Examining the complexity of Placement Stability in Residential Out of Home Care in Australia: How important is it for facilitating good outcomes for young people?

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Abstract

Just over 5% of young people in Out of Home Care (OOHC) in Australia live in residential care, which equated to approximately 2394 young people in the system in 2015. There is little research, however, that provides data on significant decision-making in residential care, such as the timing and number of placement changes. Research into foster care has established that generally worse outcomes are experienced for young people who have experienced placement instability. In a residential care setting, understanding placement stability is more complex because of subtle instabilities. These include: changing staff; changes to the co-residents; as well as shifts of the children themselves to a new house; the latter typically result from organisational decisions, or are a result of challenging behaviour by the young person, or towards them by another young person. This paper examines the current state of the literature, and identifies the need for further research and theorization on what constitutes placement stability and instability for a residential care cohort.

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Residential out of home care

Throughout much of the developed world, residential care forms part of the child protection system (Ainsworth and Thoburn, 2014). It does, however, differ significantly throughout the countries. Throughout this paper, the broader Out of Home Care system will be referred to as OOHC, and children in the OOHC system will be referred to as `in care'. Residential care refers to:

> placement in a residential building whose purpose is to provide placements for children and where staff personnel are paid. This category includes facilities where there are rostered staff, where there is a live-in carer (including family group homes), and where staff are off-site (for example, a lead tenant or supported residence arrangement), as well as other facility-based arrangements (Australian Institute for Health and Welfare [AIHW], 2005, p.42).

OOHC in an Australian context

Within Australia, residential care forms part of the child protection and OOHC systems and is run by the individual states and territories. The vast majority of young people in OOHC live in foster care or kinship care. Australia has one of the lowest rates of residential care in the world. Ainsworth and Thoburn (2014) presented a table comparing rates of children and young people in residential care internationally. The results suggested that Armenia (95%), Japan (92%), Israel (80%) and Czech Republic (72%) had the highest rates of their care populations in residential care. The lowest rates were in Australia (6%), Ireland (8%), England (14%) and USA (15%). A comparison of international residential OOHC is beyond the scope of this paper, however, it is relevant to note that Ainsworth and Thoburn (2014) speculated that the lower the rates of use of residential care, the more 'pointy end' young people are being accommodated, which can inflate the behavioural difficulties seen and possibly poorer outcomes observed.

According to the Australian Institute of Health and Welfare (AIHW), in 2014-2015, just over 5% of young people in OOHC live in residential care, which equates to approximately 2394 young people in the residential care system throughout Australia. Across Australia, the majority of those in residential care (82%) are aged between ten to 17, however, there is considerable variation between the states. Up to 42% are aged under ten years in some states (notably South Australia and Western Australia), while in others, less than 6% of those in residential care are aged under ten (notably New South Wales (NSW) and Victoria) (AIHW, 2016). It should be noted that these statistics include both staffed residential care and family group homes. A family group home is designed for low-moderate needs young people and is a house established for groups of young people, often large sibling groups, run by professional, paid carers in a family-like setting (Family and Community Services [FaCS], 2007).

There are significant differences between the two models, including the level of need of the young people involved, with family group homes accommodating lower needs young people and residential care generally accommodating young people with higher needs. Additionally, while residential care has a rostered model of care, in contrast a family model is offered in family group homes with the carers living in the house on a 24 hour, seven day per week model. Any patterns noted in the data may not capture specific difficulties or differences in residential care, as the data does not delineate between the two cohorts.

In Australia, residential care has typically been considered as a 'last resort' (Delfabbro et al., 2005). A socio-political shift took place in the second half of the 20th century away from institutional care to family-based care as a result of allegations of abuse and inappropriate care (Ainsworth and Hansen, 2005). The authors note that in the 1970s, Australian states and territories indiscriminately shut down institutions that provided care, regardless of whether they could demonstrate safe and ethical practices. It has further been argued that research in the latter part of the 20th century that investigated residential programs identified poor outcomes (e.g. Ford and Kroll, 1995). This contributed to the sense of residential care being a last resort for young people in the care system (Ainsworth and Thoburn, 2014). Today in Australia, residential care is typically reserved for young people in care who have either had multiple failed foster care placements or those who entered the care system later in life. It has been suggested that children and young people with particularly challenging and high risk behaviours make up a significant cohort of residential care alumni due to the difficulty of finding them safe and consistent housing elsewhere (Ainsworth and Hansen, 2005; Barber and Delfabbro, 2003).

A 2008 review of the Australian literature and policy found that while the state and territory child protection services were mostly providing similar interventions, legislations scaffolding these interventions were quite different (Smyth and Eardley, 2008). Three major elements show fairly consistently throughout legislation and policies, firstly that the best interests of the child are paramount; secondly, that Aboriginal children are placed according to the Aboriginal Placement Principle (which specifies preferences for the placement of Aboriginal children and young people in care to protect their sense of connection to country and culture) and thirdly, that children and young people are able to express their views (AIFS, 2014).

Residential care in NSW

For the purpose of this article, the Australian state of New South Wales (NSW) is the focus. The primary researcher conducts research and works in this state. The NSW OOHC sector is governed by the Children and Young Persons (Care and Protection) Act (1998) and the Children and Young Persons (Care and Protection) Amendment (Out of Home Care) Regulation (2003), which is also

legally binding. OOHC is managed by the Family and Community Services (FaCS) sector of the state government. Most residential care facilities and the case management of the individual children and young people are outsourced to non-government agencies (NGOs) for the day-to-day running of the facilities. Residential care in NSW generally looks like an average house on an average street inhabited by between one and four young people with ages ranging between 12-18 years. The houses run with a rotating roster of staff. The office of the NSW Children's Guardian has put boundaries on residential care so that for children younger than 12, special permission must be sought before they can enter residential care (FaCS, 2016). This is related to the perceived need of younger children to be cared for in a family-like environment that cannot be achieved in residential care (Ainsworth and Hansen, 2005), although this model is being questioned (Osborn and Bromfield, 2007).

FaCS, the funding governmental department for OOHC in NSW has permanency of placement as one of their primary goals. From 1 October 2017 a `Permanency Support Program' reform will be introduced in order to facilitate placement stability, either through restoration to families or more secure placements in care will be introduced. It is apparent that placement stability and permanency are primary goals for OOHC and as such, understanding what stability is, how to achieve it, and what value it has, are foci of significance.

Understanding residential care

There is limited research that can provide empirical data on important aspects of residential care. For the current paper, a review was conducted by searching `residential care', `placement stability', `placement instability', `residential care outcomes' and `trauma and attachment' through PsycInfo, ProQuest and Scopus. This review is limited to published articles that were available on those databases. Unpublished papers were not available to add to the review, and as such, there is likely research that has not been considered.

In considering the lack of empirical bases for decisions made in terms of implementing residential care or the policies around it, James (2015) commented that `evidence-based practice in residential care is an oxymoron' (p142). She notes that the residential care field has been built and shaped over time by developments in policy and practice through a number of fields, including mental health, juvenile justice, education and the impact of socio-political ideologies. In a review, James (2015) found that 13 studies between 1990 and 2012 had used rigorous, or semi-rigorous methodologies to look at implementing evidence-based treatment programs within residential settings. These studies looked at ten interventions, meaning that there was little to no replication of studies with potentially small subject pools. Looking at evidence-based therapeutic milieu-wide approaches to residential care, five residential care models were found to have had at least one evaluative study completed,

however, the rigor of the studies was limited. It is therefore very difficult to examine the nature of residential care, when individual approaches cannot themselves argue to be rigorously evidence-based and the international data collection for the impact of residential care is poor. In this context, significant decision-making, such as the timing and number of placement changes, is not based on empirical data.

Statistics generally demonstrate that the longer a child is in care, the greater number of placements they are likely to have experienced. AIHW data indicate that during 2014-2015 63% of children in OOHC had one or two placements, 22% had three to four placements and 15% had more than five placements; this has not been delineated for foster, kinship and residential care (AIHW, 2016). Children with large numbers of placements make up approximately 15-20% of children in foster care (Barber and Delfabbro, 2003). It may be the case that these children make up a significant part of the cohort of children in residential OOHC at some stage. So it is clear that for a significant minority, placement instability is a part of their experience of growing up in OOHC. Given that a substantial proportion of children and young people experience placement instability, this paper seeks to discuss the need for further review and evaluation of the meaning of placement stability and instability. This will address the question of how it can be measured so that further research can begin to evaluate the outcomes of placement stability or instability in residential care.

Research examining stability in foster care has found positive outcomes, including steady improvement in behaviour and psychosocial functioning (Withrington, Burton, Lonne and Eviers, 2016); improvements in cognitive ability (Proctor, Skriner, Roesch, and Litrownik, 2010) — although this may be related to reductions in levels of stress allowing cognitive ability to be more accurately assessed; and reduced mental health concerns (Perry, Pollard, Blakley, Baker and Vigilante, 1995). Given that there are positive outcomes associated with stability, in a foster care context, it seems reasonable to suggest that stability in residential care would also be beneficial. As mentioned previously, however, a definition of stability first needs to be established. Consider the following case example:

Johnny, a 14-year-old boy has been in his placement for 18 months, his first placement since entering residential care. He is fortunate enough to have a fairly stable team, and team leader. He knows, however, that one of the staff is moving to another house because of difficulties with another young person in the placement. He also knows that the team leader is going on extended leave to have a baby. There are three other young people in the house, with none of whom he has a good relationship.

Unlike in foster care, measuring stability in residential care is not as simple as counting placements. Johnny has had only one placement, however, there have

been disruptions within the placement in terms of his care team, without secure relationships with his co-residents. This will be discussed further in this paper.

Defining placement instability

Unrau (2007) completed a review of 43 studies into foster care stability and found that it was measured in a number of different ways. Some of the research papers have done so categorically by looking at how many placements a young person has had over a particular period of time and comparing outcomes across blocks of placements (e.g. 1, 2-3, 4-5; cf. Koh Rolock, Cross and Eblen-Manning, 2014; Ryan and Testa, 2005). Others have identified stability as being one placement (i.e. no moves) over an 18 month period (O'Neill, Risley-Curtiss, Ayon and Rankin Williams, 2012), others have defined 'cut-off points', generally identifying a point of 'stability' (e.g. one to two placements) and a point of 'instability' (3+ placements) over the period in care (Barber and Delfabbro, 2003). These analyses, however, assume that counting placements is the most accurate marker of stability.

Akin, Byers, Lloyd and McDonald (2015) suggested also that the timing of moves was relevant. It is particularly difficult, however, to compare findings across studies when they are potentially measuring different things, and certainly measuring them differently.

Consider the following case example: Tallulah, a 16 year old girl has ongoing difficulties with drug use and aggression. Her staff team have been fairly stable for the past 6 months, and she enjoys good relationships with them. However, all the young people that were living in the house when she moved in have moved out — one because they turned 18, another because she was incarcerated for theft offences and another because of assaulting one of the staff members.

Stability in this example is provided by the staff, however, the co-residents have been highly unstable. This may have the effect of Tallulah being unsure of who will be in the home with her, which may lead to feelings of being unsafe and that her own placement may end.

Cashmore and Paxman (2006) examined the experiences of young people transitioning from care in NSW, and proposed the concept of 'felt stability' which they define as a young person's sense of emotional security, rather than placement stability in and of itself. In their study of 41 young people who had been in both foster, kinship and residential care, they found that "felt stability" was a better predictor of outcomes, although there did appear to be a link between feeling secure and having fewer total placements ('secure' had an average of 2.3 placements while 'insecure' had an average of 9.5 placements). The participants were interviewed on four occasions, once before leaving care,

once at three months post leaving care, once at 12 months post leaving care and finally at four to five years post leaving care. They found that the greater the degree of felt stability, the better the outcomes were four to five years later in terms of educational attainment, social supports and mental health. The study authors did note, however, that those who could be contacted and were willing to participate had fewer placements and lower levels of overall pathology. Also, given the small participant numbers, this study is unlikely to be representative, however, it does provide some insight into what elements of 'stability' are significant.

One of the key predictors, however, of felt stability was the ability for the young people to stay on in the placement at the conclusion of their children protection order (turning 18 years of age, Cashmore and Paxman, 2006). In residential care in NSW this is not possible as they are considered to be under the care of the Minister only until they turn 18 and placements are no longer funded after this time, unless they are taken over by a secondary department, such as a disability service. One significant implication of their findings, however, is that the lack of placement changes does not necessarily imply a feeling of security and stability on the part of the young person and so cannot necessarily be taken as a measure of positivity.

Extant literature on instability in foster care

Research by Ryan and Testa (2005) investigated the timing of placement changes in a foster care cohort and identified rates of delinquency and looked at whether placement changes preceded delinquency or vice versa with a sample of over 18,000 from birth with at least one substantiated report of maltreatment, 4085 of whom experienced an out of home care placement. They found that simply being in an out of home care placement increases risk of delinquency, however, specifically more than two placement changes increased the risk of delinquency in male youth from 11%-23% and for females, being placed out of home doubled the risk of delinquency, irrespective of instability. The authors did note, however, that their markers of delinquency were contacts with the police. They acknowledged that it is possible that more problematic behaviours were present prior to this that increased the likelihood of placement changes. A number of other studies similarly suggest that offending is more likely among young people who have experienced greater placement instability (Barn and Tan, 2012; Cusick, Courtney, Havlicek and Hess, 2010; Jonson-Reid and Barth, 2000b; Taylor, 2006; Widom, 1991). These findings would suggest that multiple placements (identified by the discreet number of separate placements) has an impact on delinquency and criminal behaviours.

Barber and Delfabbro (2003) identified that children in foster care who have had two or more placement breakdowns in the first two years were likely to have significantly worse outcomes, controlling for age of entering care. Similarly,

Webster, Barth and Needell (2000) found that more than one move in the first year is associated with increased placement instability further on. The authors examined records for 5557 children who entered care before their sixth birthday between 1988 and 1989 in California and stayed in care for the next eight calendar years. The findings accorded with a number of other studies that suggested that longer periods of time in care were correlated with greater placements, that foster care (as opposed to kinship care) had greater numbers of placement moves and older age of entering care was associated with greater numbers of placement moves. The authors do not offer an explanation why those who have multiple moves in the first year tend to have greater numbers of placements over time. It may be related, however, to factors associated with greater impacts of early trauma exposure leading to greater behavioural problems, or poorer matching leading to greater attachment difficulties, which will be discussed further on in this paper.

Other research has also found that placement instability is an independent predictor of sexual behaviour problems, over and above maltreatment (Tarren-Sweeny, 2008a; Prentky, Lee, Lamade, Grossi, Schuler, Dube, DeMarco and Pond, 2014). Prentky and colleagues (2014) studied 559 male ranging in age from three to 18 who had been referred to child welfare between 1998 and 2004 and examined the relationship between placement instability, sexually inappropriate behaviours and aggression. They coded placement instability in four groups (0-6, 7-10, 11-18 and 19-47). The findings suggested that there was a `broad and robust influence of placement instability' (p. 268) on sexually inappropriate behaviours and aggression. This particular sample had a high number of average placement changes (10.4). Australian statistics suggest that approximately 15% of young people in OOHC have over five placements (AIHW, 2015), as such, Prentky et al.'s findings would likely be most applicable to that cohort, which would suggest that high numbers of discrete placements has a significantly negative effect on healthy adjustment, however, this can only be generalised to males.

Placement instability has also been linked to emotional and behavioural problems, poor adult outcomes (Koh et al., 2014), increased anxiety and depression and difficulties trusting and forming new relationships (O'Neill et al., 2012). Placement instability has consistently been identified in the literature over time as being associated with a range of significant problems in both male and female children.

Placement stability in residential care

Placement stability becomes more complex in residential care than in foster care. In residential care in NSW there is generally up to four young people in a house, a roster of staff plus a team leader, a caseworker and a residential manager. Certain practicalities of a staffed regime impact on stability, such as

leave allowances, organisational restructures, staff preferences for where they work (Wigley, Preston-Shoot, McMurray and Connolly, 2011). This means that on any given day a young person cannot be completely sure who will be looking after them.

Researchers from Australia have looked at placement stability in residential care and suggested that their model helped reduce placement instability, however, implied in their findings is that organisational stability was maintained rather than placement stability. This was a retrospective file-review examination that looked at 31 young people that had progressed through their programme, in both foster and residential care. The model allowed for attachment stability to be maintained with a key worker, moving with a young person to a different placement, however, this is possibly a different idea to placement stability (Cheers and Mondy, 2009).

Placement instability and outcomes: The importance of attachment

Attachment theory provides a theoretical lens through which to understand the importance of placement stability on achieving positive outcomes. John Bowlby (1970) suggested that the attachment relationship directly influences the infant's ability to cope with stress through the development of a control system in the infant's brain that regulates attachment functions.

Function of attachment

A child learns to regulate their emotions through the process of having their emotions regulated for them through the primary attachment relationship(s) (Perry, 2009). Young people in residential care often have not had positive attachment experiences, and are unlikely to have had the repeated experience of being emotionally soothed. This is likely because interpersonal trauma is often the reason for referral into the care system. According to the most recent annual report from FaCS, for 2012/2013 the top three reasons for child protection reports to be made were physical abuse, neglect and domestic violence, all of which are interpersonal traumata.

Emotional and behavioural instability and dysregulation can have a significant impact on a young person's capacity to remain in a single placement (Webster et al., 2000). Chamberlain, Price, Landsverk, Fisher and Stoolmiller (2006) found that a foster family could, on average, tolerate up to six problem behaviours before asking the child to leave. Considering Barber and Delfabbro's (2003) position that there is a small but significant portion of those in the foster care system who have had many and problematic placements, it is likely that those with multiple problem behaviours who are being asked to leave their foster placement will spend time in residential care as they age. It could be argued that

more disrupted attachments leads to poorer emotional control, and poorer emotional control leads to a greater number of placements and further disrupts attachment.

The second element of a secure attachment is that a child learns to enjoy and value the company of others (Perry and Szalavitz, 2006). They learn that adults are safe and that people can be trusted. Perry and colleagues (1995) explained the historical origins as humans as a species evolved to enjoy the company of others, to feel safety from people with others. Human history has evolved over the last million years. In the early part of that time, humans travelled in bands of 30-40 people. Being part of a band ensured safety and protection from others. A lone human had no body heat for warmth, noone to help find food, noone to protect from predators or other humans. As such, humans evolved to enjoy and need the company of others for the survival of the species (Perry et al., 1995). For a child whose needs are not responded to, that child may simply learn that they must rely on themselves for their needs to be met and may not find particular pleasure from being around others. It is often seen that young people who had multiple placement breakdowns become quite 'detached' and uninterested in forming bonds with safe adults. They can be hard to connect with, hard to bond with and hard to care for (Tarren-Sweeny, 2008b).

Consider the following case study:

Ben is 13 and lives in a house with three other boys, all of whom can be quite aggressive and have long criminal records. He has been in this placement for the past two years. The staff are not happy at work because of frequent threats of abuse from the young people and regularly call in sick. Because the house is known to be really difficult, casual staff are hard to get to come in so agency staff are often called in. As a result of the frequent casual staff, Ben often does not know the person who is on shift. The team leader has been a stable person for the past two years, however, she only comes to the house when staff cannot be found to work or to visit once a week. Ben's placement is relatively stable, in that he is not at imminent risk of being moved to another, however, his attachment figures are not stable.

Attachment theory can offer some insight into why placement stability likely matters in terms of positive outcomes for young people in case. Wigley et al. (2011) found that a key theme for young people in the care system who had experienced instability related to a lack of belonging and attachment security. One young person interviewed said, `[there is] no-one I belong to'.

Conclusion

In Australia, a key target of the governmental department responsible for OOHC is to ensure stability for the children and young people. To date, research has been relatively unanimous that placement instability (defined by discrete

placements) is associated with poorer outcomes in childhood, adolescence and adulthood, as compared to those with greater levels of stability. Very little research has examined this issue specifically relating to residential care.

In order to achieve greater stability for those in OOHC and specifically for those in residential care, firstly the question of 'what is stability in residential care' must be answered and then pathways for achieving it can be more readily identified. As mentioned through the current paper, stability is generally measured based on discrete placements, however, the case studies have sought to illustrate that stability is not simply about residing in a single address, although this is likely an important element.

Policy and practice implications

Significant implications for policy and practice here are related to the lack of effective definition of stability that can be practically applied in residential care. By reviewing the current literature, it is apparent that there is insufficient evidence that placement stability has been effectively defined for residential care. Until a multi-dimensional understanding of placement stability can be operationalised, it cannot be effectively researched, nor can practical guidelines be implemented by organisations to ensure it. Given the apparent importance of stability, it is clear that this must be a focus.

By developing further research in this area, it may be possible that practice guidelines can be implemented that direct or inform the number and timing of placement changes to reduce the impact on the young people involved. For example, Webster and colleagues' (2000) finding that more than one placement in the first year increased the likelihood of further instability. Were this to be supported by research in residential care, structures around the first year in residential care could be put in place to ensure that placement moves are restricted to absolute necessity, such as when court ordered or for reunification.

Further research should seek to interview staff and young people regarding their views of what is relevant for stability as well as identifying patterns of stability in various domains including staffing, co-residents, family access, schooling and physical address.

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