maintains positive social network or ongoing engagement in activities/ hobby. ☐ Consistently displays range of self-care strategies and maintains positive social network or regular engagement in activities/hobby.	☐

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MAPS Domain 4A: Alternate Placement Security & Safety

Consider the nature of the placement in the last 6 months.

	1	2	3	4	5	6	
	Problems with parenting style, insight or capacity pose serious concerns (2) or immediate and significant risks (1) to placement appropriateness or CYP's physical safety or well-being.		**Some concerns with parenting style, insight, capacity or carer alliance may present a risk to placement or CYP's well-being. (Rank as 3 if problems > 6 months).**		**Carer displays positive parenting style & good insight into CYP's needs (6), or minor difficulties evident & carer open to intervenion (5). Placement is secure.**		
Assessment Items	**The Carer:**						**UK**
Relationship Quality	☐ Demonstrates negative relationship with CYP.	☐ Demonstrates major relationship strain with CYP.	☐ Has a strained relationship with CYP.		☐ And CYP generally share a mutually positive relationship.	☐ And CYP share a mutually positive relationship.	☐
Interactions	☐ Has significant difficulty interacting with CYP (e.g. dismisses, demeans, overt frustration/anger towards CYP) or in understanding CYP needs (persistently rejects/cannot assume CYP's perspective).	☐ Has significant difficulty interacting with CYP (e.g. lacks warmth, patience) and/ or in understanding or responding to CYP's feelings & behaviour (e.g. dismisses, belittles, is overwhelmed by).	☐ Has some difficulty initiating attachment forming & reinforcing behaviours and/or in helping CYP understand & organise their day-today experiences & feelings.		☐ Regularly displays attachment behaviours (e.g. verbal/ physical affection, warmth, play, emotion coaching), regardless of CYP responses.	☐ Often displays attachment forming & reinforcing behaviours (e.g. verbal/ physical affection, warmth, play, emotion coaching).	☐
Parenting Style	☐ Displays significant negative or harmful parenting (e.g. aggression, inadequate supervision, physical discipline, neglect) and/or domestic violence is evident, that present a clear & significant risk to CYP's well-being.	☐ Displays negative parenting responses (e.g. dismissive, over-reactive, passive) and/or couple conflict which impact CYP's emotional-behavioural development, exacerbates problems or presents a clear risk to their well-being.	☐ Displays inconsistent, reactive or passive parenting and/or inadequate parenting alliance (couples), which impacts the CYP's emotional regulation/ problem-solving skills, maintains problems or presents a risk to CYP's well-being over time.		☐ Experiences some parenting stress but generally maintains authoritative parenting AND Carer couples display adequate parenting alliance.	☐ Flexibly responds to CYP's needs AND displays authoritative parenting most of the time AND Carer couples display good parenting alliance.	☐
Placement Stability	☐ Carer OR clinician has serious concerns regarding placement appropriateness or safety for CYP. Placement breakdown appears imminent.	☐ States or indicates placement instability OR clinician has significant concerns regarding placement appropriateness/ stability.	☐ States or indicates strains to placement stability (e.g. behavioural/concerns for foster/birth siblings in placement, financial, Carer health) OR Clinician has concerns for Carer(s) capacity to maintain placement.		☐ Is committed to maintaining placement (BOTH Carers in the instance of couples). Strains (e.g. behavioural, sibling conflict, financial, Carer health), do not threaten placement stability.	☐ Is happy with & committed to the placement (BOTH Carers in the instance of couples). No threats to placement stability on behalf of Carer.	☐
Trauma Support	☐ Rejects or inflates impact of trauma/ placement history and/or cannot distinguish CYP's trauma experiences & needs from own in ways which impede or prevent CYP's therapy or recovery.	☐ Dismisses or inflates impact of trauma/ placement history on CYP and/or has difficulty differentiating CYP's trauma experiences/needs from own or impedes external supports to CYP.	☐ Lacks insight into CYP's developmental needs and/or impact of trauma/ placement history on CYP AND/OR is resistant to developing insight/ skills.		☐ Has adequate insight into CYP's developmental needs, impact of trauma/ placement history or how to develop or support an appropriate narrative for the CYP or is willing to develop skills.	☐ Displays good insight into the developmental needs of CYP & impact of trauma/placement history AND are able to provide or reinforce an age-appropriate, positive narrative to CYP regarding being in care.	☐
Family/ Cultural Support	☐ Rejects, undermines or demeans CYP's birth family & cultural identity.	☐ Dismisses or undermines connections to birth family & cultural identity despite service intervention on matter.	☐ Inadequately supports or minimises CYP's connections to birth family/ cultural identity, despite service intervention on matter.		☐ Lacks knowledge on how to support CYP's connection to birth family & cultural identity but willing to.	☐ Actively supports CYP's connection to birth family & cultural identity (e.g. supports contact, displays family photos/keepsakes, engages with CYP around birth family stories).	☐

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MAPS Domain 4B: Birth Family Placement Security & Safety

Consider the nature of the placement in the last 6 months.

	1	2	3	4	5	6	
	Problems with parenting style, insight or capacity pose serious concerns (2) or immediate and significant risks (1) to placement appropriateness or CYP's physical safety or well-being.		**Some concerns with parenting style, insight, capacity or carer alliance may present a risk to placement or CYP's well-being. (Rank as 3 if problems > 6 months).**		**Parent displays positive parenting style & good insight into CYP's needs (6), or minor difficulties evident & parent is open to intervenion (5). Placement is secure.**		
Assessment Items	**The Parent**						**UK**
Relationship Quality	☐ Demonstrates negative relationship with CYP.	☐ Demonstrates major relationship strain with CYP.	☐ Has a strained relationship with CYP.		☐ AND CYP generally share a mutually positive relationship.	☐ AND CYP share a mutually positive relationship most of time.	☐
Interactions	☐ Has significant difficulty interacting with CYP (e.g. dismisses, demeans, overt frustration/anger towards CYP) AND in understanding CYP needs (persistently rejects/cannot assume CYP's perspective).	☐ Has significant difficulty interacting with CYP (e.g. lacks warmth, patience) or in understanding or responding to CYP's feelings & behaviour (e.g. dismisses, belittles).	☐ Has some difficulty initiating attachment forming & reinforcing behaviours and/or in helping CYP understand & organise their day-to-day experiences & feelings.		☐ Regularly displays attachment behaviours (e.g. verbal/ physical affection, warmth, play, emotion coaching), regardless of CYP responses.	☐ Often displays attachment forming & reinforcing behaviours (e.g. verbal/ physical affection, warmth, play, emotion coaching).	☐
Parenting Style	☐ Displays significant negative or harmful parenting (e.g. aggression, inadequate supervision, physical discipline, neglect) and/or domestic violence evident that present a clear & significant risk to CYP's well-being..	☐ Displays significant negative parenting responses (e.g. dismissive, over-reactive/ passive) and/or couple conflict that likely prevents CYP's emotional and behaviour development and presents a clear risk to their well-being.	☐ Displays inconsistent, reactive or passive parenting and/or inadequate parenting alliance (couples), which impacts the CYP's emotional regulation/ problem-solving skills, maintains problems OR presents a risk to CYP's well-being over time.		☐ Experiences some parenting stress but generally maintains authoritative parenting AND couples display adequate parenting alliance.	☐ Flexibly responds to CYP's needs AND displays authoritative parenting most of the time AND couples display good parenting alliance.	☐
Placement Stability	☐ Is often overwhelmed by CYP and/ or Parent OR clinicians have serious concerns regarding placement appropriateness or CYP's safety in placement.	☐ States or indicates placement instability OR clinician has significant concerns regarding placement appropriateness/ stability.	☐ States or indicates strains to placement stability (e.g. behavioural/concerns for foster/birth siblings in placement, financial, parent health) OR Clinician has concerns for parent(s) capacity to maintain placement.		☐ Is committed to ongoing care of CYP. Strains (e.g. behavioural, sibling conflict/ financial), do not threaten placement stability.	☐ Is committed to ongoing care of CYP (both parents in the case of couples).	☐
Trauma Support	☐ Rejects or inflates impact of trauma/ placement history and/or cannot distinguish CYP's trauma experiences & needs from own in ways which impede/ prevent CYP's therapy or recovery.	☐ Dismisses or inflates impact of trauma/ placement history and/or has difficulty differentiating CYP's trauma experiences & needs from own OR impedes external supports to CYP	☐ Lacks adequate insight into developmental needs of CYP & impact of trauma/placement history AND is resistant to developing insight or skills to support CYP.		☐ Has adequate insight into CYP's developmental needs & impact of trauma/ placement history OR willing to develop skills & support CYP.	☐ Displays good insight into developmental needs of CYP AND impact of trauma/ placement history on these AND takes responsibility to support trauma recovery	☐
Parental Responsibility	☐ Denies, rejects or shifts responsibility for maltreatment and/or demonstrates little or no behaviour change AND clinician has significant, concerns for CYP's immediate safety & well-being.	☐ Dismisses or denies responsibility for maltreatment and/or demonstrates little or inadequate behaviour change necessary to maintain safety & well-being for CYP.	☐ Lacks adequate responsibility for role in maltreatment and/or does not demonstrate adequate behaviour change in areas that resulted in maltreatment.		☐ Has adequate insight into & takes responsibility for role in maltreatment AND demonstrates some behaviour change in areas that resulted in maltreatment.	☐ Displays good insight into & takes responsibility for role in maltreatment, AND demonstrates significant behaviour change in areas that resulted in maltreatment.	☐

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MAPS Domain 5: Relationship Safety & Security with Birth Family

Consider family dynamics during contact in the last 6 months.

	1	2	3	4	5	6	
	Problems with parenting style, response to child maltreatment or behaviour towards CYP, carers or services during contact pose serious concerns for (2) or have caused harm to CYP's physical safety or emotional well-being (1). Child may have some detrimental appraisals of prior maltreatment.		**Some concerns with parenting style, response to child maltreatment or behaviour towards CYP, carers or services during contact may present a risk to CYP's emotional well-being. Chils may have some unreaistic appraisals of prior maltreatment. (Rank as 3 if problems > 6 months).**		**Parenting style, response to child maltreatment and behaviour towards CYP, carers or services during contact is good (6) or adequate (5) during contact. Also, CYP has some realistic appraisal of maltreatment and placement history.**		
Assessment Items	**During contact, parent(s)/ kin:**						**UK**
Relationship Quality	☐ Display significantly concerning interactions with CYP (e.g. aggression/ threats to CYP, family or staff/sibling aggression OR CYP is distressed /acts out in ways that harm self, others or property).	☐ Display significantly concerning interactions with CYP (e.g. inappropriate/ destabilising messages given to CYP, family aggression, OR CYP acts out aggressively/ sexually but does not cause harm to self, others or property). Problems likely impact CYP's well-being.	☐ Display problematic interactions with CYP (e.g. unhelpful messages given to CYP, family conflict) but do not likely cause significant risk to CYP.		☐ Generally share a positive relationship with CYP.	☐ Share a mutual & mostly positive relationship with CYP during contact.	☐
Parenting Style	☐ Display harmful parenting (e.g. inadequate supervision, aggression, physical discipline, verbal abuse to CYP, family or services, medical neglect) in ways that would be expected to cause emotional or physical harm to CYP.	☐ Display negative/ harmful parenting (e.g. inadequate supervision, overt frustration,belittling) or poor emotion regulation.	☐ Have difficulties providing adequate attention, supervision, limit setting etc. to CYP during contact AND CYP not regularly supported by other adult kin or contact staff at these times.		☐ Display adequate parenting (e.g. supervision, limit setting) during contact periods OR CYP supported by other adult kin or contact staff at these times.	☐ Display positive parenting (e.g. warmth, limit setting, play) during contact periods.	☐
Parental Responsibility	☐ Expresses blame for removal on CYP, the system, or others directly to CYP.	☐ Provide detrimental explanation of removal/ reasons they are in care (e.g. inappropriately blame service/ deny responsibility, pressure CYP to return home).	☐ Are unable to provide CYP with adequate/ realistic narrative regarding maltreatment, or take responsibility AND minimise /dismiss narrative provided to CYP by services.		☐ Provide adequate narrative to CYP regarding maltreatment, take adequate responsibility for own role in maltreatment AND/OR support agencies providing narrative to CYP.	☐ Provide suitable, developmentally-appropriate narrative to CYP regarding maltreatment AND take responsibility for own role in maltreatment.	☐
Trauma Support	☐ Regularly expresses disagreement with or denial of past maltreatment issues directly to or in front of CYP.	☐ Openly dismiss/ deny impact of maltreatment on CYP to CYP or services at contact.	☐ Have inadequate insight into impact of maltreatment on CYP, but do not discuss at contact.		☐ Display adequate insight into impact of maltreatment on CYP.	☐ Display good insight into impact of maltreatment on CYP.	☐
Placement Support	☐ Demean, is hostile towards or openly challenges carers in front of CYP or encourages carer-child discord.	☐ Undermines CYP's relationship with alternate carers (e.g. hostility towards/ challenging of Carer's parenting/rules openly with CYP).	☐ Do not adequately support or dismiss CYP's relationship with alternate Carers.		☐ Generally support CYP's connections to alternate Carers OR do not dismiss or undermine these.	☐ Support CYP's connections to alternate carers (e.g. can positively discuss CYP's Carers & CYP's activities with them).	☐
Child's	☐ The CYP has an unrealistic appraisal of maltreatment/ placement history (e.g. blames self or carers, defends parents,blames , rejects or is hostile towards child protection agency workers.	☐ The CYP has unrealistic appraisal of maltreatment/placement history (e.g. blames self or carers defends parents blames services), which likely impacts mental health or relationship with carers.	☐ The CYP has some unrealistic appraisals of maltreatment and/or placement history which may negatively impact mental health or strain relationships with carers.		☐ The CYP has some realistic appraisal of maltreatment/placement history e.g. does not blame self carers or siblings).	☐ The CYP has a substantial, realistic appraisal of maltreatment/ placement history (e.g. perceives adults as responsible, does not blame self, carers or siblings, understands reasons for removal).	☐

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MAPS Domain 6: Primary Carer's Engagement, Support & Environment

Consider Primary Carer's demonstrated behaviours & support context during contact in the last 6 months.

	1	2	3	4	5	6	
	Problems with motivation, insight, behaviour change, supports or strains pose significant (2) or have caused risk of harm (1) to CYP.		**Some concerns with motivation, insight, behaviour change, support or strains may present risk to CYP's well being. (Rank as 3 if problems > 6 months).**		**Good motivation, insight, ability to proactively meet CYP's needs & available supports (6), or minor problems are adequately managed (5).**		
Assessment Items	**The Primary Carer:**						**UK**
Parenting Skills	☐ Lacks adequate motivation AND sufficient responsibility or willingness to understand, prioritise & sufficiently manage CYP's needs which impacts OR presents a significant risk to, CYP's safety.	☐ Lacks adequate motivation and/or responsibility to understand, prioritise or sufficiently addressing CYP's needs which likely impacts CYP's well being.	☐ Demonstrates limited motivation and/or responsibility to understand, prioritise or manage CYP's needs in a timely way.		☐ Demonstrates good motivation to understand CYP's needs AND generally prioritises & manages important needs in an effective & timely way.	☐ Demonstrates high motivation to understand CYP's needs AND consistently prioritises & manages those needs in an effective & timely way.	☐
Reflectivity & Change	☐ Lacks cognitive or emotional capacity to self-reflect AND implement learning to change parenting behaviour.	☐ Lacks adequate cognitive or emotional capacity to effectively self-reflect and/or apply learning to make change parenting behaviour.	☐ Demonstrates limits to cognitive or emotional capacity to self-reflect and/ or apply learning to make necessary behaviour change.		☐ Demonstrates good cognitive & emotional capacity to self-reflect, apply learning AND is able to make necessary behaviour change.	☐ Demonstrates high cognitive & emotional capacity to self-reflect and/ or apply learning to make necessary behaviour change.	☐
Help-Seeking	☐ Rejects or avoids or denies need for services to address key needs of CYP and/or often is negative /hostile to services, which prevents necessary help to CYP.	☐ Rejects or does not adequately access services to address key needs of CYP and/or regularly develops negative relationships with services.	☐ Does not adequately access services to address key needs of CYP and/or Primary Carer has difficulty developing effective working alliance with services.		☐ Accesses services to address key needs of CYP AND develops an adequate working alliance with services.	☐ Accesses available services to address needs of CYP AND develops a good working alliance with services.	☐
Supports	☐ Has significantly limited supports (e.g. family, friends, religious or interest groups) AND does not access available services which likely impairs parenting.	☐ Has significantly limited supports (e.g. family, friends, religious or interest groups) OR does not access available services which likely impairs parenting.	☐ Has limited social supports OR doesn't access available services which likely increase parenting stress.		☐ Has an adequate support network (e.g. services, family, friends, religious or interest groups) AND accesses these when strained.	☐ Has a good support network available (e.g. services, family, friends, religious or interest groups) AND anticipates own needs & accesses supports ahead of time or as needed.	☐
Accessibility	☐ Nil/limited services available/ accessible to meet CYP's significant medical & developmental needs & significantly impacts CYP's safety.	☐ Nil / limited services available/ accessible to meet CYP's significant medical & developmental needs & significantly impacts CYP's daily functioning.	☐ Limited services are available/accessible to meet CYP's significant medical & developmental needs.		☐ Adequate services are available/ accessible to meet CYP's significant medical & developmental needs.	☐ Services are available/accessible to meet CYP's significant medical & developmental needs.	☐
Psychosocial Strains	☐ Significant psychosocial strains (e.g. housing/ finances/ legal/ neighbourhood conflict) are exacerbated by Primary Carer AND impact parenting & present a demonstrated risk to CYP safety.	☐ Significant psychosocial strains (e.g. housing/ finances/ legal/ neighbourhood conflict) are, in part, exacerbated by Primary Carer AND/OR impact parenting & present a clear risk to CYP safety, well being.	☐ Significant socio-economic strains (e.g. housing/ finances/ legal/ neighbourhood conflict) AND impact parenting OR are poorly managed/ exacerbated by Primary Carer.		☐ Some socio-economic strains (e.g. housing/finances/legal/neighbourhood conflict) but do not impact parenting & are managed well by Primary Carer.	☐ No or low socio-economic strains (e.g. housing/finances/legal/neighbourhood conflict) OR low strains are well managed by Primary Carer.	☐

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MAPS Domain 7: Systemic Alliance & Support.

Consider the working relationship in the last 6 months

	1	2	3	4	5	6	
	Overall, problems with case management, knowledge of CYP & family needs, may lead to increased risk (2), or has directly impacted the safety of the CYP (1). Significant problems with working reationship between Care agency, services & family is evident.		**Overall, case management, knowledge of CYP & family needs is adequate. Working alliance & communication between Care agency, services & family is adequate. (Rank as 3 if problems are near, but don't meet rank of 2).**		**Overall, Care agency has a comprehensive knowledge of the CYP & family needs & optimises the safety, welfare & well-being of CYP. Working alliance & communication between Care agency, services & family is effective.**		
Assessment Items	**The Care Agency:**						**UK**
Case Management	☐ Lacks capacity to meet case management responsibilities; e.g. Necessary meetings/ reviews not held, case unallocated to degree that risks are not addressed and may be exacerbated.	☐ Has limited capacity to meet case management responsibilities; e.g. attend meetings, case allocation, develop case plans so that risks to safety, welfare & well-being of CYP (including in relation to contact) are unresolved or continue to escalate.	☐ Generally meets the necessary case management responsibilities; e.g. attends meetings, allocates worker to family so that case plans address risks to CYP in a timely manner, including issues relating to contact.		☐ Meets case management responsibilities; e.g. attends & manages meetings, allocates worker to family so that clear case plans are achieved.	☐ Meets case management responsibilities to a high degree; e.g. attends & manages meetings, allocates worker to family so that relevant & clear case plans are achieved	☐
Response	☐ Demonstrates difficulties responding to issues impacting safety or well-being of CYP AND which has resulted in significant risk of harm to CYP (e.g. repeated assault/ exposure to domestic violence). ,	☐ Demonstrates difficulties responding to issues impacting safety or well-being of CYP in a timely manner which leads to ongoing concern/ exposure to problems and increased risk of harm to CYP.	☐ Addresses basic issues which may impact CYP's safety and well-being or delays in responding do not cause significant risk to child.		☐ Addresses issues of CYP's safety & well-being generally within adequate time-frames, including organising & responding to contact needs.	☐ Addresses issues of CYP's safety & well-being in a timely manner, including organising and responding to contact needs.	☐
Knowledge of Child	☐ Lacks adequate knowledge of CYP's child protection history & psychosocial needs.	☐ Has limited knowledge of CYP's history or understanding of CYP psychosocial needs.	☐ Has adequate knowledge of CYP's child protection history & psychosocial needs.		☐ Has good knowledge of CYP's child protection history & psychosocial needs.	☐ Has comprehensive knowledge of CYP's child protection history & CYP's psychosocial needs.	☐
Communication	☐ Withholds basic communication with parents or cares to the degree that impacts working relationship.	☐ Does not maintain sufficient communication with parents or carers and/or attempt to resolve communication problems.	☐ Maintains necessary & timely communication with parents & carers. Attempts to resolve communication problems.		☐ Maintains generally clear & timely communication with parents & carers.	☐ Maintains very clear & timely communication with parents & carers.	☐
Working Alliance	☐ There is an ineffectual working alliance between Care agency, services & family which directly impacts appropriate effective case planning/ interventions.	☐ There is a poor working alliance between Care agency, services & family (e.g. role confusion)which may effect case planning.	☐ There is an adequate working alliance between Care agency, services & family Issues (e.g. role confusion/ responsibilities are adequately resolved).		☐ There is a good, respectful working alliance between Care agency, services & family.	☐ There is a very positive respectful working alliance between Care agency, services. & family.	☐

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Health
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MAPS Profile and Clinical Planning Tool.

1. Child Well-being	☐	☐	☐	☐	☐	☐
2. Educational functioning	☐	☐	☐	☐	☐	☐
3. Caregiver Well-being	☐	☐	☐	☐	☐	☐
4A. Placement safety OR	☐	☐	☐	☐	☐	☐
4B. Birth Family safety	☐	☐	☐	☐	☐	☐
5. Family Relationship	☐	☐	☐	☐	☐	☐
6. Caregiver Engagement	☐	☐	☐	☐	☐	☐
7. Systemic Support	☐	☐	☐	☐	☐	☐
	Immediate Risk	**Significant Risk**	**Moderate Risk >3 mths**	**Moderate Risk**	**Low Risk**	**Strengths/ Low Risk**

Any domains within the Immediate or Significant Risk category:

- Is a child-at-risk report required? Consult Mandatory Reporter Guide; MRG and Clinical Senior/ Lead or Service Manager.
- Ensure concerns are raised with the family or document why you have not done so. E.g. Will this place child at risk?
- Ensure concerns are communicated to FaCS or relevant Foster Care Agency? Consider Case Review Meeting or Worker's Meeting.
- Is greater interagency collaboration required to resolve problems identified? Is there interagency disagreement/ role confusion. Consider a Worker's Meeting.
- Is a review of the CPCS assessment, formulation and counselling plan to date required? Has family made adequate changes to ensure safety of children? Is there adequate safety for therapeutic intervention? Are key psychosocial needs met e.g. housing, access to health care, sufficient mental health treatment, neighbourhood safety? Are parents/ carers motivated/ engaged in change process?

Any domains within the Moderate (> 3 months) or Moderate Risk category:

- Discuss further with Clinical Senior/ Lead or Service Manager if family is not adequately addressing safety issues after 3 months CPCS intervention.
- Consider need to review family participation and engagement with counselling. Has the family been given an opportunity to provide feedback on counselling process/ ideas of progress? Are goals clear and agreed upon? Have barriers to change been sufficiently identified and considered in the counselling plan?
- Discuss concerns with FaCS or Foster Care Agency.
- Consider a review of the CPCS assessment, formulation and counselling plan to date.

Domains within the Low Risk category:

- Ensure that key changes, strengths and protective factors within family are explicitly identified with family, FaCS and Foster Care Agency.
- Focus on promoting child and family strengths into the future (i.e. Are there services, educational plans, activities, respite plans that could be put in place now to maintain support and promote family strengths post CPCS closure)?
- Ensure a clear counselling closure plan is developed with the family and key agencies.

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Health
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MAPS Counselling & Case Management Planning Sheet

Dated: _____ Counsellor(s): _____

Case Manager: _____

Specific strengths and risks identified	Key Goals (In consultation with family)	Key Interventions
Parents/ Caregiver(s) (list separately as needed):		

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Specific strengths and risks identified	Key Goals (In consultation with family)	Key Interventions
Child/ Young Person (list separately as needed):		

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MACQUARIE University

MIA MARKOVIC <mia.markovic@students.mq.edu.au>

Approved- Ethics application- McMahon (Ref No: 5201200456)

Ethics Secretariat <ethics.secretariat@mq.edu.au> Mon, Aug 13, 2012 at 11:36 AM
To: A/Prof Cathy McMahon <cathy.mcmahon@mq.edu.au>
Cc: Ms Mia Markovic <mia.markovic@students.mq.edu.au>

Dear A/Prof McMahon

Re: "Child and carer characteristics associated with foster/kin carer satisfaction and placement stability" (Ethics Ref: 5201200456)

Thank you for your recent correspondence. Your response has addressed the issues raised by the Human Research Ethics Committee and you may now commence your research.

This research meets the requirements of the National Statement on Ethical Conduct in Human Research (2007). The National Statement is available at the following web site:

http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf.

The following personnel are authorised to conduct this research:

A/Prof Cathy McMahon
Ms Mia Markovic

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).

2. Approval will be for a period of five (5) years subject to the provision of annual reports.

Progress Report 1 Due: 13 August 2013
Progress Report 2 Due: 13 August 2014
Progress Report 3 Due: 13 August 2015
Progress Report 4 Due: 13 August 2016
Final Report Due: 13 August 2017

NB. If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

3. If the project has run for more than five (5) years you cannot renew

approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. All amendments to the project must be reviewed and approved by the Committee before implementation. Please complete and submit a Request for Amendment Form available at the following website:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that affect the continued ethical acceptability of the project.

6. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University. This information is available at the following websites:

http://www.mq.edu.au/policy/

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/policy

If you will be applying for or have applied for internal or external funding for the above project it is your responsibility to provide the Macquarie University's Research Grants Management Assistant with a copy of this email as soon as possible. Internal and External funding agencies will not be informed that you have final approval for your project and funds will not be released until the Research Grants Management Assistant has received a copy of this email.

Please retain a copy of this email as this is your official notification of final ethics approval.

Yours sincerely
Dr Karolyn White
Director of Research Ethics
Chair, Human Research Ethics Committee

Department of Psychology
Faculty of Human Sciences
MACQUARIE UNIVERSITY NSW 2109

INFORMATION FORM TO FOSTER/ KIN CARE AGENCIES

Chief Investigator's / Supervisor's Name: Ms. Cathy McMahon; Associate Professor
cathy.mcmahon@psy.mq.edu.au Ph: 98506213
Co-Investigator's Name: Mia Markovic mia.markovic@students.mq.edu.au Ph: 0423362119
Name of Project: Child and Carer Characteristics associated with Foster/Kin Carer Satisfaction and Placement Stability.

To: [XXXX]
[Position: XXXX: / Service: XXXX],

Your agency is invited to support an online study of foster and kin carer placement stability being conducted by Mia Markovic, under the supervision of Associate Professor Cathy McMahon, Department of Psychology, Macquarie University. This research is being conducted to meet the requirements of Masters of Clinical Psychology for Mia Markovic.

As you would be aware, stability in out-of-home-care (OOHC) placements is essential in assisting children and young people to begin to recover from the impacts of abuse and neglect. Unfortunately, children and young people in OOHC are a vulnerable and at-risk group and often present with a range of needs that may impact their ability to form stable relationships with their foster/kin carers. Placement breakdowns can lead to further deterioration in the mental health of children and young people and as such, ongoing research into factors impacting placement stability within Australia is needed.

There are a number of factors identified in research to date that play a role in placement breakdowns. Children's externalizing (or aggressive/ acting out) behaviours has been identified as a clear risk for long-term placement stability. Sexualized behaviours, a common impact of early trauma, has not been investigated in relation to placement stability but studies have suggested that these are a problematic and potentially persistent behaviour for children in care. This research project aims to investigate how child emotional and behavioural problems, including sexualized behaviours, as well as foster and kin carer's parenting styles and experiences, influence the level of satisfaction foster and kin carers have and their view of placement stability.

A number of foster and kin carer agencies are being invited to support this study. Should your agency do so, you will be asked to forward information about the study to your network of foster and kin carers. An e-mail link and flyer will be provided to you to do this.
Given that foster/kin carers range in the level of support they access; the e-mail will also include a number of key support services that may be helpful for carers. Carers will also be able to contact the researcher directly should they have difficulties contacting support services or require further information. Both researchers are mandatory reporters and should researchers form concerns that a child or young person is at risk of significant harm, a helpline report may be made.
Foster and kin carers who read the information, and agree to participate, will be able to follow a link to the study questionnaire. The questionnaire will ask about child or adolescent behavioural factors, as well as carer parenting style, experiences, and their view on placement stability. **All information in this questionnaire is confidential - carers will not be required to provide any identifying information about themselves or the child in their care**. If you identify a carer who has problems with literacy and would like to take part in the study, they may contact the researcher Mia Markovic directly who can dictate the questionnaire by phone.

The questionnaire may take 30-40 minutes to complete and responses will be sent directly to the researcher to maintain confidentiality. For their time, all carers will be eligible to be in a draw for a number of $100 vouchers from a Woolworths or Franklins store. A summary of the findings of the study will be provided to all agencies that support this study.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.
Should you have any further queries on this study, please feel free to contact Mia Markovic directly on the contact details provided. Should you agree to support this study, please fill in the attached form which will be forwarded to the Macquarie University Research Ethics Committee.

Sincerely,

Mia Markovic
Registered Psychologist/ Masters of Clinical Psychology

Department of Psychology
Faculty of Human Sciences
MACQUARIE UNIVERSITY NSW 2109

LETTER OF SUPPORT:
Child and Carer Characteristics associated with Foster/Kin Carer Satisfaction and Placement Stability.
Chief Investigator's / Supervisor's Name: Ms. Cathy McMahon; Associate Professor
cathy.mcmahon@psy.mq.edu.au Ph: 98506213
Co-Investigators Name: Mia Markovic mia.markovic@students.mq.edu.au Ph: 0423362119

I _____, (_____)
Name Service Role/ Title

Of _____, _____,
Agency Name Address

Agree to support the above named research project. In supporting this study our service agreed to forward information about the study to our network of foster and/or kin carers.

I understand that:

- Foster/kin participation is voluntary and no identifying information will be collected and carers cannot be identified (except in the event that a carer contacts the researcher directly and provides this)
- That participating foster/kin carers or your agency can contact the Macquarie University Human Research Ethics Committee through the Director, Research Ethics (telephone (02) 9850 7854; email ethics@mq.edu.au), should a carer or your agency have any complaints or reservations about any ethical aspect of this research and that any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome
- That your agency will be provided with a summary of the study findings

Please e-mail this form to Mia Markovic through the contact details provided above.

Department of Psychology, Faculty of Human Sciences, MACQUARIE UNIVERSITY NSW
Mia Markovic mia.markovic@students.mq.edu.au Ph: 0423362119, Chief Investigator's / Supervisor's Name:
Ms. Cathy McMahon; Associate Professor cathy.mcmahon@psy.mq.edu.au Ph: 9850 6213

ARE YOU A FOSTER OR KIN CARER PROVIDING A MEDIUM TO LONG TERM PLACEMENT TO A CHILD AGED 6 – 12 YEARS?

You are invited to take part in an online study of foster and kin carer placement experiences. The purpose of the study is to learn more about some of the factors that may influence the long-term care of children in foster and kinship care.

The study is being conducted by Mia Markovic as part of a Doctor of Clinical Psychology program, under the supervision of Associate Professor Cathy McMahon of the Department of Psychology, Macquarie University.

If you decide to participate, you will be asked to complete an on-line survey which will ask about emotional, behavioural and sexualised problems your child may have as well as information about your parenting style and experiences. The survey may take 30-40 minutes, and for your time, you will be **eligible to be in a draw to win a $100 shopping voucher** at a major supermarket.

Any information gathered in the course of the study is confidential, except as required by law. Both researchers are required to make a report to the Family and Community Services Helpline if there are concerns that a child or young person is at risk of significant harm. **No individual will be identified in any publication of the results.** At any time you can request a summary of findings from Mia Markovic. Participation in this study is entirely voluntary; you are not obliged to participate and are free to withdraw at any time.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

To receive access to the survey just email Mia:
mia.markovic@students.mq.edu.au

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

ARE YOU A FOSTER OR KIN CARER PROVIDING A MEDIUM TO LONG TERM PLACEMENT TO A CHILD AGED 6 – 12 YEARS?

Providing stable, secure & long-term placements are essential and powerful experiences which assist children & young people's recovery from trauma as well as their long term mental health and well-being.

The study aims to identify factors which may stress placement stability & ways that agencies can better support carers and children and young people in out of home care. We consider how challenging child behaviour, carer parenting styles & supports influence carers' satisfaction & their views on placement stability.

You are invited to complete an on-line survey which may take 30-40 minutes. For your time, you will be eligible to be in a draw to win one of 10 $100 shopping voucher at a major supermarket.

To access more information and the link to the study please e-mail 'survey' to:

mia.markovic@students.mq.edu.au

If you prefer to do the survey over the phone please contact Mia on 0423362119.

Default Question Block

The purpose of this study is to learn about some of the factors that may influence the long-term care of children in foster or kinship care.

This study is being conducted by Mia Markovic (mia.markovic@students.mq.edu.au Ph: 0423362119), under the supervision of Associate Professor Cathy McMahon, Centre for Emotional Health, Department of Psychology, Macquarie University (cathy.mcmahon@mq.edu.au Ph: 9850 6213). This research is being conducted to meet requirements of a Doctor of Clinical Psychology for Mia Markovic.

The survey asks about emotional, behavioural and sexualized problems your child may have as well as information about your parenting style and experiences. The survey may take 20-30 minutes. At the end you can enter the draw to win a $100 shopping voucher.

Any information gathered in the course of the study is confidential, except as required by law. The survey is anonymous, however you may contact us if you wish to discuss any difficulties accessing the services listed at the end of the survey or about any concerns you may have. If you do contact us and if there are concerns that a child or young person is at risk of significant harm, the researchers will be required to make a report to the Family and Community Services Helpline.

Comments made by carers in the survey may be used for educational purposes but no individual will be identified in any publication of the results.

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics ((02) 9850 7854; or via email on ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Participation in this study is entirely voluntary; you are not obliged to participate and if you decide to participate, you are free to withdraw at any time.

Please tick one of the following:

- ○ I understand the information above and consent to participate in this study
- ○ I do not wish to participate in this study

As you progress please do not spend too much time on any one question - your first response is often the most useful. There may be times when you will just need to choose an answer that 'best fits' your experience. Sometimes people may miss a question. If this happens the computer will remind you to check all items before you move on.

The first set of questions ask about some of your background and training as a foster or kinship carer.

What is your gender?

Female ○ Male ○

What is your age in years?

what is your postcode

What country were you born in?

What ethnic background do you identify with?

- Indigenous Australian (Aboriginal or Torres Strait Islander)
- Anglo-Celtic
- European
- Asian
- Other

What is the highest educational qualification you have completed?

- Did not go to school
- Primary school
- Yr 7-8
- Yr 9 or equivalent
- Yr 10 or equivalent
- Yr 11 or equivalent
- Yr 12 or equivalent
- Trade certificate/ apprenticeship
- University Undergraduate Degree
- University Postgraduate Degree
- Other

Have you received any formal training through an agency (e.g. Family and Community Services or a Foster Care Agency) to become a foster or kinship carer?

- Yes
- No

Please describe what type of training you received to become a foster or kinship carer

What was the length of formal training you received?

- A few hours or 1-day training
- 10 - 20 hours
- 20 - 40 hours (up to 1 week)
- 40 - 80 hours (1-2 weeks)
- 80 - 120 hours (2 - 3 weeks)
- 3 or more full time weeks

How long in total have you been a foster or kinship carer?

- 6 months or less
- 6 months - 1 year
- 1-2 years
- 2-3 years
- 3-5 years
- 5-10 years
- Over 10 years

Do you also do paid or unpaid work outside the home?

- No
- Yes

How many hours do you work outside the home each week:

These next few questions help tell us about your foster child's background and his or her placement with you.

Please think of only ONE foster child in your care. If you have more than one, think of the child who you may have more difficulties with caring for or who you have the most concerns about.

What is the FIRST NAME ONLY of this child?

For this child are you a:

- Foster Carer
- Kinship Carer (family member)

What is your relation to this child:

- Grandparent
- Uncle/ Aunt
- Brother/ Sister
- Other

What is the age of this child in years?

What is this child's gender?

- Male
- Female

Is this child of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- I do not know or am unsure

What is the ethnic background of this child? If you do not know or are unsure, please write 'don't know' or 'unsure'.

How long has this child been in your care?

- 6 months or less
- 6 months - 1 year
- 1 - 2 years
- 2 - 3 years
- Over 3 years

Before coming into your care, how many other foster or kinship placements had this child had?

- None
- 1
- 2
- 3-5
- 6-9
- 10 or more
- I do not know or am unsure

How long had this child been in other placement(s) before coming into your care? Do not include respite care.

- Less than 3 months
- 3-6 months
- 6 months - 1 year
- 1-2 years
- 2-3 years
- More than 3 years
- I do not know or am unsure

Please show how many other children under 18 years of age are also living in your home:

- No other children under 18 years of age
- 1
- 2
- 3
- 4
- 5 or more

The next few questions ask about the levels of support you might have received in helping you to care for this specific child. Please just think about the support you have received for this child only, since they have been in your care.

Please click which is true for you

- I do not have a partner / spouse
- I have a partner /spouse

What level of support do you receive from your partner / spouse in caring for this child?

Low level of support ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ High Level of support

In the last 6 months, how often have you generally had contact face-to-face or by phone with the following services in relation to your care of this child:

	Weekly	Fortnightly	Monthly	Every 2-3 months	Once	None
Family and Community Services (FaCS or DoCS)	○	○	○	○	○	○
Foster Care Agency	○	○	○	○	○	○

Please tick any counselling or parenting support services **you** have received in relation to caring for this child (in addition to earlier training you may have taken). You can tick more than one option if you like.

- ☐ Individual counselling
- ☐ Parent-training or behaviour management support
- ☐ Family counselling
- ☐ Group Counselling (group work that you considered a type of therapy)
- ☐ Group work (such as education or extra training than any initial training you had to become a carer)
- ☐ Parent-Child therapy (e.g. play therapy or joint counselling with you and your child)
- ☐ Other
- ☐ I have not received counselling, extra training or formal parenting support to care for this child

Please add any comments you would like to about the level of support you receive in caring for this particular child.

Children in foster or kinship care may present with a range of needs and challenges. The next section asks in detail about social, emotional and behavioural problems your child may have inside and/or outside the home. These questions help us understand some of the specific challenges your family and child may be facing at this time.

In the following questions 'parent', refers to you, their foster or kinship carer.

Eyberg Child Behavior Inventory (Eyberg 1998,1999).

Below are a series of phrases that describe children's behaviour. Please click the option that best describes how often the behaviour occurs.

	Never			Sometimes			Always
Dawdles in getting dressed	○	○	○	○	○	○	○
Dawdles or lingers at mealtime	○	○	○	○	○	○	○
Has poor table manners	○	○	○	○	○	○	○
Refuses to eat food presented	○	○	○	○	○	○	○
Refuses to do chores when asked	○	○	○	○	○	○	○
Slow in getting ready for bed	○	○	○	○	○	○	○
Refuses to go to bed on time	○	○	○	○	○	○	○
Does not obey house rules on own	○	○	○	○	○	○	○
Refuses to obey until threatened with punishment	○	○	○	○	○	○	○
Acts defiant when told to do something	○	○	○	○	○	○	○
Argues with parents about rules	○	○	○	○	○	○	○
Gets angry when doesn't get own way	○	○	○	○	○	○	○
Has temper tantrums	○	○	○	○	○	○	○
Sasses (talks back) to adults	○	○	○	○	○	○	○
Whines (whinges)	○	○	○	○	○	○	○
Cries easily	○	○	○	○	○	○	○
Yells or screams	○	○	○	○	○	○	○

continued:

	Never			Sometimes			Always
Hits parents	○	○	○	○	○	○	○
Destroys toys and other objects	○	○	○	○	○	○	○
Is careless with toys and other objects	○	○	○	○	○	○	○
Steals	○	○	○	○	○	○	○
Lies	○	○	○	○	○	○	○
Teases or provokes other children	○	○	○	○	○	○	○
Verbally fights with friends own age	○	○	○	○	○	○	○
Verbally fights with sisters and brothers	○	○	○	○	○	○	○
Physically fights with friends own age	○	○	○	○	○	○	○
Physically fights with sisters and brothers	○	○	○	○	○	○	○
Constantly seeks attention	○	○	○	○	○	○	○
Interrupts	○	○	○	○	○	○	○
Is easily distracted	○	○	○	○	○	○	○
Has short attention span	○	○	○	○	○	○	○
Fails to finish tasks or projects	○	○	○	○	○	○	○
Has difficulty entertaining self alone	○	○	○	○	○	○	○
Has difficulty concentrating on one thing	○	○	○	○	○	○	○
Is overactive or restless	○	○	○	○	○	○	○
Wets the bed	○	○	○	○	○	○	○

The next section asks about some of the thoughts, feelings or experiences you may notice your child to have. Please click on the answer that best describes how often, to your knowledge, things happen for your child.

	Never	Sometimes	Often	Always
My child worries about things	○	○	○	○
My child feels sad or empty	○	○	○	○
When my child has a problem, he/she gets a funny feeling inside his/her stomach	○	○	○	○
My child worries when he/she thinks he/she has done poorly at something	○	○	○	○
My child feels afraid of being alone at home	○	○	○	○
Nothing is much fun for my child anymore	○	○	○	○
My child feels scared when taking a test	○	○	○	○
My child worries when he/she thinks someone is angry with him/her	○	○	○	○
My child worries about being away from me	○	○	○	○
My child is bothered by sad or silly thoughts or pictures in his/her mind	○	○	○	○
My child has trouble sleeping	○	○	○	○
My child worries about doing badly at school work	○	○	○	○
My child worries that something awful will happen to someone in the family	○	○	○	○
My child suddenly feels as if he/she can't breathe when there is no reason for this	○	○	○	○
My child has problems with his/her appetite	○	○	○	○
My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	○	○	○	○
My child feels scared to sleep on his/her own	○	○	○	○

continued:

	Never	Sometimes	Often	Always
My child has trouble going to school in the mornings because of feeling nervous or afraid	○	○	○	○
My child has no energy for things	○	○	○	○
My child worries about looking foolish	○	○	○	○
My child is tired a lot	○	○	○	○
My child worries that bad things will happen to him/her	○	○	○	○
My child can't seem to get bad or silly thoughts out of his/her head	○	○	○	○
When my child has a problem, his/her heart beats really fast	○	○	○	○
My child cannot think clearly	○	○	○	○
My child suddenly starts to tremble or shake when there is no reason for this	○	○	○	○
My child worries that something bad will happen to him/her	○	○	○	○
When my child has a problem, he/she feels shaky	○	○	○	○
My child feels worthless	○	○	○	○
My child worries about making mistakes	○	○	○	○
My child has to think of special thoughts (like numbers or words) to stop bad things from happening	○	○	○	○
My child worries what other people think of him/her	○	○	○	○

continued:

	Never	Sometimes	Often	Always
My child is afraid of being in crowded places (like shopping centres, movies, buses, busy playgrounds)	○	○	○	○
All of a sudden, my child will feel really scared for no reason at all	○	○	○	○
My child worries about what is going to happen	○	○	○	○
My child suddenly becomes dizzy or faint when there is no reason for this	○	○	○	○
My child thinks about death	○	○	○	○
My child feels afraid if he/she have to talk in front of the class	○	○	○	○
My child's heart suddenly starts to beat too quickly for no reason	○	○	○	○
My child feels like he/she doesn't want to move	○	○	○	○
My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	○	○	○	○
My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	○	○	○	○
My child feels afraid that he/she will make a fool of him/herself in front of people	○	○	○	○
My child has to do some things in just the right way to stop bad things from happenning	○	○	○	○
My child worries when in bed at night	○	○	○	○
My child would feel scared if he/she had to stay away from home overnight	○	○	○	○
My child feels restless	○	○	○	○

The above scale was adapted and reproduced with permission of the author Dr. Bruce Chorpita, Ph.D.

Research shows that some children in foster or kinship care may display sexualized behaviours. There are many reasons why children might display these problems and carers are encouraged to access services available for families that are listed at the end of this questionnaire if they are concerned about these behaviours.

If present, these behaviours can present an extra challenge for children and their foster or kin family.

The questions below ask about sexualized behaviours your child might display. Please show if, and how often your child has shown the following behaviours (within the last 6 months).

Child Sexual Behavior Inventory (Friedrich 1997)

	Never	Less than 1 time/month	1-3 times /month	At least 1 time/ week
Dresses like opposite sex	○	○	○	○
Stands too close to people	○	○	○	○
Talks about wanting to be the opposite sex	○	○	○	○
Touches sex (private) parts when in public	○	○	○	○
Masturbates with hand	○	○	○	○
Draws sex parts when drawing pictures of people	○	○	○	○
Touches or tries to touch their mother's or other women's breasts	○	○	○	○
Masturbates with toy or object (e.g. blanket, pillow or plastic toy)	○	○	○	○
Touches another child's sex (private) parts	○	○	○	○
Tries to have sexual intercourse with another child or adult	○	○	○	○
Puts mouth on another child's/ adult's sex parts	○	○	○	○
Touches sex (private) parts when at home	○	○	○	○
Touches an adult's sex (private) parts	○	○	○	○
Touches animal's sex parts	○	○	○	○

continued:

	Never	Less than 1 time/ month	1-3 times / month	At least 1 time/ week
Makes sexual sounds (sighs, moans, heavy breathing etc.)	○	○	○	○
Asks another to engage in sexual acts with him or her	○	○	○	○
Rubs body against people or furniture	○	○	○	○
Puts objects in vagina or rectum	○	○	○	○
Tries to look at people when they are nude or undressing	○	○	○	○
Pretends that dolls or stuffed animals are having sex	○	○	○	○
Shows sex (private) parts to adults	○	○	○	○
Tries to look at pictures of nude or partially dressed people	○	○	○	○
Talks about sexual acts	○	○	○	○
Kisses adults they do not know well	○	○	○	○
Gets upset when adults are kissing or hugging	○	○	○	○
Over friendly with adults they don't know well	○	○	○	○
Kisses other children they do not know well	○	○	○	○
Talks flirtatiously	○	○	○	○
Tries to undress other children against their will (e.g. opening shirt, pants)	○	○	○	○
Wants to watch TV or movies that show nudity or sex	○	○	○	○
When kissing tries to put their tongue in other person's mouth	○	○	○	○

continued:

	Never	Less than 1 time/ month	1-3 times / month	At least 1 time/ week
Hugs adults they do not know well	○	○	○	○
Shows sex (private) parts to children	○	○	○	○
Tries to undress adults against their will (e.g. opening pants, shirt)	○	○	○	○
Is very interested in the opposite sex	○	○	○	○
Puts their mouth on mother's or other women's breasts	○	○	○	○
Knows more about sex than other children their age	○	○	○	○

Other sexual behaviours, please describe:

continued:

	Never	Less than 1 time/ month	1-3 times / month	At least 1 time/ week
Makes sexual sounds (sighs, moans, heavy breathing etc.)	○	○	○	○
Asks another to engage in sexual acts with him or her	○	○	○	○
Rubs body against people or furniture	○	○	○	○
Puts objects in vagina or rectum	○	○	○	○
Tries to look at people when they are nude or undressing	○	○	○	○
Pretends that dolls or stuffed animals are having sex	○	○	○	○
Shows sex (private) parts to adults	○	○	○	○
Tries to look at pictures of nude or partially dressed people	○	○	○	○
Talks about sexual acts	○	○	○	○
Kisses adults they do not know well	○	○	○	○
Gets upset when adults are kissing or hugging	○	○	○	○
Over friendly with adults they don't know well	○	○	○	○
Kisses other children they do not know well	○	○	○	○
Talks flirtatiously	○	○	○	○
Tries to undress other children against their will (e.g. opening shirt, pants)	○	○	○	○
Wants to watch TV or movies that show nudity or sex	○	○	○	○
When kissing tries to put their tongue in other person's mouth	○	○	○	○

continued:

	Never	Less than 1 time/ month	1-3 times / month	At least 1 time/ week
Hugs adults they do not know well	○	○	○	○
Shows sex (private) parts to children	○	○	○	○
Tries to undress adults against their will (e.g. opening pants, shirt)	○	○	○	○
Is very interested in the opposite sex	○	○	○	○
Puts their mouth on mother's or other women's breasts	○	○	○	○
Knows more about sex than other children their age	○	○	○	○

Other sexual behaviours, please describe:

This next section asks about any specific diagnoses your child may have been given as well as support your child may have received.

Please indicate if your child has been diagnosed, by a specialist ONLY (e.g. Paediatrician, Clinical Psychologist, School Psychologist, Psychiatrist), with any of the items listed below. You can tick more than one option if needed.

- ☐ Attention-Deficit/ Hyperactivity Disorder
- ☐ Oppositional Defiant Disorder or Conduct Disorder
- ☐ Intellectual Disability
- ☐ Autistism or Asperger's
- ☐ A Learning Disorder (e.g. language, reading, mathematics disorder)
- ☐ Posttraumtic Stress Disorder
- ☐ Other
- ☐ None

Please tick any of the counselling/ therapy services listed below **your child** has received while in your care. You can tick more than option if needed.

- ☐ Individual counselling
- ☐ Groupwork or 'group counselling'
- ☐ Groupwork (e.g. a special group for social skills, ADHD management, Anxiety problems
- ☐ Other
- ☐ None

Please add any comment you would like about the level of support your child receives.

This next section asks about some of the strategies you use to manage this specific child in different situations.

At one time or another, all children misbehave or do things that could be harmful, that are 'wrong' or that parents don't like. Parents have many different ways or styles of dealing with such problems. Below are items that describe some styles of parenting. For each item, click on the circle that best describes your style of parenting during the past two months with this child.

Parenting Scale (Arnold, O'Leary, Wolff & Acker, 1993)

For example, the statement below asks about how you might manage your child's eating behaviour. That is, if you decide how much your child eats or if you let them decide how much.

if you let your child decide all the time, you might click on the circle furthest to the left.
If you decided all the time, you may click on the circle furthest to the right.
However, if you were somewhere in the middle, but a little closer to the statement 'I let my child decide how much to eat', you may click the circle below:

At meal time.....

I let my child decide how much to eat ○ ○ ● ○ ○ ○ ○ I decide how much my child eats

When my child misbehaves....
I do something about it right away ○ ○ ○ ○ ○ ○ ○ I do something about it later

Before I do something about a problem...
I give my child several reminders or warnings ○ ○ ○ ○ ○ ○ ○ I use only one reminder or warning

When I'm upset or under stress...
I am picky and on my child's back ○ ○ ○ ○ ○ ○ ○ I am no more picky than usual

When I tell my child not to do something....
I say very little ○ ○ ○ ○ ○ ○ ○ I say a lot

When my child pesters me...
I can ignore the pestering ○ ○ ○ ○ ○ ○ ○ I can't ignore the pestering

When my child misbehaves...
I usually get into a long argument with my child ○ ○ ○ ○ ○ ○ ○ I don't get into an argument

I threaten to do things that...
I am sure I can carry out ○ ○ ○ ○ ○ ○ ○ I know I won't actually do

I am the kind of parent that....
Sets limits on what my child is allowed to do ○ ○ ○ ○ ○ ○ ○ Lets my child do whatever he/she wants

When my child misbehaves....
I give my child a long lecture ○ ○ ○ ○ ○ ○ ○ I keep my talks short and to the point

When my child misbehaves....

I raise my voice or yell | I speak to my child calmly

If saying 'No' doesn't work right away....

I take some other kind of action | I keep talking and try to get through to my child

When I want my child to stop doing something....

I firmly tell my child to stop | I coax or beg my child to stop

When my child is out of my sight....

I often don't know what my child is doing | I always have a good idea of what my child is doing

After there's been a problem with my child....

I often hold a grudge | Things get back to normal quickly

When we're not at home....

I handle my child the same way I do at home | I let my child get away with a lot more

When my child does something I don't like....

I do something about it every time it happens | I often let it go

When there is a problem with my child.....

Things build up and I do things I don't mean to | Things don't get out of hand

When my child misbehaves, I spank, slap, grab or hit my child....

Never or rarely | Most of the time

When my child doesn't do what I ask....

I often let it go or end up doing it myself | I take some other action

When I give a fair threat or warning....

I often don't carry it out | I always do what I said

If saying 'No' doesn't work....

I take some other kind of action | I offer my child something nice so he/ she will behave

When my child misbehaves...

I handle it without getting upset ○ ○ ○ ○ ○ ○ ○ I get so frustrated or angry that my child can see I'm upset

When my child misbehaves...

I make my child tell me why he/ she did it ○ ○ ○ ○ ○ ○ ○ I say 'No' or take some other action

If my child misbehaves and then acts sorry...

I handle the problem like I usually would ○ ○ ○ ○ ○ ○ ○ I let it go that time

When my child misbehaves...

I rarely use bad language or curse ○ ○ ○ ○ ○ ○ ○ I almost always use bad language

When I say my child can't do something....

I let my child do it anyway ○ ○ ○ ○ ○ ○ ○ I stick to what I said

When I have to handle a problem...

I tell my child I'm sorry about it ○ ○ ○ ○ ○ ○ ○ I don't say I'm sorry

When my child does something I don't like, I insult my child, say mean things, or call my child names

Never or rarely ○ ○ ○ ○ ○ ○ ○ Most of the time

If my child talks back or complains when I handle a problem...

I ignore the complaining and stick to what I said ○ ○ ○ ○ ○ ○ ○ I give my child a talk about not complaining

If my child gets upset when I say 'No'...

I back down and give in to my child ○ ○ ○ ○ ○ ○ ○ I stick to what I said

The next section asks about your level of satisfaction as a carer for this child and your view of the placement.

The statements below describe different ways some parents may feel about their children. For each statement, indicate how true it is or is not for you.

The feelings parents have may change with regard to different children at different times, so when choosing your responses, think about the child you have been answering about so far.

Parent-Child Relationship Inventory (Gerard 2005)

	Strongly Agree	Agree	Disagree	Strongly Disagree
I get as much satisfaction from having my child as other parents do	○	○	○	○
My feelings about being a parent change from day to day	○	○	○	○
I often wonder what the rewards are in raising this child	○	○	○	○
I get a great deal of satisfaction from having this child in my care	○	○	○	○
I regret having this child in my care	○	○	○	○
Being a parent isn't as satisfying as I thought it would be	○	○	○	○
Being a parent is one of the most important things in my life	○	○	○	○
I wonder if I did the right thing having this child	○	○	○	○
I would really rather do a lot of other things than spend time with this child	○	○	○	○
If I had to do it over, I would probably not have this child in my care	○	○	○	○

Please feel free to add any comments about how satisfied you feel as a carer for this child.

Some carers may have concerns about the placement of a particular child. They may feel that they cannot continue to care for that child long term, or for the time that they have agreed to. Please show how true this statement is for you with regard to the child you have been thinking of throughout this survey.

" I am concerned that I will not be able to continue to care for this child long term (or for the amount of time asked of me)".

Not true at all ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Very True

Please give reasons for the answer you gave above (e.g. reasons to do with the child, or services involved, financial, time issues or other reasons regarding your birth family). This helps us to understand more about what may help or lead to breakdown of long-term placements.

In these last sections, we ask you how you see yourself, your relationships as well as about some things that are important to you.

Show how much you agree or disagree with each of the following items by clicking on the response that best describes how you think and feel.

Attachment Style Questionnaire (Feeney, Noller & Hanrahan 1994)

	Totally Disagree	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree	Totally Agree
Overall, I am a worthwhile person	○	○	○	○	○	○
I am easier to get to know than most people	○	○	○	○	○	○
I feel confident that other people will be there for me when I need them	○	○	○	○	○	○
I prefer to depend on myself than other people	○	○	○	○	○	○
I prefer to keep to myself	○	○	○	○	○	○
To ask for help is to admit that you're a failure	○	○	○	○	○	○
People's worth should be judged by what they achieve	○	○	○	○	○	○
Achieving things is more important than building relationships	○	○	○	○	○	○
Doing your best is more important than getting along with others	○	○	○	○	○	○
If you've got a job to do, you should do it no matter who gets hurt	○	○	○	○	○	○
It's important to me that others like me	○	○	○	○	○	○
It's important to me to avoid doing things others won't like	○	○	○	○	○	○
I find it hard to make decisions unless I know what other people think	○	○	○	○	○	○
My relationships with others are generally superficial	○	○	○	○	○	○

continued:

	Totally Disagree	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree	Totally Agree
Sometimes I think I am no good at all	○	○	○	○	○	○
I find it hard to trust other people	○	○	○	○	○	○
I find it difficult to depend on others	○	○	○	○	○	○
I find that others are reluctant to get as close as I would like	○	○	○	○	○	○
I find it relatively easy to get close to other people	○	○	○	○	○	○
I find it easy to trust others	○	○	○	○	○	○
I feel comfortable depending on other people	○	○	○	○	○	○
I worry that others won't care about me as much as I care about them	○	○	○	○	○	○
I worry about people getting too close	○	○	○	○	○	○
I worry that I won't measure up to other people	○	○	○	○	○	○
I have mixed feelings about being close to others	○	○	○	○	○	○
While I want to get close to others, I feel uneasy about it	○	○	○	○	○	○
I wonder why people would want to be involved with me	○	○	○	○	○	○

	Totally Disagree	Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree	Totally Agree
Its very important to me to have a close relationship	○	○	○	○	○	○
I worry a lot about my relationships	○	○	○	○	○	○
I wonder how I would cope without someone to love me	○	○	○	○	○	○
I feel confident about relating to others	○	○	○	○	○	○
I often feel left out or alone	○	○	○	○	○	○
I often worry that I do not really fit in with other people	○	○	○	○	○	○
Other people have their own problems so I don't bother them with mine	○	○	○	○	○	○
When I talk over my problems with others, I generally feel ashamed or foolish	○	○	○	○	○	○
I am too busy with other activities to put much time into relationships	○	○	○	○	○	○
If something is bothering me, others are generally aware and concerned	○	○	○	○	○	○
I am confident that other people will like me and respect me	○	○	○	○	○	○
I get frustrated when others are not available when I need them	○	○	○	○	○	○
Other people often disappoint me	○	○	○	○	○	○

This is the last section. For each item, indicate how well you think it describes you.
Read each item carefully before responding. Answer as honestly as you can.

Interpersonal Reactivity Index (Davis 1980)

	Does not describe me well	Slightly disagree	Unsure	Slightly agree	Describes me well
I often have tender, concerned feelings for people less fortunate than me	○	○	○	○	○
I sometimes find it difficult to see things from the 'other guy's' point of view	○	○	○	○	○
Sometimes I don't feel very sorry for other people when they are having problems	○	○	○	○	○
In emergency situations I feel apprehensive and ill at-ease	○	○	○	○	○
I try to look at everybody's side of a disagreement before I make a decision	○	○	○	○	○
When I see someone being taken advantage of, I feel kind of protective towards them	○	○	○	○	○
I sometimes feel helpless when I am in the middle of a very emotional situation	○	○	○	○	○
I sometimes try to understand my friends better by imagining how things look from their perspective	○	○	○	○	○
When I see someone get hurt, I tend to remain calm	○	○	○	○	○
Other people's misfortunes do not usually disturb me a great deal	○	○	○	○	○
If I'm sure about something, I don't waste much time listening to other people's arguments	○	○	○	○	○
Being in a tense emotional state scares me	○	○	○	○	○
When I see someone being treated unfairly, I sometimes don't feel much pity for them	○	○	○	○	○
I am usually pretty effective in dealing with emergencies	○	○	○	○	○
I am often quite touched by things that I see happen	○	○	○	○	○
I believe that there are two sides to every question and try to look at both of them	○	○	○	○	○
I would describe myself as a pretty soft-hearted person	○	○	○	○	○
I tend to lose control during emergencies	○	○	○	○	○
When I'm upset at someone, I usually try to 'put myself in his/her shoes' for a while	○	○	○	○	○
When I see someone who badly needs help in an emergency, I go to pieces	○	○	○	○	○
Before criticizing somebody, I try to imagine how I would feel if I were in their place	○	○	○	○	○

Thank you for your time and patience in completing this questionnaire. Your responses will help us better understand the experiences of foster and kinship carers.

Below are some support services which may be of assistance to you and your family.

Just click on the arrow at end of page to be forwarded to the raffle entry.

If you recognize your child as needing further assistance we advise that you share this with your caseworker and/or counsellor from Family and Community Services (previously DoCS), and/or your Foster Care Agency.

Foster Care Association of NSW Inc.
www.fcansw.org.au
Provides information, support and advocacy to carers

Foster Care Support
www.fostercaresupport.org.au
Provides support and training to kinship and foster carers in Australia

Foster Care Support Network (Inc) NSW
www.fosterparentsupportnetwork.org.au
Provides telephone support and advocacy

Aboriginal Statewide Foster Care Support Service
www.absec.org.au
Ph: 1800 888 698
Provides support and advocacy for Aboriginal and non-Aboriginal foster and kinship carers who provide care for Aboriginal children and young people

Connecting Carers NSW
www.connectingcarersnsw.com.au
24 hour support line: 1300 794 653
Provides training, education and support for foster and kinship carers

24-hour Counselling Services:

Lifeline: 13 11 14 www.lifeline.org.au

Mensline Australia 1300 78 99 78 www.menslineaus.org.au

Kids Helpline 1800 55 1800 www.kidshelp.com.au

Parentline 1300 1300 52 www.parentline.org.au

Child Protection Helpline 132 111 www.community.nsw.gov.au/preventing_child_abuse_and_neglect /protecting_children.html>

Block 1

MACQUARIE University

MIA MARKOVIC <mia.markovic@students.mq.edu.au>

Re: HREC External Application Noted

Ethics Secretariat <ethics.secretariat@mq.edu.au> Tue, Jan 27, 2015 at 11:39 AM
To: MIA MARKOVIC <mia.markovic@students.mq.edu.au>
Cc: Cathy McMahon <cathy.mcmahon@mq.edu.au>

Thank you for your email advising the Human Research Ethics Committees (HRECs) of your involvement in the following application approved by the Western Sydney Local Health District Human Research Ethics Committee.

'Multi-Systemic Assessment of Phychosocial Safety (MAPS): Utility and Inter-Rater Reliability Study'

In accordance with ch 5.3 of the *National Statement on Ethical Conduct in Human Research* (2007) the Macquarie University HRECs note your authority to proceed under this external approval.

No further action is required. Any amendments must be submitted to the approving HREC.

The HRECs wish you the very best for your research.

Regards

Michelle Thorpe
--

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MACQUARIE University
SYDNEY·AUSTRALIA

NSW GOVERNMENT Health
Western Sydney
Local Health District

HREC Ref: **(4043) AU RED LNR/14/WWMEAD/243**
SSA Ref: **AU RED LNR SSA/14/WMEAD/258**

1 September 2014

Ms Britt Sedgmen
Child Protection Counselling Service
Department of Community Health
PO Box 762
SEVEN HILLS NSW 2147

Dear Ms Sedgmen

LNR Research Project: 'Multi-Systemic Assessment of Psychosocial Safety (MAPS): Utility and Inter-Rater Reliability Study'

Thank you for Ms Mia Markovic's email dated 15 August 2014 addressing the items raised in the Scientific Advisory Committee's letter dated 21 July 2014.

Your request to undertake the above protocol as a Low and Negligible Risk (LNR) research project was reviewed by a subcommittee of members of the Scientific Advisory Committee and the Human Research Ethics Committee. We are satisfied that your protocol meets the criteria for an LNR research project and does not require review by the full HREC.

This HREC has been accredited by the NSW Department of Health as a lead HREC to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

I am pleased to advise that the HREC has granted ethical approval of this LNR research project to be conducted by you at:

- Blacktown Hospital, Western Sydney Local Health District
- Erina Community Health Centre, Central Coast Local Health District
- Lemongrove Community Health Facility, Nepean Blue Mountains Local Health District

T:\RESEARCH OFFICE\ETHICS\COMMITTEES\HREC\CORRESPONDENCE\2014\1408 CORRESPONDENCE\140825 - 4043 Sedgmen - LNR.doc

HUMAN RESEARCH ETHICS COMMITTEE
Research Office, Room 1072, Level 1, Education Block
Westmead Hospital, Hawkesbury & Darcy Roads, Westmead NSW 2145
Telephone 02 9845 8183 Facsimile 02 9845 8352
Email: WSLHD-ResearchOffice@health.nsw.gov.au

WESTERN SYDNEY LOCAL HEALTH DISTRICT
ABN 48 702 394 764
WSLHD Office, Westmead Hospital Campus
Institute Road, Westmead NSW 2145
PO Box 533, Wentworthville NSW 2145
Telephone 02 9845 5555

The following documentation has been reviewed and approved by the HREC:

- LNR Application Form AU/6/258814
- Study Protocol version 1, dated 8 June 2014
- Participant Information and Consent Form, version 2, dated 1 August 2014
- MAPS Profile and Clinical Planning Tool, version 1, dated 8 June 2014
- MAPS User Guide, version 1, dated 8 June 2014
- MAPS Dimension 1: Child Health & Psychosocial Functioning (6-16 years), version 1, dated 8 June 2014
- MAPS Participant Survey, version 1, dated 8 June 2014

Please note the following conditions of approval:

- The coordinating investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- The coordinating investigator will immediately report any protocol deviation / violation, together with details of the procedure put in place to ensure the deviation / violation does not recur.
- Proposed amendments to the protocol or conduct of the research which may affect the ethical acceptability of the project, must be provided to the HREC to review in the specific format. Copies of all proposed changes must also be provided to the research governance officer.
- The HREC must be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
- The coordinating investigator must provide an annual report to the HREC and a final report at completion of the study, in the specified format. HREC approval is valid for 12 months from the date of final approval and continuation of the HREC approval beyond the initial 12 month approval period is contingent upon submission of an annual report each year.
- It should be noted that compliance with the ethical guidelines is entirely the responsibility of the investigators.

You are reminded that this letter constitutes *ethical approval only*. You must not commence this research project until separate Governance authorisation from the Chief Executive or delegate has been obtained. Copies of this letter, together with any approved documents as enumerated above, have been forwarded to the WSLHD Research Governance Officer. For Governance authorisation at sites outside WSLHD you must forward a copy of this letter and any approved documents to the Research Governance Office at each additional site.

In all future correspondence concerning this study, please quote approval number (The HREC wishes you every success in your research.

Yours sincerely

Mrs Patricia Fa
Secretary
WSLHD Human Research Ethics Committee

cc Ms Margaret Piper, Research Governance Officer

NSW GOVERNMENT | Health
Western Sydney
Local Health District

Research Governance Officer
Western Sydney Local Health District
Room 1072, Level 1 Education Block Westmead Hospital
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Facsimile: (02) 9845 9636
Email: margaret.piper@health.nsw.gov.au

30 October 2014

Ms. Britt Sedgmen
PO Box 762
Seven Hills NSW 2147

Dear Ms. Sedgmen

HREC reference number: LNR/14/WMEAD/243
SSA reference number: LNRSSA/14/WMEAD/258
Project title: multi - systemic assessment of psychosocial safety (MAPS) utility and inter-rater reliability study
Protocol number: Version 1 dated 8th June 2014

Thank you for submitting a Low/Negligible Risk (LNR) application for site authorisation of this project. I am pleased to inform you that site authorisation has been granted for this study to take place at the following site:

- Child Protection Counselling Services – Blacktown Hospital

The approved information and consent documents for use at this site are:

- Participant Information Sheet and Consent Blacktown version 1 dated 30 October 2014 based on Master version 2 dated 1 August 2014

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the research governance officer.

Yours faithfully

Maggie Piper
WSLHD Research Governance Officer

Cc: Ms Mia Markovic, PO Box 762, Seven Hills, NSW, 2147

6 November 2014

Ms Britt Sedgmen
Child Protection Counselling Service
PO Box 762
Seven Hills, NSW 2147

Dear Ms Sedgmen,

RE: **0714-049C:** Multi-systemic assessment of Psychosocial Safety (MAPS) utility and inter-rater reliability study

Site Investigators; B Sedgmen, M Markovic, C McMahon
Site Contact; M Markovic

I am pleased to inform you that the Research Governance Officer (Research Manager CCLHD) authorised the Site Specific Assessment for the above study on behalf of Central Coast Local Health District (CCLHD).

It is noted that this approval covers:

- Child Protection Counselling Service- CCLHD

The documentation included in the approval is as follows:

- Site Specific Assessment (SSA) Form for LNR Research Application; AU/7/5588111, dated 20 May 2014
- Low and Negligible Risk (LNR) Research Application; AU/6/258814, dated 20 May 2014
- HREC Approval (Western Sydney HREC) letter dated 1 September 2014
- Participant Information and Consent Form, Version 2, dated 1 August 2014
- MAPS Profile and Clinical Planning Tool, Version 1, dated 8 June 2014
- MAPS User Guide, Version 1, dated 8 June 2014
- MAPS Dimension 1: Child Health & Psychosocial Functioning (6-16 years), Version 1, dated 8 June 2014
- MAPS Participant Survey, Version 1, dated 8 June 2014.

At this time, we also remind you that, in order to comply with the *Guidelines for Good Clinical Research Practice (GCRP) in Australia*, and in line with CCLHD policy, the Principle Investigator is responsible to ensure that:

1. *CCLHD Research Office is notified of anything that might warrant review of the ethical approval of the project by a lead NSW Human Research Ethics Committee (HREC), including unforeseen events that might affect the ethical acceptability of the project. It is noted this project has been reviewed by an Executive of the CCLHD Board Research Committee and not a Lead HREC as it involves research that is considered under the National Statement of Ethical Conduct in Human Research (2007) to be Low/Negligible Risk Research and is for a single CCLHD site.*
2. *Proposed amendments to the research protocol or conduct of the research that may affect the ethical acceptability of the project are submitted to the CCLHD Research Office on an amendment form (including any relevant attachments).*
3. *Proposed changes to the personnel involved in the study are submitted to CCLHD Research Office.*
4. *The CCLHD Research Office must be provided with an annual progress report for the study and a final report upon completion of the study.*

SITE ANNUAL REPORT DUE: 1st September Annually

AURED SSA REF:*LNRSSA/14/CCLHD/75*
CCLHD REF NO: 0714-049C
AURED LNR REF: *LNR/14/WMEAD/243*
LNR HREC EXPIRY: *conditional*

RESEARCH - Central Coast Local Health District
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Health
NSW GOVERNMENT Central Coast
Local Health District

5. *The CCLHD Research Office is notified, giving reasons if the project is discontinued at a site before the expected date of completion.*

The HREC approval associated with this project remains valid dependant on the submission of annual reports. Therefore the HREC approval on this project will expire when the submission of annual reports ceases. Site Authorisation will remain valid as long as the HREC approval remains valid.

The CCLHD Library Services provides the following resources to support researchers:

1. Literature searches – the library staff will work with you to develop a search strategy and advise on bibliographic databases available to CCLHD staff;
2. Document delivery – where journal articles are not available in full text via CIAP or the library's other subscribed resources, library staff will obtain full text copies of journal articles from other health libraries at no charge to you; and
3. Managing your references – the library maintains an LHD-wide subscription to EndNote reference management software. You may request EndNote to be installed on your work computer by logging a job with the Statewide Service Desk. Disks are also available for loan from Gosford and Wyong Hospital libraries to enable you to install EndNote on your home computer and/or laptop. Library staff provide training in the use of EndNote.

For further information, please contact Gosford (4320 3370) or Wyong (4394 9022) Hospital Libraries or contact the Library Manager, Suzanne Lewis (4320 3856; suzanne.lewis@health.nsw.gov.au).

Yours sincerely

Jodi Humphreys
Research Officer
CENTRAL COAST LOCAL HEALTH DISTRICT

SITE ANNUAL REPORT DUE: 1st September Annually

AURED SSA REF:*LNRSSA/14/CCLHD/75*
CCLHD REF NO: 0714-049C
AURED LNR REF: *LNR/14/WMEAD/243*
LNR HREC EXPIRY: *conditional*

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TRIM Ref: NBM14/198

18 November 2014

Ms Britt Sedgmen
Clinical Senior – Community Health
Child Protection Counselling Service
PO Box 762
Seven Hills, NSW 2147

Dear Ms Sedgmen

HREC reference number: LNR/14/WMEAD/243
SSA reference number: LNRSSA/14/NEPEAN/65
Project title: MULTI - SYSTEMIC ASSESSMENT OF PSYCHOSOCIAL SAFETY (MAPS) UTILITY AND INTER-RATER RELIABILITY STUDY
Protocol number: version 1, dated 08 June 2014

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site:

- Lemongrove Community Health Facility - Nepean Blue Mountains Local Health District

The approved information and consent documents for use at this site are:

- Participant Information Sheet and Consent Form, Lemongrove Community Health Facility, version 1, dated 28 October 2014, based on the master version 2, dated 01 August 2014.
- The Multi-Systemic assessment of psychosocial safety (MAPS) - user guide, Lemongrove Community Health Facility, version 1, dated 28 October 2014, based on the master version 1, dated 08 June 2014.
- MAPS Profile and Clinical Planning Tool, Lemongrove Community Health Facility, version 1, dated 28 October 2014, based on the master version 1, dated 08 June 2014.

- The Multi-Systemic assessment of psychosocial safety (MAPS) – Participant Survey, Lemongrove Community Health Facility, version 1, dated 28 October 2014, based on the master version 1, dated 08 June 2014.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. **All non-Nepean Blue Mountains Local Health District (NBMLHD) research team members involved in your study must organise a time with the Research Governance Officer to sign a confidentiality agreement and obtain ID badge prior to conducting study visits at any of the facilities across the NBMLHD;**

2. Honorary appointments must be current for investigators to continue working on this study. Please submit updated honorary contracts when issues .

3. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;

4. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

I wish you every success in your research

Yours Sincerely

Yasoda Sathiyaseelan
Research Governance Officer

MULTI-SYSTEMIC ASSESSMENT OF PSYCHOSOCIAL SAFETY

Consultation document for CPCS staff

Name: _____ Service: _____

Years as a CPCS worker: _____

Years of experience as a counsellor/ therapist: _____

Prior experience in areas of family work:

_____

_____

Welcome!! It is great to have you review the MAPS. Over the last 6 months a number of additions and changes have been made to the MAPS in consultation with CPCS staff. We would really appreciate written feedback now on specific aspects of the MAPS. There are 3 steps to your evaluation and review. Just follow the directions as you go. We are asking that you send this information back to Mia and Britt by end of February at the latest. Please feel free to type in your responses and e-mail back. The e-mail address is on the last page. Thanks again and look forward to getting your input.

Step 1:
In this document there are two versions of the MAPS – one vertical, one horizontal. Please take a moment to review both formats.

FORMAT: 1. Which format do you prefer?

- ☐ The horizontal one (with numbers 1-10 at top of page) OR
- ☐ The Vertical one (numbers 1-10 on side of page)

2. Please comment on why you prefer this format

Please use your preferred format to answer the next few pages of questions.

Step 2:
This section asks you about each domain in turn. Before you begin, it may be helpful to briefly look over all 8 domains (on your preferred format) so you get an idea of what each domain generally tries to tap into. When you are ready please read over each domain carefully before answering the questions.

DOMAIN 1: Child Health and Personal Functioning [a]

RELEVANCE:

1. Please indicate and comment on how relevant or irrelevant the issues listed in this domain are to child or young person affected by abuse and neglect issues. Please also comment on any issues that you think should be added to this domain.

2. Are the areas mentioned in this domain issues that you think CPCS counsellors work on directly with children or their families? Please comment on how relevant they are to CPCS service delivery.

3. The italicised summary within each scale has been designed to assist clinicians to decide how to rate the individual or family context for that specific domain. For example, the summary for the first MAPS Domain 1: Child Health and Personal Functioning is:

' Overall, CYP has good physical & mental health, displays age-appropriate self-care, social skills, self-concept & positively engages in age-appropriate interests and activities'…

4. Can you comment on how clear the specifiers are in the domain you are now reviewing. Do they adequately sum up the key issues identified?

5. Do you think they are different enough to help clinicians make a judgment between the scores provided? Do you have any other comments or suggestions about these summaries?

6. Do you think this domain is sensitive enough to pick up on changes within the individual or family context over time – say a period of 6 months?
   Comments:

Note [a]These questions were repeated for each domain. For brevity the example for Domain 1 was included only.

Step 3: ALMOST THERE!
This next section asks some overall questions as to the utility of the MAPS in CPCS assessment, planning, intervention and outcomes data.

The MAPS was designed to be used by CPCS clinicians to assist their assessment of the functioning and specific needs of children and families specific to child protection work.

EASE OF USE

1. How easy or difficult do you think the MAPS domains are to use?

2. What level of clinical experience within the child protection field do you think is needed for a clinician to be able to use this scale?

□ Nil □ 3- 6months □ 6-12months □ Over 1 year
Other/ any comments:

CLINICAL UTILITY:
Please look at the MAPS summary score sheet and MAPS Clinical Planning sheets. These have been designed to assist clinicians to record and keep with client files, their specific MAPS scores at each time of measurement. Please comment on how helpful/ unhelpful the summary score sheet would be in:

a) Recording scores and specific reasons

b) Do you have any suggestions about how scores may be recorded differently?

c) How helpful/ unhelpful is the Clinical Planning sheet in summarising key counselling and case management issues at the time of using the MAPS?

d) In your view, would this help clinicians review the progress of CPCS intervention and track changes overall if completed every 6 months?

Any other comments:

USER GUIDE:
Please consider the user guide provided at the beginning of the document. How well does it explain the MAPS (aims, function) and use? Do you have any suggestions for additions or changes to the user guide?

VALUES:

1. It is important that clinicians feel comfortable in using the MAPS in that it fits in with their values as a child protection counsellor.

2. Are there any aspects of the MAPS that you are in opposition to - or that are inconsistent with your professional practice?

Other comments:

Please take a moment to provide any further comments on the MAPS. Are there things that you particularly find helpful or useful to CPCS and/or things you think are not helpful or useful? Are there things you would like to change which have not been discussed so far?

Thank you for your time!

Please e-mail your comments back to Mia and Britt on:
Mia Markovic on mia.markovic@ wsahs.nsw.gov.au
If you need to call you can get either of us on (02) 9881 8787

THE MULTI-SYSTEMIC ASSESSMENT OF PSYCHOSOCIAL SAFETY (MAPS): USER GUIDE

DESCRIPTION

The MAPS is a clinician-rated set of scales developed for use within Child Protection Counselling Services (CPCS) that provide counselling and case management to children and young people who have experienced maltreatment (aged 6-16years). The MAPS is comprised of eight scales that consider numerous areas in a child/young person's life known to impact their immediate and long-term health and well-being, including the stability of their placement. These aspects are difficult to capture using qualitative instruments (e.g. surveys) or psychological measures (e.g. behaviour scales) alone, as they typically assess only a single Domain of a child or family's functioning. By considering the child's well-being and functioning, alongside that their direct carers and micro systems of support, the MAPS aims to be sensitive to individual *and* systemic change over time.

The MAPS delineates family contexts where risks and strains are evident from those where strength and protective factors are evident. In doing so it highlights where and when services are best to direct counselling and case management interventions toward abuse and neglect *prevention* or circumstances where a shift to health *promotion*, less intense service delivery or closure is viable and appropriate.

It is hoped that the MAPS will provide a shared language among CPCS services for assessing child and family needs. The MAPS is easy to use and suitable for multidisciplinary teams. It can be used on its own or alongside additional psychometrics or client surveys and thus offers sensitive and relevant outcome data for child protection counselling services.

This User guide provides an outline of the MAPS subscales and suggested processes for use in clinical work. The MAPS also includes a 3-page summary sheet and clinical planning tool to record ratings and any counselling and case management plans and is discussed in this document.

DOMAINS INCLUDED IN THE MAPS

There are eight Domains that make up the MAPS. Importantly, the MAPS considers both *individual* child factors (e.g. mental health, social-emotional and behavioural presentations) and *systemic* factors (e.g. care-giver presentations, current level of placement stability, family engagement and level of systemic support and care). The Domains are as follows:

1. Child Health and Psychosocial Functioning:

This Domain considers the child or young person's (CYP's) current:

- Physical/ mental health functioning and management of any existing challenges
- Developmentally appropriate self-care and safety behaviours (towards self and others)
- Engagement in peer and adult relationships
- Sense of self/ confidence and engagement in age-appropriate responsibilities/ activities

2. Educational Engagement and Functioning

This Domain considers the CYP's current:

- Attendance at school
- Engagement with school activities/ tasks
- Developmentally appropriate peer and adult relationships within the school environment
- Academic performance
- Level of working alliance between Carer and school and the shared current ability to appropriately respond to educational needs of CYP

3. Primary Caregiver Health and Psychosocial Functioning

This domain attempts to capture the Caregiver's (birth parent or foster/kin carer) current ability or experiences in relation to:

- Physical/ mental health functioning and management of existing challenges (as it impacts parenting capacity)
- Coping skills/ insight (anticipating, delineating and managing own and child's needs)
- Parenting confidence and engagement in healthy relationships
- Self-care strategies

4A. Alternate Placement Security and Safety

This Domain is filled in when the CYP resides in a foster or kinship placement. Fill in EITHER 4A or 4B.

This Domain considers Carer's:

- Attempts to initiate and maintain positive carer-child relationship
- General parenting style
- Commitment to maintain and perception of placement stability
- Insight into the impact of trauma on CYP and their ability to provide/ support a therapeutic narrative around trauma and separation
- Ability/ willingness to support birth family and cultural

4B. Birth Family Security and Safety

This Domain is filled in when the CYP resides with their birth parent(s). Fill in EITHER 4A OR 4B.

This Domain considers Parent's:

- Attempts to initiate and maintain positive parent-child relationship
- General parenting style
- Commitment to maintain and perception of ongoing care of CYP
- Insight into the impact of trauma on CYP and their ability to appropriately provide and support recovery
- Insight into any personal and/or family role in child maltreatment and demonstrated behaviour change (as needed).

5. Relationship Safety and Security with Birth Family

This Domain is filled in when the CYP resides in a foster or kinship placement and has contact with their birth family.

This Domain considers the nature of parent-child relationships and interactions with the CYP in the instance where the CYP is residing in alternate care and has contact with his/her parent(s). It considers both parental and child factors, specifically:

- Parent's attempts to initiate and maintain positive parent-child relationship during contact
- General parenting style during contact
- Parent's ability to provide/support a developmentally appropriate narrative to CYP regarding past maltreatment and removal, including parent's own role in maltreatment (if applicable)
- Parent's ability to support CYP's relationships with foster/kin family
- CYP's understanding of past maltreatment and removal

6. Primary Carer's Engagement Support and Environment

This Domain considers the Carer's:

- Demonstrated motivation to understand and respond to CYP's needs
- Cognitive and emotional capacity to reflect and make necessary behaviour changes
- Appropriate access of support services and ability to maintain working alliance with crucial agencies to meet CYP's needs
- Support networks and ability to anticipate own needs for support
- Management of socio-economic strains and the level of strains present

7. Systemic Alliance and Support

This Domain considers the key care agency's capacity (e.g. FaCS or NGO Foster Care agency) to address and meet the needs of the CYP and their family – **to the extent that it causes or does not cause** a risk to safety and well-being of the CYP. It considers the Care Agency's ability to:

- Meet the case management responsibilities in a timely way (including contact issues)
- Knowledge of the CYP's maltreatment history and current psychosocial needs
- Ability to maintain communication with CYP's parents and/or carers, and considers;
- The quality of the working alliance between Care Agency, other agencies and carers.

CLINICIANS' RATINGS ON THE MAPS AND CLINICAL SIGNIFICANCE

Each MAPS Domain describes individual, family and systemic functioning across different aspects of a CYP's life and clinicians are able to ascribe a range of functioning between 1 – 6 based on how those descriptions fit with a given family (with 1 indicating most risks and 6 indicating most strength/ protective factors). Generally, it could be said that a range of 6 or 5 on a Domain indicates that the child/young person and/or their family and care systems are functioning at a high level (on that Domain) that is optimal to the child or family health and well-being into the future. At this level, there is likely to be less of a focus on abuse prevention and more on health promotion. Ranges of 3 or 4 and below (1 or 2), suggest decreasing levels of functioning, if not multiple problems.

A range of 3 or 4 indicates strains that warrant intervention (clinical or case work or both), as problems identified within that given Domain are either likely to impact the safety or well-being of a CYP or demonstrated harm has occurred. Importantly, on any Domain, a rating of 3 will be given instead of a 4, if the problems identified in that range have been present for more than 6 months, as this is likely to reflect ongoing neglect, greater entrenchment of problems and/or the need to assess impediments to progress. For example, parenting may be sub-optimal, not necessarily causing immediate harm but rather reflecting chronic or accumulative neglect. A range

of 1-2 indicate greater levels of risk and warrant tertiary intervention. At these levels, it is likely that there is a predominant focus on addressing risk issues and on abuse prevention.

Importantly, these Domains assess different and complex individual capacities and support systems across a child's life. As such, the MAPS system is not homogenous. A clinician may give a high rating in one Domains but not another, because strengths or protective factors are being demonstrated in one area of a child's life but risks or strains appear in another.

GUIDING PRINCIPLES IN USING THE MAPS

The following are some questions that have arisen as part of our initial consultations in developing the MAPS and some guidelines. Please note that this will be easier to fully comprehend when you come to use the MAPS on clinical vignettes on the MAPS training/study day.

What do I do if I don't have enough information to fill in a Domain?

Assessing risk, safety and well being is multi-faceted. There is international consensus that assessments and interventions need to consider *systemic* factors operating in a child's life and these require interagency collaboration and multi-disciplinary perspectives (Howarth & Morrison; 2011). Moreover, assessment and evaluation tools should consider children's strengths and adaptations alongside potentially mediating influences such as parental / caregiver roles, caregiver reactions and responses to trauma, as well as community support and acceptance (Ager et. al. 2012). The MAPS considers areas of a CYP's life evidenced in the literature to impact safety, health and well-being into the future. While clinicians may not have all available data with which to fill in each Domain, the researchers do recommend that attempts be made to incorporate these Domains into a general assessment of children and young people accessing CPCS. Missing one aspect of a given Domain is acceptable. In the event that you cannot reasonably ascribe a risk/protective factor level to two points in a given Domain, we would suggest you leave that Domain unscored. An example of this will be covered in the MAPS training/study day.

What do you mean by developmentally-appropriate skills/ abilities as compared to age-appropriate skills/abilities in a child when filling in the MAPS?

The term 'developmentally appropriate' is frequently used within the MAPS in favour of 'age-appropriate' for a number of reasons. It means to assists clinicians to assess how children are faring in a range of psychosocial domains, including those who may have an intellectual disability. Many children entering care have experienced disruption to their psychosocial and learning development and would be expected perform below their developmental ideal. For instance, a 10 year old boy who does not have an intellectual or physical disability would be expected to be able to dress himself, brush his own teeth and perform a chore (e.g. put dinner plate on kitchen bench/ clothes in laundry basket etc.) perhaps with regular prompting/ reminding. However, if the child cannot achieve these or similar things (e.g. requires carer to consistently dress him, persistently refuses to engage in any chores over a long period of time) than the child is not performing as would be expected and this would likely impact their well-being and social integration. Reasons *why* the child is not achieving these things may differ (e.g. anxiety, oppositionality, a delay in fine gross motor skills difficulties etc.) but in the case of these examples, the child's abilities would be expected to progress with appropriate intervention and support.

Where a child has an intellectual disability (a stable prognosis), it is helpful to know if they are functioning at the level they are developmentally expected to do so and not to the standard expected by their chronological age. So if a 10 year old boy with an intellectual disability, who is expected to have the adaptive skills of a 5-6 year old, based on testing/ professional consultation, could be rated as functioning high for meeting developmental chores/ self-care if he is actually performing at a 5-6 year old capacity. Where a clinician is unsure what should be expected from a child developmentally, the researchers strongly recommend professional consultation and supervision to help determine how best to assess and support that child.

Who do I include – one parent or both, one child or all?

The MAPS can be used to assess a child or young person's psychosocial safety. CPCS are often referred multiple siblings from one family. Because each child or young person is unique and presents with different emotional, behavioural, interpersonal and learning needs, we suggest that the MAPS can be used for each child (within 6-16years) and their parents. Where there are two

parents or carers, the MAPS can be used for both. For example, if there are two foster carers involved in the care of a given child, and the counsellors has been able to assess the needs and capacities of both carers, they may have two ratings for *Domain 3: Primary Caregiver Health and Psychosocial Functioning,* one for each carer. This may be particularly important in helping to delineate where there may be disturbed parenting functioning, parenting capacity or poor carer-child relationship in one dyad but not the other. Whatever the context, each child in a given family is likely to have a unique profile or summary of risks and/or strengths.

What overall score do I give for a Domain if some aspects are high and others low?

This refers to the circumstance where some parts of the system for a CYP are working well but others are not within the same Domain. For instance, Harry is 9 years old. On Domain 1: Child Health and Psychosocial Functioning, his counsellor determines in her assessment and in consultation with his carer and school that Harry demonstrates good overall physical and mental health (a score of 6 on point 1). He has been diagnosed with ADHD, but has a reasonable understanding of this, complies with medication and is able to take on tips for better management of his 'restlessness' in the classroom by his teacher. Harry's carer states that Harry displays good general self-care (will seek help from his carer or uncle if has a problem) and hygiene for his age (complied with general need for cleanliness like showering/ changing clothes as needed) (a score of 6 on point 2). His carers describe him as generally confident to approach new tasks, but of needing regular encouragement and sometimes direct modelling to remind him how to do previously learned tasks like buying milk and bread from local store. Harry is also said to generally performing age-appropriate tasks (making his bed each day, putting clothes in laundry when prompted!!) (thus counsellor gives a score of 5 on point 4). However, Harry displays ongoing social skills/ emotion regulation problems that continue to impact his engagement with other children. He regularly gets into physical fights with children from the carer's extended family, including children younger than him. At times he has ben observed to push and bully other children without provocation. This has required a great deal of social skills training and monitoring by the carers who are always watchful when on family outings. This has ben an ongoing problem over the last 12 months (Score of 3 on point 3). Clearly, Harry has a great deal of strengths – and most ratings fall in the 5 to 6 range. **However, his overall rating for this Domain would be a 3** as it

represents an area of current risk to his safety or well-being and thus a clear area for intervention. The rule here is to assign the lowest rating given for any Domain.

What does the MAPS mean by the term 'Mental Health'? Can another word be used?

The term 'Mental health' is a widely used within NSW health literature and material. It refers to aspects of a child or young persons thinking, emotional and behavioural functioning. Mental health is often viewed as a spectrum and includes those problems outlined in the Diagnostic and Statistical Manual of Mental Disorders Revised (DSM-IV) some of which are commonly presented amongst children and adolescents in care (e.g. Attention-Deficit Hyperactivty Disorder; ADHD, Oppositional Defiant Disorder; ODD, Conduct Disorder; CD, Depression, Anxiety, Post Traumatic Stress Disorder; PTSD). The term also refers to conditions associated more with adult mental health such as bipolar disorder, schizophrenia, Depression etc. Some conditions are considered severe as they seriously impair an individuals mental functioning (temporarily or permanently) and may include delusions, hallucinations, thought disturbance, severe disturbance of mood, irrational behaviour etc.).

The MAPS tool employs 'Mental Health' as an umbrella term to include not only formal diagnoses but also important experiences such as confidence, self-esteem, either iterated by the child or observed the care system. The MAPS does not use the terms 'emotional health' as an umbrella term as it does not cover formal diagnoses. It also does not use the term 'cognitive health' as this may be easily confused with cognitive testing more often confined to assess a child or young person's intellectual abilities.

What does the MAPS mean by the term 'self-harm' and 'risk-taking behaviours?

Sadly, a portion of children and young people may display varying degrees of risk to self (suicidal ideation, suicidal intent or risk-taking behaviours). 'Self-harm' refers to the deliberate, non-life threatening self-afflicted bodily harm or disfigurement of a socially unacceptable nature. Those who engage in self-injury are deliberately doing physical harm to themselves in ways that are not intended to end their lives (Kidshelpline 2014; Vivekananda; 2000). Examples may include cutting of skin (e.g. arms/ legs), deliberate overdose of prescription or over-the-counter medications not designed to be fatal. Other behaviours include burning, skin pulling or picking, pulling of hair

(Kidshelpline 2014). 'Suicidal ideation' refers to thinking about, considering or planning for suicide and a suicide attempt refers to a non-fatal, self-directed potentially injurious behaviour with any intent to die as a result of the behaviour (Centre for Disease Control & Prevention; 2014). 'Risk-taking behaviour' refers to a range of behaviours that may place the child or young person at risk of harm (not *intended* to be life threatening but may be nonetheless). Risk-taking behaviour can take on many different forms, including the misuse of alcohol or drugs, engaging in unprotected sexual activity, some types of criminal activity or risky, adrenaline-producing sports like skydiving or motocross (TEEN Mental Health 2014). Other risk-taking behaviour observed among children accessing CPCS services include absconding from home or school, staying out/ hanging out with older youth groups, alcohol consumption, underage sexual activity, indiscriminant/ sexualised behaviours, climbing tall buildings at school when under duress etc. The researchers urge CPCS clinicians to use professional judgement in assessing risk-taking behaviours in the context of the impact of such behaviours on a child's safety and well-being and where needed, in consultation with other professionals or supervisors.

Does the MAPS consider cultural differences in areas such as parenting/ developmental expectations of children?

The MAPS is still in the developmental stages and has not been assessed for cultural sensitivity at this stage. The researchers encourage CPCS clinicians to consider all aspects of their assessments with families with regard to cultural differences using their current cultural consultants.

End of User Guide.

MAPS STUDY CLINICAL VIGNETTES

Teaching Example

A. Jack, Frank & Capri (Birth family – CP support)

Background:

- Jack (12 yrs) lives with his mother Capri and Frank. Referred to CPCS for assessment and child and family counselling to address impacts of abuse and enhance parenting skills. FaCS involved to support family and maintain placement.
- History of DV by Frank towards Capri occurring from Jack's infancy to age of 10 years. Capri hospitalized twice. No reports of violence in the last two years and Capri denies any fears of harm from Frank.
- Frank and Capri have previously engaged with Relationships Australia for 6 months (re: DV groups), Family Preservation Service for 3 months (re: parenting issues/ children's routines) and Capri saw a psychologist for six months regarding management of depression.
- CPCS have worked with this family for 6 months, providing individual and joint counselling to Capri and Jack (re: parental mood and parenting alliance). Jack attends a CPCS social skills group.
- Frank is a full time mechanic and Capri is a full time homemaker.

Jack:

Presents as a shy, withdrawn boy who is artistic. He is prescribed medication for AD/HD and significant sleep problems. Jack is described to have a history of anxiety since early childhood and currently has difficulty leaving his mother's presence and the family home on weekends. He recently told the CPCS Counsellor in the social skills group, that he worries something bad may happen to his mum. Jack has refused to join any sports groups, in-school support groups or vacation care camps. His mother says it is because he has always been shy and has difficulties making friends. He has one, 'best' friend, who he has known since kindergarten but only sees him if he comes over to Jack's house. Jack avoids and rarely speaks to adults other than his parents. Jack's mother often has to communicate his needs to others (e.g. Capri will buy his lollies/ toys for him as Jack avoids speaking to shop staff). Capri does not try to encourage Jack to become more independent as thinks it is unfair to make him anxious. Capri and Frank think nothing can be done to assist Jack, rather he will 'grow out of it' one day.

Capri states that Jack is generally compliant but will have regular outbursts 'if he doesn't get what he wants', whereby he punches the walls and windows in the home (Jack cut and bruised his hand last month during such an outburst). He has also started self-cutting on his arms. Jack often refers to himself as an 'idiot'. Capri says he is good at getting himself ready for school and doing some chores in the home.

Capri and Frank regularly attend paediatric appointments and ensure Jack is compliant with medication. His parents have not sought psychological intervention/ counselling for Jack. They believe Jack is genetically vulnerable to anxiety as there are 'mental problems' in the extended family. Capri denies that the past domestic violence has impacted stating that Jack didn't really 'see it', 'it happened years ago' and there is no current physical violence. Both parents acknowledge frequent

arguing in the home about parenting issues. In an individual session recently, Capri acknowledged that Frank and her had an argument in the last week, in front of Jack, and Frank broke the TV in anger.

Consider Dimension 1: Child Health & Psychosocial Functioning.

School:
Jack started High School this year and his attendance has been good. Jack says he likes school but misses some classes he doesn't like. He would like to become an artist or paramedic when he finishes school.

Jacks Year Advisor reports that Jack rarely speaks up in class but does respond to teachers' questions in class or when they say hello to him. Jack is accepted by peers but tends to hang around his best friend only. For the first few months of this school year he avoided classes where he didn't know any other child and he missed out on pieces of school work. While he is now used to his classes, he will still try to avoid new school-related events, tutorials etc. if his best friend is not part of it and this problem has been evident for over 12 months.

There are no behavioural concerns at school. However, Jack has not handed in any homework or assignments all term and this will effect his half-year grades. His current reading and comprehension skills are delayed (equivalent skills of an 8-year-old) but cognitive testing indicates he is capable of managing the work. Jack is performing below expectation for a couple of classes, but is performing average in Science and woodwork.

Capri and Frank are aware that Jack does not hand in homework or assignments and is behind academically but say there is nothing they can do. They have not attended parent-teacher interviews or discussed the problems with the school. Capri states that Jack was asked to attend a tutorial afternoon at school on a weekly basis but she said that he doesn't like the kids there so should not have to go. They have not discussed this problem with the school. Both parents seem unable able to help Jack set up a homework routine as they have difficulty maintaining routines. They have declined Jack's grandmother's offer to assist him with his homework as she has been responsible for making Helpline reports in the past and they do not want her in the home. The school have not made attempts to discuss the problem with Jack's parents all year.

Consider Dimension 2: Educational Engagement and Functioning

Capri:
Capri has a history of recurring depression since adolescence. Currently, Capri states feeling stressed and down. Capri states that her mood is due to Jack's behaviours and that her main stress is Jack's 'tantrums'. Over the last few months, Capri has found it difficult to get out of bed some mornings due to feeling down, but manages to get Jack to school, ensure he has breakfast and has packed his

lunch. In the last month she and Frank have received a complaint from the local council ordering them to clean the front yard of the house, which is full of rubbish (old furniture, toys, clothes). They had a similar complaint 6 months ago, when Capri's mood deteriorated, and had to organise a clean up. CPCS counsellors have noticed a dramatic decline in the cleanliness within the house over the last 2 months (e.g. lack of floor/ couch space due to clothes/toys strewn and smell of urine from their numerous cats). Capri seems unaware of how the house might appear to CPCS Counsellors and has also 'forgotten' the times and dates of recent CPCS appointments.

Capri identifies her sister as a main support person but states that they frequently argue and are currently not speaking. Capri acknowledges she is likely to just 'stay at home on her own' if feeling down, smoke cigarettes more and not eat very well. When asked about her prior counselling and strategies, Capri said she had developed a 'keeping well' plan with her prior counsellor but cannot recall any strategies in the plan. After speaking with you about her mood and the changes you have noticed, Capri says she will discuss her mood with her GP and, if needed, recommence antidepressant medication.

Capri describes herself as a loving mum but says she is at a loss as to how she or Frank can encourage Jack to develop more positive behaviours, express his needs or try new things. Counsellors get the sense that Capri lacks agency or confidence in parenting Jack and hopes that individual counselling for him, his AD/HD medication and the school will manage and help him.

Consider Dimension 3: Primary Carer Health & Psychosocial Functioning

Parenting:
Capri and Jack like each other's company, will often play games together and appear to share a generally good relationship most of the time. Capri says she is affectionate towards Jack and he reciprocates. Capri says though that it has always been hard to talk to Jack and find out what is upsetting him. Capri always tries to comfort Jack when he is upset and but describes a history of difficulty helping him make sense of his feelings or helping him problem-solve.

Capri and Frank often disagree about parenting issues. Frank wants to be stricter - 'make' Jack socialise more and do house chores like make his bed/ clean his room. Capri doesn't want to be too forceful with Jack and does not enforce things like bedtime or homework routines. They regularly verbally argue in front of Jack about this, which recently led to Frank breaking the TV in anger. Both parent's minimise the impact of prior domestic violence and do not consider that current arguing in front of Jack would cause potential and significant stress for Jack. However, both are happy for him to receive individual counselling.

Despite the current parenting strain, both parents strongly indicate their love for Jack and their ongoing care for him into the future. Clinician has serious concerns for Jack's emotional and physical (self-harm) safety with escalating arguments in the home and lack of understanding of Jack's underlying emotional needs.

Consider Dimension 4B: Birth Family Placement and Safety

Parental Engagement & Supports:
Both Frank and Capri state their willingness to assist Jack. However, many of the problems underlying initial FaCS involvement still remain (e.g. DV concerns/ parental conflict, child mental health issues).

There has been significant service intervention over last two years. Frank and Capri have not been able to develop more effective and consistent strategies to assist Jack (e.g. build parenting alliance, improve parental communication, consider impacts of trauma on Jack, emotion-coach Jack or sufficiently communicate with the school etc.). The family live near all major amenities (health/ medical, social support services). The parents report some financial strain but manage all major bills and are saving to buy an apartment.

Consider Dimension 6: Primary Carer's Engagement, Support and Environment

Interagency:
FaCS, CPCS and the family liaise regularly around counselling and case management of the family's needs. Due to the recent escalation of conflict between Frank and Capri, Case Review meetings are held bi-monthly to closely monitor the parents' engagement and progress in counselling. FaCS is organising help with the clean up of the family home and the caseworker has begun monthly visits to the parents as well as Jack. FaCS acknowledge improvements to family functioning over last 4 years of their involvement however are open with the family regarding concerns about the recent escalation of conflict within the home despite years of intervention to date and the impact this must have on Jack.

There is regular communication between CPCS and FaCS and there is a shared understanding of the family's progress, risk issues and Jack's needs.

Consider Dimension 7: Systemic Alliance and Support

Teach notes for Clinical Vignette 1.

Dimension 1: Child Health and Psychosocial Functioning.

- Management of physical /mental health problems = 1. Child has harmed self. Carer lacks understanding of child's emotional regulation problems – and links to trauma past and current. Accesses some supports (medication) but not therapeutic support and direct cessation of distress and anxiety-provoking family conflict.
- Self care (hygiene/ coping) = 1. Not enough information regarding hygiene/ self-care, however coping skills are significantly underdeveloped – has caused harm to self. Has no obvious coping skills to manage anxiety (uses avoidance, dependence, self-harm, aggression).
- Social relationships = 2. Has one friend and is accepted by adults – however had significant social problems which impact developmentally appropriate functioning and engagement.
- Sense of self/ confidence, engagement in developmentally appropriate activities = 2. Does manage chores and some self-care. Unsure of Jack's sense of self – not enough info. However, lacks confidence to degree that significantly impacts his involvement in activities.

Risk Category: 1

Dimension 2: Educational Engagement and Functioning

- School attendance = 6. Good, willing attendance.
- Experience of school/ view of future = 5. Skips some classes, but generally likes school. Has positive sense of future.
- Social relationships = 3. Has significant social problems impacting learning for longer than 3 months – but NO disciplinary actions.
- Performance = 2. Likely to need more information – however appears to be performing poorly on only some subjects.
- Carer-School relationship = 2. Poor relationship – lacks communication and effective working alliance. However not hostile.

Risk Category = 2.

Dimension 3: Primary Carer Health and Psychosocial Functioning

- Carer's management of mental health = 3. Whilst care meets basic child needs, her mood problems are not adequately managed. There is a sense of recurring depression and loss of functioning (e.g. unkempt home) that is not consistently managed. Mother does seek assistance but current mood may present a risk to child. Problems > 6 months.
- Coping and Access = 2. Does access assistance – just not in timely way.
- Parenting confidence/ relationship with services = 3. Fairly positive sense of self as parent however has difficulty maintaining positive relationships that may be helpful for her. However – not a 2 as does maintain positive relationship with services.
- Accesses supports = 2. Limited self-care strategies, interests/ supports but will access services/GP.

Risk category = 2

Dimension 4B: Birth Family Placement, Safety and Security

- Parent-child Relationship = 6. Generally positive.
- Attachment formation/ emotional care = 3. Demonstrates positive attachment forming behaviours but lacks emotion-coaching and ability to help child learn self-regulation. Long-standing problem.
- Harmful parenting = 1. DV dynamics present and Capri is not cognizant of this or acting to stop this.
- Placement stability = 1. Carers committed to care but clinician has serious concerns based on DV dynamics, lack of parental insight and effective action.
- Insight into trauma = 2. Denies/minimises impact. Does not deny supports.
- Responsibility = 1. Dismissed prior and thus current role in child's trauma. Ongoing level of conflict in home present current risk of harm.

Risk category = 1.

Dimension 6: Primary Carer's Engagement, Support and Environment

- Motivation/ responsibility = 1. Has motivation but lacks adequate responsibility to manage child's needs in relation to safety in the home (DV).
- Reflection and Change = 2. Demonstrates some reflective capacity but not sufficient change to effectively manage issues which caused major child protection concerns.
- Accesses services for child = 3. Accesses a range of services but not always to the degree necessary and demonstrates difficulty building an effective working relationship (e.g. school). Longer than 6 months. Schooling issues do present some risk – mental health does, but is accessing medical professional (paediatrician).
- Supports = 2. Accesses services but has limited network.
- Accessibility = 6. Is in an area which has services available (school, medical, psychological, welfare).
- SES strain = 5. Some but manageable financial strain.

Risk category = 1.

Dimension 7: Systemic Alliance and Support

- Case Management needs = 6. Regular meetings responsive to risk.
- Knowledge of child =6. Has historical understanding of child's history and needs.
- Communication = 6. Maintains honest, regular communication with parents.
- Working alliance = 6. Positive working alliance – shared goals.

Risk category = 6.

Vignette 1: Angel and Rena (Birth family – supervision order).

Background:

- Angel (11years) lives with her mother Renae (33yrs). They have been residing in Renae's sister Michelle and Michelle's husbands house as part of a supervision order for 8 months. Renae is currently unemployed.
- Angel was exposed to chronic domestic violence (between Renae and Angel's father), physical abuse and neglect. Renae was often hit by both parents for misbehaving and locked in her room for hours as part of 'behaviour management'.
- Additionally, Angel was diagnosed with a mild intellectual disability and speech problems by age 4years, however her parents did not follow up with recommended speech therapy appointments and educational meetings when Angel began school. Angel has missed significant amounts of time from school between ages 7-10 years and now attends a specialist behavioural school due to dysregulated behaviour.
- FaCS have been involved for 8 months now and hold has regular meetings with Angel's school, paediatrician, CPCS Counsellor and Renae, to monitor both Angel's progress and needs as well as to monitor Renae's participation in and management of Angel's psychosocial needs.
- CPCS have been involved with Renae and Angel over the last 4 months for the purpose of addressing the impacts Angel's history of trauma and increasing insight and parenting capacity of Renae.

Angel:

Angel has been diagnosed with a mild intellectual disability and receives specialist educational support on the school. She displays significant and frequent behavioural problems (hitting, biting others, breaking windows, punching doors at school and at home), in response to even minor stressors or when frustrated about not getting her own way. Angel has incurred bruises and minor cuts in such incidents and has also begun hitting her mother. Renae recently sustained a fractured finger in one incident. Angel's aggressive behaviour prevents Renae from taking her out to many social events, and the school are not allowing Rena attend excursions until she is better able to manage her anger.

Angel displays poor self-care skills (e.g. often refuses to wear sanitary products while menstruating, refuses to shower and dresses provocatively). Angel refuses to do basic chores (e.g. put clothes in laundry, eat at table, put plates in sink), and believes others should do this. She was recently caught texting naked pictures of herself to a 27-year-old man she met through a school mate and has once absconded after school until early hours of night and refused to tell her mother where she went.

Angel has difficulty maintaining friendships and is currently hanging around boys and girls 15-17yrs at school. The school are concerned about this as these older children are known to frequent the city late at night and may also take drugs. Angel tends to pick on younger children (tease, push, spit at and steal from). Angel thinks she is very smart and doesn't need to be in school. She wants to leave home and rent an apartment.

Consider Dimension 1: Child Health & Psychosocial Functioning.

School:
Angel is currently on a 2-hour a day planned attendance at school, to help build her tolerance and success at managing the school environment. She willingly attends and has had only a few absent days due to behavioural issues at home. Although she likes some classes, Angel says she doesn't really like school much and thinks she is smarter than the other kids and teachers. She looks forward to leaving high school. Angel says she will then go on the dole and move out of home and then get rich through modelling.

Angel has difficulty maintaining friendships and is currently hanging around boys and girls 15-17yrs at school. The school are concerned about this as these older children are known to frequent the city late at night and may also take drugs. Angel tends to pick on younger children (tease, push, steal from). Angel was suspended 3 months ago for 2 weeks, after throwing a chair at a teacher and breaking a classroom window.

Angel is performing below her cognitive expectations by as much, or more than, 3-4 years in most subjects. The school are mainly concerned with assisting her emotional, behavioural and social problems as these are impeding her learning. Renae actively blames the school for Angel's current behavioural problems, despite Angel having significant problems in he school environment since she was 5years of age. Although she attends school meetings, Renae often sides with Angel's version of events and believes that the teachers pick on Angel and that they should have her there for the whole day instead of just two hours as this will 'not help Angel learn anything'.

Consider Dimension 2: Educational Engagement and Functioning

Renae:
Renae has a history of depression. She currently states feeling stressed with Angel's behaviour. Of late, she has become so upset with Angel that she has walked out of the home for a few hours and left her sister to manage Angel. Renae has not left Angel on her own – and will ensure someone is there if she feels she cannot cope and has to leave for a while. Renae has often had to rely on family to provide direct parental care to Angel when she is stressed over the last year.

In session, Renae demonstrates difficulty thinking about what may stress or trigger Angel and how her own responses may add to the escalation of arguments. Renae has not been able to consider any patterns in Angel's behaviour, which may help pinpoint underlying problems and is unable to offer any strategy that has worked in helping Angel calm down, express her needs or de-escalate an argument. Renae seems at a loss as to how to better manage things into the future, and their arguments and Angel's aggression appear to be escalating each week.

Renae describes feeling victimised by services. She states that she and Angel would be fine without FaCS or service involvement. She states that she is a good parent and that Angel will do better with her when she finds her another school to go to.

Renae states that she 'lost all her friends' when she was 'forced' by FaCS to leave her hometown (due to DV with partner) and has no one to talk to. She has conflictual relationships with her parents and

other siblings. Renae states that she is too stressed to look for work. Renae has not followed up on personal therapy appointments agreed to with FaCS and also has forgotten 3 CPCS appointments and has not been home when you arrive to see her.

Consider Dimension 3: Primary Carer Health & Psychosocial Functioning

Placement:
Renae and Angel both say they love one another and like to spend some time together (e.g. shopping, Renae brushing Angel's hair). However, almost every day they argue. Renae tries to show affection and care for Angel (gives hugs, makes Angel hot chocolate the way she likes it). Renae struggles with understanding what Angel is thinking, feeling or what she might need, especially if discussing impacts of past abuse/ neglect. Renae is better able to imagine what Angel may be experiencing in situations that do not involve Renae (e.g. when having problems with friends). Renae can best comfort Angel around friendship problems.

Renae is observed to be very impatient with Angel. Renae acknowledges that at times, she raises her voice at Angel. Renae has been observed to over-react to Angels' behaviour (e.g. raising voice and walking out of room because Angel is packing her school bag too slowly). Renae and has significant difficulty taking the time to coach or teach Angel skills to the degree that Angel requires.

Although often overwhelmed by Angel, Renae states that she wants Angel in her care. However, Renae has not been able to change her parenting behaviour to date, and does not appear to understand the level of consistent emotional and behavioural support Angel needs to manage her distress and not hurt herself or others.

Renae describes feeling victimised by services. She states that she and Angel would be fine without FaCS or service involvement. Renae denies that Angel is affected by prior DV and at times, appear to deny that it occurred. Renae denies any neglect on her behalf and will blame prior schools for Angel's lack of schooling and educational support to date. Renae has been observed to state this in front of Angel.

Consider Dimension 4B: Birth Family Placement and Safety

Vignette 2: Hadi and Sue (Kinship Placement).

Background:

- Hadi is an 8yr old boy who lives with his grandmother Sue (63yrs) and Sue's eldest son and his wife and family. Hadi was removed from Sue's daughter Shelly and her husband Sufi, after exposure to chronic DV, physical abuse of Hadi and parental drug use (marijuana/alcohol) and maternal mental health issues (untreated Bipolar disorder).
- Hadi has lived with his grandmother for 2 years and has contact with both parents every 2 months.
- FaCS are case managing this family and referred them to CPCS for counselling for Hadi and parenting support for Sue.

Contact:

FaCS Caseworker has raised significant concerns about the parents' behaviour during contact. Both parents display warmth towards Hadi (e.g. eye contact, hugging). Hadi appears anxious at contact, not answering any neutral questions by caseworker who he has known for a long time, rather looking at his father. During contact, Hadi's father often aggressively questions the caseworker as to why he is talking to Hadi or supervising them. A month ago, Hadi's father got angry and yelled and swore at the caseworker. Hadi wet himself during this incident and had to change.

During contact, the parents will let Hadi play with the toys present or will offer him their phone to play games on. They often bring home-cooked food and eat together as a family.

Hadi's father has, on numerous occasions, told Hadi that they will get him back soon. Both parents have told the caseworkers that it is their fault that Hadi was taken and that DoCS are 'liars', in front of Hadi. Neither parent ever discusses Sue or asks Hadi about his grandmother and Hadi never mentions Sue.

Sue states that she does not discuss the reason why Hadi lives with her to Hadi and he has not asked. Due does not know how to explain it. No one knows what Hadi understands about the matter.

Consider Dimension 5: Relationship Safety and Security with Birth Family

Sue:

Sue has continued to engage with CPCS services around the therapeutic care of Hadi. She has been open to considering Hadi's experiences and although is not aware of much of the history, understands that he was emotionally and physically hurt and continues to have fear responses. To assist, she has engaged him in a social skills program (to help build confidence) and soccer group (to reinforce his sporting talent). Sue has managed all Hadi's health care needs as they have arisen.

Although an experienced parent and sensitive carer, Sue has made some changes to her behaviour in order to help address Hadi's anxiety. She has begun to coach Hadi some more in learning about different feeling states and will set aside some quiet time each week to play and talk about his feelings and thoughts. Sue is very open with services about what she is noticing in Hadi and has actively sought assistance from FaCS to help cover the costs of a camp that Hadi would like to attend.

Sue has very positive relationships with all of her children and their own family. Her eldest daughter will babysit Hadi one weekend a month to help provide Sue with respite. She regularly attends a social group for grandparent carers and plays weekly bowls.

Sue lives in a metropolitan area close to necessary amenities. She owns her own home but has raised concerns about some neighbourhood problems that are causing her and her family some worry (e.g. drugs in area, loud parties). Sue and her son are considering combining resources, selling up and moving the family somewhere safer.

Consider Dimension 6: Primary Carer's Engagement, Support and Environment

Interagency:
The FaCS caseworker has regular contact with Sue and CPCS by way of case reviews and phone updates. Case plans to address Hadi's school and health needs have been timely. However, contact issues have remained a concern. The caseworker acknowledges that they have avoided stopping contact at times for fear of the parent's aggressive behaviour escalating. As such, the parents have continued to make derogatory comments to FaCS staff, be verbally aggressive and discuss Hadi coming home - all in front of Hadi on a number of occasions across the last 8 months.

The caseworker has extensive knowledge of Hadi's history and psychosocial needs, and will advocate for Hadi to receive services or engage in activities that may be therapeutic for him. The caseworker has regular communications with Sue when necessary, however Sue was unaware of the extent of problems on contact. The caseworker has promised to keep her more aware of any significant events in the future.

Overall, there is an effective working relationship between CPCS, the school and FaCS. There is a shared idea about how best to assist Hadi and his grandmother and respective roles between services are clear. When in doubt, workers appear comfortable asking services questions and clarifying matters relating to the needs of Hadi.

Consider Dimension 7: Systemic Alliance and Support

Vignette 3: Ricky, Denise & Mark (Foster placement)

Background:

- Ricky (6yrs) is in long-term foster care with his foster parents Mike and Denise. Mike and Denise have an 18month old biological son Hugo. Ricky has been in this placement for 10 months.
- Ricky was removed due to severe physical abuse and following the suspicious death of his youngest sibling at 3 months of age. This death is still under investigation and Ricky is serving time in jail for the physical assault of Ricky (which left spiral fractures to Ricky's arm and bruising to his back from being hit with coat-hanger). Ricky's mother was not granted care of Ricky as she refused to cooperate with the investigation or leave her husband following abuse charges.
- Ricky sees his mother for supervised contact every 2 months.

Ricky:

Ricky is a shy but friendly young boy who loves bike riding, drawing and playing with lego. He has no major disturbances to functioning (i.e. eats and sleeps well, nil problems with toileting or mood). The only issue presented by his carers are that Ricky is said to become sad, withdrawn and 'moody' following contact with his mother. The carers distract Ricky after contact by taking him to one of their friend's homes to play with their children. They state that Ricky soon gets back into his usual calm self and routine following this distraction.

Ricky brushes his teeth and showers with prompting and some assistance, and he is able to dress himself. He is still earning to tie shoelaces properly. He will go to his carers or teachers if uncertain or feeling scared at school or home and knows basic road rules. He does not use the kitchen stove (as it not yet allowed) and has to ask to go outside to play in front yard so his carers know where he is.

Ricky has two best friends at school and is also friends with two other children in his street. He seems well-liked and never gets into physical fights. Ricky sometimes gets nervous when trying new things. For instance, when invited to try bike-riding or a new dish, or learning a new maths problem, he will often look a little scared and say 'I can't, don't' want to do it'. With prompting and encouragement however, Ricky will eventually try the new task or experience and after a time, gain greater confidence. He needs a lot of encouragement to feel able to do new things at times as approaches new things with trepidation, rather than excitement.

Consider Dimension 1: Child Health & Psychosocial Functioning.

School:

Ricky has excellent school attendance since being in care and says he likes going to school. He gets excited about excursions and school events and likes getting positive feedback from his teacher. The school report that he is well-liked and accepted by peers and that he is a lovely boy to have in the classroom. Ricky is performing below grade and age expectations. He is in year 1 but producing work at a level equivalent to or below kindergarten in reading and comprehension but is performing to

expectations for maths. His delay in spelling and reading is impacting his learning in other subjects. The school have organised additional in-class support and have placed him into a reading recovery program, which Denise attends.

Mark and Denise have a positive relationship with the school. Every few weeks they check in with his teacher to see how he is progressing with learning tasks. They feel positive about the level of support Ricky is getting at school.

Consider Dimension 2: Educational Engagement and Functioning

Denise:
Denise provides majority of day-today care of Ricky and her biological son. She states having good mood, and no health problems. Denise states only experiencing mild stressors and some tiredness due to her biological son's sleeping patterns. When feeling tired or strained, Denise will ask her mother to stay with her for a couple of days to help her rest and manage both boys.

Denise is proud of being a foster carer and believes that Ricky responds to her well, most of the time. She acknowledges feeling inadequate often after Ricky has contact with his mum, as she cannot seem to make him feel happy when he returns home. She feels abler to soothe her biological son. Denise does not access foster carer support services because she feels well-supported by her family.

Denise regularly meets up with friends and engages in gym classes to get some adult time and time to maintain her health.

Consider Dimension 3: Primary Carer Health & Psychosocial Functioning

Placement:
Denise and Ricky appear to enjoy each other's company. Denise speaks positively of being around Ricky and Ricky says Denise is 'nice' and 'fun'. Denise has demonstrated verbal and physical affection towards Ricky and Ricky responds well to this. Denise appears confident and able to help Ricky manage day-to-day emotional challenges like minor problems with school or arguments with friends.

Denise acknowledges that she does not know why Ricky is still sad after contact and worries about upsetting him more by talking about it. She thinks it is best to help him forget his sadness and move on. After contact, when Ricky is 'moody' she tells him that she won't hug him until he shows her his happy face and gets a 'better attitude'. Denise does not know how to talk with Ricky about his feelings for his mother.

Denise and Mike tend to agree on parenting strategies and reinforce each other's rules with Ricky. They both indicate a strong desire to care for Ricky into the future and often talk about the boys growing up together and hopefully being close.

Denise imagines that Ricky must feel scared about new things because he experienced a lot of physical abuse previously – and so worries about making mistakes or somehow doing the wrong thing. Denise makes a point of telling Ricky that it is okay to make mistakes and will sometimes act silly when doing a new activity to try to lighten the mood and show him that things can be fun. Denise feels unable to talk to Ricky about why he is in care at this stage. She says she is angry with his parents and doesn't understand why he wants to still see his mother. Denise is willing to work with CPCS and FaCS to develop some explanation on why he is in care.

Denise does not wish contact to continue. She believes that Ricky's contact with his mother is unhelpful and that he would be better off not seeing her. She does not say anything negative about his mother but does not invite him to talk about his mum or refer to her.

Consider Dimension 4A: Alternate Placement Security and Safety

The caseworker reports that contact is positive and that Ricky and his mother appear to enjoy seeing each other and playing. Ricky's mother appears to manage well and spends all the time talking and playing with Ricky. She has some difficulties ending contact and can become teary. She needs the caseworker to prompt them to slowly back up and get ready to go. Despite this, contact ends smoothly.

Ricky's mum cannot talk to Ricky about the past. Ricky is starting to ask when he is coming home to her and where is his dad. Ricky's mum doesn't know how to respond and looks to the caseworker for support. The caseworker tends to say that he will talk to Ricky about it all soon as sees that Ricky does not understand he is long term care.

Ricky's mum often asks Ricky how his carers are and asks if he can say a hello to them for her. She appears comfortable listening to him talking about his carers in contact.

Consider Dimension 5: Relationship Safety and Security with Birth Family

Denise is very busy developing a private business part time, however is amenable to meeting with CPCS workers regularly. Denise is keen to reflect on Ricky's experiences and how this may impact him day to day, but acknowledges she has difficulty thinking about his mum. In session, when the counsellor attempts to explore Ricky's emotional attachment to his mother, Denise will often focus on his mother's neglect of Ricky and the negative impact of that. Denise organises and follows through with all of Ricky's medical and educational appointments. She is also ensuring he attends a new music therapy group to help him express himself more confidently.

Denise states that although she loves Ricky and cannot imagine her life without him, caring for him has been more difficult than she expected. She describes feeling anxious at times because he still sees his mum and worries that his mum may take him back one day. She understands that this may make her want Ricky to show her how much she needs him and how she doesn't expect this of her son Hugo. Denise is trying to be more aware of her own feelings and not expect Ricky to be so affectionate towards her.

Denise does not access foster carer support services because she feels well-supported by her family. She calls on her mum to help babysit if she needs some time to rest. Denise regularly meets up with friends and engages in gym classes to get some adult time and time to maintain her health.

The carers live close by to all amenities and both drive. They state no financial problems.

Consider Dimension 6: Primary Carer's Engagement, Support and Environment

The family have had 3 different caseworkers in the last 8 months. They have had 6-monthly case reviews to help sort out case planning, contact schedules and to get updates regarding Ricky's father's court matters. There have been some delays on getting camps organised for Ricky, and the family are still waiting to get a passport for him and this frustrates the carers. However, all key needs are addressed through the meetings.

The caseworkers tend not to meet Ricky but generally know about his trauma history and ensure they action services or initiatives to assist his current needs (e.g. organised financial assistance to fund music therapy group).

Mark and Denise express frustration at their caseworker at times and confusion over what their role is. However, they state that they can generally clarify things with the caseworker or manager as needed.

Consider Dimension 7: Systemic Alliance and Support

Multi-Systemic Assessment of Psychosocial Safety (MAPS)

Participant Survey

Please write down your designation or training background (e.g. Art Therapist, Social Worker, Psychologist, Counsellor, Mental Health nurse)

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Please indicate what is the highest level of education you have achieved to date in relation to your work designation:

☐ High School Certificate
☐ Diploma in Counselling/ Therapy
☐ University degree (e.g. bachelor of Social Work/ Psychology)
☐ Masters Degree
☐ Doctorate/ PHD

Other: ……

How many years' experience has you had in working with CPCS?

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How many additional years' experience (minus those working in CPCS) have you had in working with families at risk? (e.g. Community Health, mental health, parent-infant mental health, tertiary counselling services)

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1. **Please rate the experience you had using the MAPS to determine risks and strengths in the clinical vignettes provided:**

Very difficult O ---------- O ---------- O ---------- O ---------- O --------- O Straightforward

Comments:

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2. **How relevant do you think each domain was in identifying risks to children's psychosocial safety and well-being:**

Domain 1. Child Health and Well-being:
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 2. Educational Engagement & Functioning:
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 3: Caregiver Health & Well-being
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 4A. Placement Safety & Security
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 4B. Family Safety & Security
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 5. Relationship Safety with Birth Family
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 6. Caregiver Engagement, Support & Environment
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

Domain 7. Systemic Alliance & Support
Not relevant at all 0 ---------- 0 ---------- 0 ---------- 0 ---------- 0 --------- 0 Highly relevant

If you did not find a domain relevant to helping determine a child's psychosocial safety can you please explain why:

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2. The MAPS PROFILE and Clinical Planning Tool aim to provide a 'snapshot' summary of current areas of strengths and risks for a child across their care systems. **Please look at the MAPS Profile Summary page 1.** Consider the risk categories (Immediate and Significant, Moderate > 3months and Moderate, and Low Risk/ Strengths). Consider the risk categories you assigned the vignettes today after using the MAPS scales. How well do you think the Risk categories accurately reflected the risk level in the vignettes?

The Immediate and Significant Risk categories:

Very well O ---------- O ---------- O ---------- O ---------- O ---------- O Very Poor

The category 'fit' the level of risks or strengths in the vignettes

The category did not 'fit' the level of risk or strengths in the vignettes.

The Moderate Risk Categories:

Very well O ---------- O ---------- O ---------- O ---------- O ---------- O Very Poor

The category 'fit' the level of risks or strengths in the vignettes

The category did not 'fit' the level of risk or strengths in the vignettes.

The Low Risk/ Strengths Categories:

Very well O ---------- O ---------- O ---------- O ---------- O ---------- O Very Poor

The category 'fit' the level of risks or strengths in the vignettes)

The category did not 'fit' the level of risk or strengths in the vignettes.

Do you have any comments about the relevance or accuracy of the Risk/ Strengths Categories:

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Please rate how useful you think the MAPS might for CPCS counsellors in the following:
Overall assessment of child and family risks and strengths:

Not at all useful O ---------- O ---------- O ---------- O ---------- O ---------- O Highly useful

In helping to formulate <u>counselling objectives</u> (e.g. where and with whom to focus counselling interventions):

Not at all useful O ---------- O ---------- O ---------- O ---------- O ---------- O Highly useful

In helping to formulate a <u>case management</u> plan (e.g. identifying strains, social support needs, interagency issues that need to be addressed via advocacy, management meetings etc.):

Highly useful O ---------- O ---------- O ---------- O ---------- O ---------- O Not at all useful

In assessing change in individual or family needs/ capacities over time:
Highly useful O ---------- O ---------- O ---------- O ---------- O ---------- O Not at all useful

Do you think this domain is sensitive enough to pick up on changes within levels of support and working alliance over time – say a period of 6 months?

O Yes O No O Unsure

Comments:
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What level of clinical experience within the child protection field do you think is needed for a clinician to be able to effectively use this scale?

O Nil O 3 - 6months O 6 -12months O Over 1 year

Other:
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Please list if you use measures to currently assist your counselling assessment and/or outcomes data. For instance, if you use a standardised measure, please name (e.g. Depression, Anxiety & Stress Scale or a Client Satisfaction Survey. Please also indicate how frequently you use that specific measure (e.g. at assessment/ closure, every week/ month/ six months etc.

O We currently do not use measures of clinical ssessment or outcomes

OR please list what your service uses now:

Type of Measure	Frequency of use
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Please feel free to give any further feedback about the scale or associated tools. Your feedback is appreciated.

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Thank you for your participation in this study and for your feedback.