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EVIDENCE BRIEF

Complex Needs

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The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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EXECUTIVE SUMMARY

This evidence brief focuses on the recognised factors affecting children and young people involved in care and youth justice, specifically complex needs, including behavioural/attachment issues and mental health/substance use issues.

This evidence brief summarises up-to-date, relevant international literature on complex needs in children and young people involved in care and youth justice. Given the nature of the evidence brief it should be considered a general descriptive document to be read in conjunction with referenced sources. It is a time-constrained examination that draws on a limited research base.

'Complex needs' and 'care' definitions

- There is no consensus on the definition of 'complex needs' in care populations; instead the literature assumes that the term doesn't need to be defined and that it presents issues of fact only.
- In the literature, 'complex needs' is linked with a number of other terms and used interchangeably with them – these include 'multiple disadvantage', 'special needs', 'high support needs', 'complex health needs' and 'multiple and complex needs'.
- International definitions of 'complex needs' vary by jurisdiction, and emphasise different aspects, including care placement, the level of need and/or the level of cross-agency collaboration required.
- Oranga Tamariki—Ministry for Children defines 'complex needs' as needs that have both breadth and depth, and varying levels of complexity

Complex needs in the care and youth justice populations

- Young males and those who identify as indigenous are over-represented in the care population.
- The Common Approach Wheel, developed as part of the National Framework for Protecting Australia's Children, provides a useful framework for categorising the ways in which complex needs are exhibited in care and youth justice populations. Categories include: physical health; mental health and emotional wellbeing; relationships; material wellbeing; learning and development; and safety.

Complex needs risk and protective factors

- There are a number of identified risk factors, including socio-economic factors; age at placement; parental behaviour and disorders including substance abuse; and trauma and neglect history.
- The absence of strong attachment can lead to complex needs and subsequent care and youth justice intervention.

Complex needs service and therapeutic responses

- The primary aim is to keep children from requiring intervention by providing preventative services that are adequate, accessible and universal.
- Joined-up and wrap-around services ensure necessary coordination and cross-agency collaboration.
- Child and family services in New Zealand, Australia and Canada for indigenous children with complex needs are increasingly moving to kinship and community-based care.

- Inadequate ongoing support after children leave care is a significant gap in the care continuum.
- Attachment-based models of care are the primary approach to managing complex needs in care.
- More evaluation and research is needed on the interplay between complex needs, risk and protective factors, services, and welfare outcomes.

INTRODUCTION

Background

This evidence brief provides a high-level review of complex needs in care

In order to ensure a successful care continuum, it is necessary to understand established factors affecting children and young people involved in care and youth justice, how these needs exhibit, and the likely risk and protective factors. There is also a need for an up-to-date understanding of the most effective services and therapeutic responses.

Children in the care and youth justice populations exhibit multiple complex needs that are interrelated and serious

The needs of children and young people in care and youth justice are often 'complex'. Oranga Tamariki currently defines 'complex needs' as needs that have both breadth (multiple needs that are interrelated or interconnected) and depth (profound, severe, serious or intense needs) (Rankin & Regan, 2004). The level of complexity will vary depending on the child or young person, their support system (and its capabilities), and the identified need or needs.

The evidence base for 'what works' in addressing complex needs in care is relatively limited

The evaluative research and evidence base on interventions is relatively limited. However, a number of common themes feature in the types of services and therapeutic responses trialled and used in comparable jurisdictions, such as:

- preventative and early years interventions, in recognition of the fact that age at placement appears to be a significant predictor of welfare outcomes
- comprehensive assessment of the child or young person, and their carers
- joined-up or wrap-around services
- attachment-based interventions
- placement stability and appropriately supported carers
- integrated and appropriate aftercare.

This evidence brief is a time-limited examination that draws on a limited research base

The literature reviewed includes journal articles and grey literature. The majority of sources referenced were provided by Oranga Tamariki.

'COMPLEX NEEDS' DEFINITIONS

'Complex needs' is used interchangeably with other terms such as 'special needs', 'high support needs', and 'multiple disadvantage'

In the literature, the term 'complex needs' is linked with a number of other terms and used interchangeably with them – these include 'multiple disadvantage', 'special needs', 'high support needs', 'complex health needs' and 'multiple and complex needs' (Rosengard, Laing, & Ridley Susan Hunter, 2007). Oswald, Heil and Goldbeck (2010) use the term 'compromising situation' to refer to children who have suffered neglect, physical abuse, or sexual abuse, and/or who have a trauma history. Recognising the lack of consensus and consistency within the literature on defining 'multiple and complex needs' the Scottish Executive Social Research uses the pragmatic definition 'active framework for response' (Rosengard et al., 2007), as does Oranga Tamariki (2017b), that was put forward by Rankin and Regan (2004). This identifies that 'complex needs' implies both:

- breadth – multiple needs (more than one) that are interrelated or interconnected, and
- depth of need – profound, severe, serious or intense needs.

The level of complexity will vary depending on the child or young person, their support system (and its capabilities), and the identified need or needs.

There is no standard definition of 'complex needs' and international definitions emphasise the conditions the child has and the support they require, or the multifaceted nature of needs/wellbeing

Definitions in other jurisdictions emphasise the multifaceted nature of needs (Australia, Wales and England) or service levels and cross-agency collaboration (Alberta in Canada). In England, 'complex' needs is not defined in legislation but the Children and Young Persons Act 2008 places a general duty on the Secretary of State to promote the wellbeing of children. In this context, 'wellbeing' refers to: physical and mental health and emotional wellbeing; protection from harm and neglect; education, training and recreation; the child or young person's contribution to society; and social and economic wellbeing (Department for Children Schools and Families, 2008). However, for England and Wales, the Children Act 1989 (section 17(10)) defines a child as being 'in need' if:

a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

c) he is disabled.

'Development' means physical, intellectual, emotional, social or behavioural development; and 'health' means physical or mental health (section 17(11)).

The Australian Government's Department of Social Services, under the National Framework for Protecting Australia's Children (Council of Australian Governments, 2009), has a Common Approach

to Assessment, Referral and Support (Common Approach), which was developed by the Australian Research Alliance for Children and Youth. The Common Approach Wheel is a tool designed to help practitioners identify the needs of families and children across six life domains: physical health; mental health and emotional wellbeing; relationships; material wellbeing; learning and development; and safety (Department of Social Services, 2016).

In Canada, the Government of Alberta emphasises the importance of cross-agency collaboration for defining 'complex needs'. In addition to the standard definitions of 'multiple impairments, complex mental health issues, and/or severe behavioural needs', it also recognises that young people with complex needs are those 'for whom all currently available resources have been utilised with limited success' and who 'require fiscal and human resources that strain the capacity of any one ministry' (Burnside, 2012).

The literature review and consultation programme undertaken by Scottish Executive Social Research concluded that 'complex needs' is used interchangeably with many other similar terms and the literature assumes that 'complex needs' are a matter of fact and can be understood without definition (Rosengard et al., 2007). Interestingly, some 10 years after that literature review, we find that, in general, the research continues to progress without first defining the phenomenon of interest.

For children and young people with complex needs in care, the traditional focus on institutional and residential care is shifting to foster care, kinship care and preventative interventions

While the majority of journal articles and grey literature publications do not define 'complex needs', 'care' is usually defined, in recognition of international differences in models of care. Traditional models of care for children and young people have predominantly involved foster families, group homes and residential/institutional care facilities.

Institutional and residential care facilities are still a major focus in the international literature on children in care. However, their use differs by jurisdiction; for example, there has been a decrease in their use in England and Wales over time but they are an important part of the care model in Scandinavian countries (Forrester, Goodman, Cocker, Binnie, & Jensch, 2009). Institutional and residential care typically involve group facilities with at least 10 children (Camp, 2011).

Modern practice, and the literature, continues to shift to more family-style placements (Burnside, 2012; Forrester et al., 2009), with better staff pay rates and increased caregiver interaction. Treatment foster care is one example of specialised, family-based care that can support children with complex needs. Foster care can be with kin or non-kin carers and is often termed 'out-of-home' (OOH) care. Domestic and international adoption can also be included in the 'care' definition. In some cases, 'in care' also includes children who are 'home with parents' but also receiving services.

The United States (US) (Browne, 2009), Canada (Province of Manitoba, 2016), Western Europe (Browne, 2009) and Australia (Council of Australian Governments, 2009) focus on child protection, rather than on family-based alternative care. The focus is on early intervention, particularly in the first three years (Department of Social Services, 2015).

Oranga Tamariki defines 'being in care' as "a legal responsibility to keep the child or young person safe and secure, whether they're living with someone in their family or with other caregivers" (Oranga Tamariki, 2017a). In New Zealand, care typically refers to (Lambie, Krynen, Best, & Parkes, 2016; Office of the Children's Commissioner, 2017):

- placement with extended family/whānau (kinship care)
- placement with non-family/whānau (ie, non-kin care or foster care, including Family Homes)
- placement in one of the four youth justice and four care and protection residences owned by Oranga Tamariki
- placement in residential homes run by non-governmental organisations (NGOs), which are partly funded by Oranga Tamariki, including Cholmondeley Children's Centre in Governors Bay, the Dingwall Trust in Papatoetoe, Waikura House in Kaiapoi and Hohepa Trust in Hawke's Bay
- receiving specialist treatment services from the NGO Barnardos (under contract from Oranga Tamariki) to address the child or young person's harmful sexual behaviour.

Oranga Tamariki also works with birth parents who may be considering adoption for their child and families wanting to adopt a child.

COMPLEX NEEDS IN CARE AND YOUTH JUSTICE POPULATIONS

Young males and those who identify as indigenous are over-represented in the care population

The majority of children in New Zealand who are referred to Oranga Tamariki come from families with high levels of long-term need and disadvantage. These are children and young people who experience a combination of issues, including: the impacts of long-term unemployment; low income; unaddressed physical and mental health needs; parental alcohol and drug addictions; and family violence (Modernising Child Youth and Family Expert Panel, 2015).

Māori are over-represented in care and protection secure residences as well as in the overall care system. While 30 percent of all children in New Zealand under five years old are Māori, Māori make up more than half (57 percent) of children who are seen by Child, Youth and Family by the time they are five years old (Modernising Child Youth and Family Expert Panel, 2015).

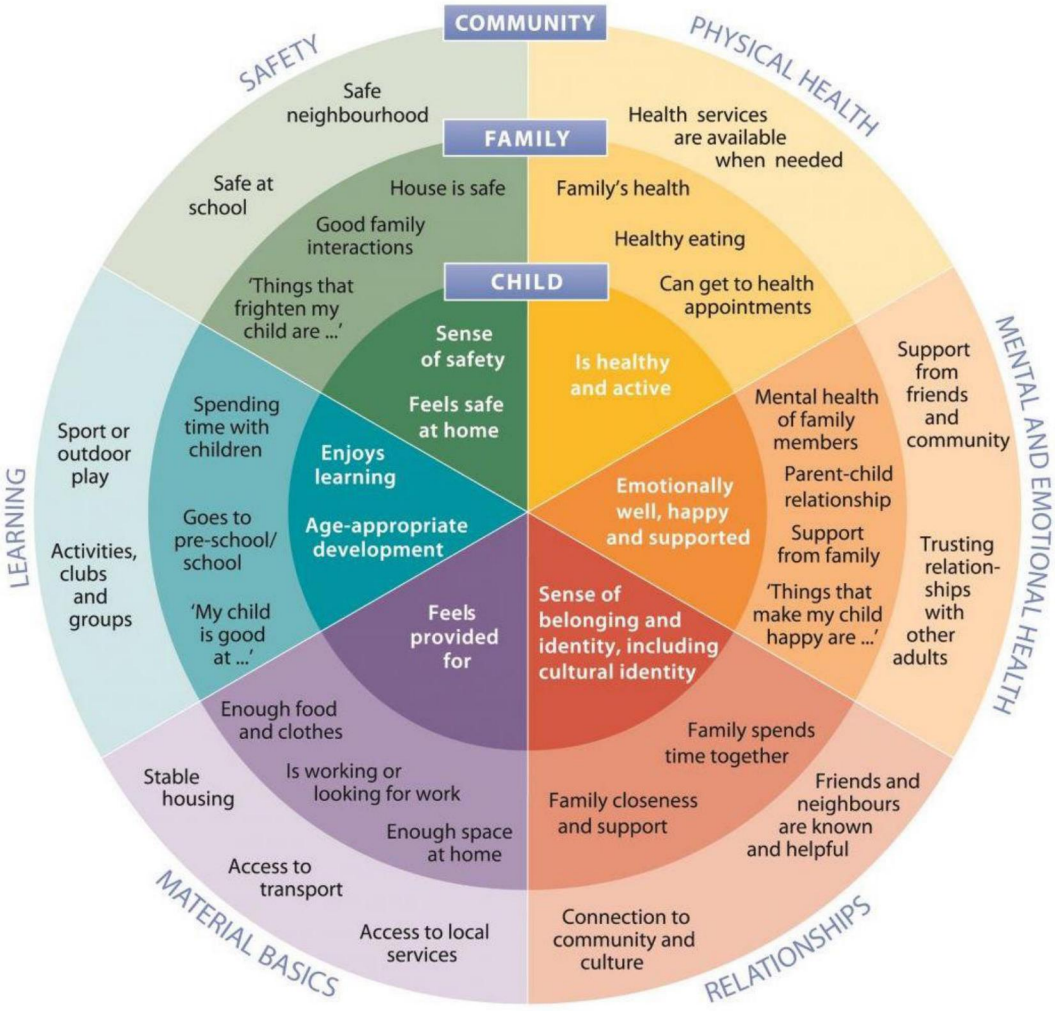
Over-representation of indigenous children among children with complex needs in the care system has also been identified in Australia (Australian Institute of Family Studies, 2017a) and in Canada (Indigenous Services Canada, 2017; Province of Manitoba, 2016; Sinha & Kozlowski, 2013). In relation to the over-representation of indigenous children in OOH care in Australia, the research suggests there is a complex interplay between geographical isolation, the legacy of past policies of forced removal and cultural assimilation, intergenerational effects of forced removals, and cultural difference between child protection agencies and Aboriginal and Torres Strait Islander peoples in understandings of child rearing practices (Australian Institute of Family Studies, 2017a; Higgins, Higgins, Bromfield, & Richardson, 2007).

There is limited national-level information on the specific physical, mental health, behavioural and educational needs and the maltreatment histories of the care and protection population (Lambie et al., 2016). However, international research suggests that the overall care and protection population will exhibit a range of difficulties, such as violence towards family, peers, or the public, absconding, and alcohol and drug abuse, manifested in different ways. Additionally, there appears to be high prevalence of comorbidity among the population (Oswald et al., 2010).

'Complex needs' covers a broad spectrum of needs, including difficulties related to physical health, mental and emotional wellbeing, relationships, material wellbeing, learning and development, and safety

The Australian care and protection system's strengths-based Common Approach Wheel provides a useful framework for categorising how complex needs are exhibited in care and youth justice populations, including: physical health; mental health and emotional wellbeing; relationships; material wellbeing; learning and development; and safety (Figure 1).

Figure 1: Common Approach Wheel (Common Approach to Assessment, Referral and Support)



Source: Australian Research Alliance for Children and Youth (ARACY) (2016)

Physical health

As discussed above, 'complex needs' refers to one or a number of difficulties. While many difficulties will be 'out of sight', the care and protection population often presents with physical health difficulties. For example, Osborn and Delfabbro's (2006) study of 364 children and young people with 'high support needs' in Australian OOH care found that 13 percent of the sample had a physical disability. Of the sample, 58 percent had had health appointments in the last six months for dental, eye or allergy problems, or for pregnancy or sexually transmitted infections (Osborn & Delfabbro, 2006). The children and young people with high support needs had a similar weight distribution to the rest of the Australian child and youth population.

Low birth weight (Scott, 2009) and prolonged admission to hospital (Lenehan, 2017) are other markers identified in the literature. Browne (2009) comments that children with physical disabilities can be over-represented in the residential/institutional care population because of negative social attitudes and discrimination.

Mental health and emotional wellbeing

The international literature identifies multiple mental health and behavioural difficulties in the care and youth justice populations, often stemming from a history of trauma, neglect and/or abuse.

Serious emotional and behavioural problems (Camp, 2011; Osborn & Delfabbro, 2006), self-concept, cognitive and self-regulation difficulties (Conn, Szilagyi, Jee, Blumkin, & Szilagyi, 2015), and mental health disorders (Oswald et al., 2010) have been found in care populations. Mental health issues can include hyperactivity, depression, anxiety, ADHD, personality disorders, mental illness, suicidal ideation, PTSD and oppositional defiance disorder (Osborn & Delfabbro, 2006).

There is a general lack of research examining the extent to which difficulties pre-date care, and examining the impact of care on wellbeing (Forrester et al., 2009). Forrester et al (2009) review identified only 12 studies that attempted to isolate those effects. They concluded that those who enter care have serious problems and that, in general, their welfare improves over time. This is consistent with McMillen et al (2005) study, which found that older youths in the foster care system had a high prevalence of psychiatric disorders and that many had at least one disorder before they entered foster care.

Relationships

Within the Common Approach Wheel, 'relationships' includes social networks and relationships, and family relationships and functioning. A child's sense of belonging and identity, including their cultural identity, is important in this dimension.

Few studies examine the longitudinal outcomes for children in care. However, a qualitative, interview-based study of 20 individuals in Victoria, Australia, including 11 who had been in care, found that complex needs and care was associated with individuals in later life having unstable and/or violent relationships, little or no contact with family, and few friends and few contacts with the wider social environment and neighbourhood (Frederick & Goddard, 2008). Tarren-Sweeney (2017) notes that in international studies those in care often have social and interpersonal relationship difficulties, which can add to symptom complexity.

Attachment theory is an oft-cited framework in the literature: this states that a strong emotional and physical attachment to at least one primary caregiver is critical to personal development. In the context of this evidence brief and the literature, the absence of this strong attachment can lead to complex needs and subsequent care and youth justice intervention. Difficult or entangled relationships with one's family, unresolved issues; and major familial grief and loss have all been identified as factors underpinning children's entry into the care and youth justice systems (Forrester et al., 2009; Frederick & Goddard, 2008).

Material wellbeing

As mentioned above, the Modernising Child, Youth and Family Expert Panel (2015) found that those in the care system are disproportionately from families with long-term unemployment and low income. Internationally, deprived backgrounds and poverty appear to be risk factors for complex needs and care (Browne, 2009; Dozier et al., 2012; Forrester et al., 2009; Kenny & Nelson, 2008), as are higher residential mobility and low adult-to-child ratios (O'Donnell, Scott, & Stanley, 2008).

Learning and development

Developmental delays and poor school achievement are features of the care population internationally (Camp, 2011). Developmental difficulties may include learning disabilities and developmental disabilities such as autism (Lenehan, 2017). Social development can also be hindered by social exclusion, which many children in care can experience (Lenehan, 2017).

In his discussion of the risk of harm to young children in institutional care, Browne (2009) comments that the environment of institutional care can often lead to a number of negative effects, including

learning disabilities. He cites a number of studies that report an association between institutional care and poor cognitive performance and lower IQ scores, delays in language acquisition, and deficits in language skills and early reading performance (such as poorer vocabulary and less spontaneous language) (Browne, 2009; Dozier et al., 2012). Dozier et al. (2012, p. 6) state that observational and randomised clinical trials show that "institutionalised children have significant developmental deficits across virtually every domain that has been examined".

While the studies report significant differences between children in institutions versus children in foster care, it is clear that cognitive performance and language deficits can be a difficulty faced by a proportion of the overall care population, regardless of whether they are in residential or foster care.

Safety

The difficulties faced by children in care may be genetic, or they may have existed before they entered care as a result of neglect, physical abuse, sexual abuse, trauma history. However, for some the difficulties may have developed only during their experience in care, or been exacerbated by it (for example, due to placement instability and/or abuse while in care) (Lenehan, 2017; McMillen et al., 2005). The next section of this brief includes more detailed discussions of how these needs exhibit while in care and the risk factors associated with complex needs.

Both the underlying physical and mental health issues, as well as the risk factors associated with a child's entry into state care, contribute to challenging behaviour and conduct disorder issues. These can include intense and frequent "antisocial, aggressive, dishonest, delinquent, defiant and disruptive behaviours" (Advisory Group on Conduct Problems, 2013) that can threaten the child or others' quality of life or physical safety (Lenehan, 2017). Within adolescent populations, psychological difficulties often present as self-harm, involvement with or fear of gang-related violence, and sexual exploitation (Munro, 2011).

The literature notes that there appears to be an association between care and criminality, with those with a history of care being over-represented in the youth justice and adult justice systems (McFarlane, 2008; Scott, 2009). Discussing the New South Wales criminal justice system and a cohort of children in out of home care, McFarlane's PhD thesis and subsequent journal articles report that from 160 case files, children in out-of-home care appeared before the Children's Court on criminal charges at disproportionate rates compared to children not in out-of-home care (McFarlane, 2017). The research also suggests that, rather than care being protective and part of the 'treatment', it instead created the environment for offending.

Other Australian research found that many young people under community orders come from very disadvantaged backgrounds and have engaged in a number of high-risk behaviours from an early age (Kenny & Nelson, 2008). Almost a quarter of the 800 young offenders studied had a history of out-of-home care. In relation to the complex needs detailed above, 15 percent had an intellectual disability, 40 percent scored in the clinical range on at least one of the scales of the *Adolescent Psychopathology Scale-Short Form (APS-SF),* and 74 percent reported some sort of abuse or neglect. Further, 38 percent were classified as risky drinkers, while 46 percent had used amphetamines, 18 percent had used cocaine and 14 percent had used heroin.

RISK AND PROTECTIVE FACTORS

Deprivation and poverty appear to be risk factors for complex needs and care

As discussed earlier in this evidence brief, deprived backgrounds and poverty appear to be risk factors for complex needs and care (Browne, 2009; Dozier et al., 2012; Forrester et al., 2009). There also appears to be some link with countries being in economic transition (Browne, 2009). Poverty may lead to families being unable to cope, providing the conditions that may lead to care. Nevertheless the link between child poverty and institutional care is unclear. While studies find that countries in economic transition have high prevalence of institutional care, researchers are careful to point out that institutional care still exists in economically developed countries (Browne, 2009).

A history of trauma, particularly neglect and emotional abuse, are prevalent in the care population

In addition to socio-economic factors, children in care with backgrounds of abuse and neglect are more likely to exhibit complex needs such as behavioural, physical and mental health problems, and/or educational underperformance, compared with most children (Forrester et al., 2009). Scott (2009) reports that in Australia those in care are mostly there because of neglect and emotional abuse (two-thirds), with the remainder there for physical and/or sexual abuse.

Tarren-Sweeney (2017) comments that in international studies where children in care have attachment and trauma-related difficulties, recovery can be slow, even with optimal care conditions where children receive sensitive, loving care.

Males, and those identifying as indigenous, are over-represented. Males also appear to not respond as well as females to treatment care

The research suggests that gender and ethnicity can be moderating factors. Some studies suggest that boys do not benefit from foster care as much as girls (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010), and that boys are at greater risk of placement instability and increased use of behavioural intervention services (Osborn & Delfabbro, 2006). Australian reviews cite findings that indigenous populations are over-represented in care; that is, Aboriginal/Torres Strait Islanders' rates of being in state care are eight times higher than the rest of the population (Scott, 2009), and in OOH care 9.5 times higher than the rest of the population (Australian Institute of Family Studies, 2017a). Ratios of indigenous to non-indigenous children differ by state, ranging from 2.9 in Tasmania to 16.5 in Western Australia (Australian Institute of Family Studies, 2017a). In Canada, child welfare services fall under the jurisdiction of provincial and territorial authorities and each province has different legislation pertaining to child protection interventions. This can make it difficult to compare rates of children, and Aboriginal children, in out-of-home care across provinces. Research suggests that percentages of Aboriginal children as a percentage of children in care range from 21 percent in Ontario to 85 percent in Manitoba (Sinha & Kozlowski, 2013).

Age at placement is a significant moderator of care outcomes

A growing body of evidence finds that age at placement is a significant moderator of attachment security and disorganisation, and thus of overall welfare. Studies continue to support the notion that placement after a child's first birthday decreases their capability of developing secure attachments (Browne, 2009; Smyke et al., 2010; Tarren-Sweeney, 2008a; van den Dries, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2009). In adoption studies, this moderating effect appears to be independent of the type of placement (for example, domestic versus international adoption) and race (whether same race or transracial adoption) (van den Dries et al., 2009).

However, Oswald et al. (2010) advocate for more research in this area, to disentangle the association between age at placement, instability, and the extent of complex needs, as they find the research is inconsistent. In their literature review of studies between 1998 and 2009, they found few studies that investigated the link between foster care and complex needs, or the consequences of traumatic experiences. The researchers called for longitudinal research to isolate the influence of genetic, prenatal and environmental factors, before and during care (Oswald et al., 2010).

There is a worrying movement of some children and young people from care to crime

The care-and-crime nexus discussed previously extends to more serious offending. Those with early-start juvenile delinquency, cautions or convictions, detention, custodial sentences and recidivism were more likely to reoffend, and that new offending was more likely to be violent and serious (McFarlane, 2008).

Parental substance abuse, mental health problems and difficult child-parent relationships are risk factors for complex needs and care

The literature shows that a significant cluster of risk factors relates to parental behaviour and disorders. Parental drug and alcohol measures were the biggest predictors of positive welfare outcomes, along with no longer living with a birth parent, in a literature review of studies that focus on the impact of care on welfare (Forrester et al., 2009). Similarly, in Australia, very high levels of parental drug and alcohol abuse, mental health problems, and domestic violence were identified in the care population (Scott, 2009). Other literature reviews also find that the following are significant risks for care and complex needs: substance abuse by parents; psychosocial, environmental or neurobiological risk factors (such as intrauterine exposure to drugs, alcohol and nicotine) (Oswald et al., 2010); psychological disorders in biological parents (Dozier et al., 2012; Oswald et al., 2010); and parental learning disabilities (Scottish Government, 2014).

Difficult or entangled relationships with the birth family is also a significant risk factor. Forrester et al (2009) cite studies suggesting that those who have difficult relationships with their birth family, unresolved issues and ongoing contact problems have a 'downward spiral' within the care system. Relationship problems with parents, child abuse, and major grief and loss were also associated with care and complex needs in other studies (Frederick & Goddard, 2008).

Being in care can be a protective factor but this may be negated by placement instability

There is also an association between placement instability and complex needs (Osborn & Delfabbro, 2006). Scott (2009) cites US research which finds that multiple placements in the first 18 months in

care led to increased behavioural problems, regardless of whether the child had behavioural problems when they entered care.

However, being in care appears to be a protective factor in itself. Despite a pervading policy narrative in a number of jurisdictions about the negative aspects of institutional care, empirical studies find that in general being in OOH care can result in improvements in general welfare over time (Conn et al., 2015; Forrester et al., 2009; Tarren-Sweeney, 2017).

A number of longitudinal and retrospective studies are underway to isolate some of the risk and protective factors related to complex needs and care

The research on risk and protective factors has led to more retrospective and longitudinal studies (Chambers, Saunders, New, Williams, & Stachurska, 2010; Tarren-Sweeney, 2008a). Below is a short overview of some of the studies undertaken internationally.

National Survey of Child and Adolescent Well-Being (NSCAW II)

The second National Survey of Child and Adolescent Well-Being (NSCAW II) is a longitudinal study intended to answer a range of questions about the functioning, service needs, and service use of children who come in contact with the child welfare system in the US. It examines the wellbeing of children involved with child welfare agencies; captures information about the investigation of abuse or neglect that brought the child into the study; collects information about the child's family; provides information about child welfare interventions and other services; and describes key characteristics of child development. Of particular interest to the study are children's health, mental health, and developmental risks, especially for those children who experienced the most severe abuse and exposure to violence.

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are stressful or traumatic events and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, and incarcerated household member. The US Division of Violence Prevention at the Centers for Disease Control and Prevention (CDC), in partnership with Kaiser Permanente, conducted the original ACE studies between 1995 and 1997 with more than 17,000 participants. Middle-aged adults with four or more ACEs (of the 10 ACEs within the studies) were at the greatest risk of negative outcomes (Felitti et al., 1998 as cited by Conn et al. 2015).

Children in Care Study (CICS)

The Children in Care Study (CICS) is a prospective, epidemiological study of the mental health of children in court-ordered foster and kinship care in New South Wales, Australia.

The CICS baseline survey involved collecting carer-reported mental health estimates of children in care, as well as concurrent and retrospective measures of potential risk and protective factors. Data were collected from a mail-out carer questionnaire, and from the child welfare and alternate care

database of the then-Department of Community Services. The survey included the Child Behaviour Checklist (CBCL) and the Assessment Checklist for Children (ACC).

The study found that age at entry into care, developmental difficulties (intellectual disability and reading problems), three specific types of maltreatment,[1] recent adverse events, and factors related to placement insecurity or lack of permanence were key predictors of mental health (Tarren-Sweeney, 2008b). These findings have implications for care services, including the need to identify children who are in need of care at younger ages, and the harmful effects of perceived instability for children in long-term care. These responses are discussed further in the next section of this brief.

[1] Physical abuse, sexual abuse and confirmed exposure to 'classic' emotional abuse, such as scapegoating, emotional blackmail, and overt rejection.

COMPLEX NEEDS SERVICES AND THERAPEUTIC RESPONSES

The findings presented in the previous three sections – particularly the risks presented by age at placement, socio-economic factors, and parental/family difficulties – point first to the need to keep children and young people from requiring intervention by ensuring there is access to universal and preventative services. It is then critical that, if intervention is required, the child receives joined-up, wrap-around support that improves their welfare rather than making it worse. Models of care need to be child-centred, so that they allow and encourage the child to form secure attachments, and they need to adequately address aftercare issues.

International care and protection systems attempt to pre-empt placement of children with complex needs

There has been a movement across child welfare systems internationally towards a 'public health' model of child protection (Valentine & Katz, 2015). In practice this refers to:

- the provision of universal services to all families, such as schools and primary health services
- families with specific vulnerabilities receiving early intervention services
- families who have an identified risk of maltreatment being subject to an investigative response and possibly also receiving intensive family preservation services.

Children with complex needs are likely to receive primary, secondary and – in the case of 'at risk' children – tertiary services.

Universal services

Scott (2009) advocates for universal children's services, including maternal-child health, early childhood education, and schooling. She also recognises that this approach can destigmatise complex needs and being in care. Financial support for parents is another service recommended by researchers, particularly those who acknowledge the relationship between poverty and institutional care (Dozier et al., 2012).

Universal services implemented in international jurisdictions include the Head Start programme in the US and Australia, and Home Start and Sure Start in the United Kingdom (UK). However, evaluations of Sure Start, Home Start and the US Intensive Family Preservation programme have been criticised for their lack of evidence and lack of significant impact (Forrester et al., 2009).

Preventative services

A report from the Australian National Health and Medical Research Council (2017) identifies a number of preventative initiatives aimed at improving parenting quality, improving infant development and preventing maltreatment. These include:

- antenatal and postnatal education and/or support
- home-visiting interventions
- interventions for enhancing sensitivity and/or attachment security

- interventions for parents in low-income and middle-income countries
- interventions for parents of infants with, or at risk of, developmental delay or impairment
- interventions for preventing later antisocial behaviour and delinquency.

The focus of these services is on the adult/parent, recognising the influence that parental difficulties can have on complex needs and on care. Other programmes include integration of adult mental health services with children's needs (for example, a mental health liaison nurse in the care system) or parental drug and alcohol treatment programmes and domestic violence processes in the criminal justice system that are responsive to the needs of children (Munro, 2011; Scott, 2009).

Browne (2009) discusses engaging mothers during pregnancy, and identifying those with a high risk of abandonment, which may be exhibited by a lack of support, poverty and cultural stigma. Conn et al. (2015) comment that parent training programmes are "grossly understudied". We note that the Australian Institute of Family Studies has undertaken a comprehensive evaluation of the Victorian Cradle to Kinder programme, which is an ante- and post-natal support service that provides intensive family and early parenting support to vulnerable young mothers and their children (Australian Institute of Family Studies, 2017b).

Comprehensive assessment, such as that suggested by the Common Approach Wheel, can also be a feature and entry point for preventative services and/or care. For example, an assessment clinic for children and young people within the Sydney West Area Health Service was piloted. In this pilot, the local children's hospital, the mental health clinic and the area child welfare service allocated specific staff to develop an assessment clinic, which would establish a process, and then assess 50 children who were entering long-term care and review them 6–12 months later (Chambers et al., 2010). The assessments included paediatric, allied health, dental and psychological assessments.

The study highlighted the importance of coordinated assessments and care, but within a resource-constrained environment this can be difficult to achieve. Chambers et al (2010) found that whether assessment recommendations were followed was influenced by both the availability of services and ease of referral. Medical and allied health referrals were more likely to be acted on, while recommendations for parenting assistance, family counselling and respite care were less likely to be followed. For the latter set of services, availability of services was a factor, and significant waiting lists were common.

Mental health services

Burnside (2012) identifies that the presence of a mental health condition can complicate access to services for other comorbid conditions in youth populations with complex needs. Burnside (2012) cites Elliott (2005) who describes how the co-occurrence of mental health issues with either addictions or intellectual disability can create the most complex constellation of issues that result in this population suffering the greatest unmet needs. She advocates for system reform that supports the creation of professionals with comprehensive skillsets who are versed in responding to each of these issues, individually and in interaction with one another, as well as new interventions that include behavioural strategies and alternatives to incarceration for persons whose complex needs bring them into contact with the criminal justice system. Kutcher and McDougall (2009) outline that because many Canadian youth do not receive the mental health supports they need early on, they are more prone to becoming involved in the youth corrections system.

Burnside (2012) also notes that the presence of adolescent mental health services alone is not necessarily sufficient to ensure that youth are accessing them. Burnside (2012) further identifies numerous reviews that have identified that mental health services are often not sought by minority groups (A Berland Inc, 2008; Standing Senate Committee on Social Affairs, 2006; Zimmerman, 2005)

or families of lower socioeconomic status (Ungar, 2005), and that youth in general, as a manifestation of normative adolescent development, are resistant to accessing such services (Logan & King, 2001).

Burnside's (2012) work also identifies the different interpretations of mental health and mental illness across cultures which affect decisions to reach out to services (Roberts, Alegría, Roberts, & Chen, 2005).

It is important children receive joined-up, wrap-around support where intervention is required

Where intervention is required, it is critical to ensure the child receives joined-up, wrap-around support that improves their welfare rather than making it worse. This includes models of care that are child-centred, allowing and facilitating children to form secure attachments, and adequately addressing aftercare issues. The general understanding is that complex needs and maltreatment is a multifactorial phenomenon that the child protection system cannot address by itself; it requires the involvement of multiple human services (Valentine & Katz, 2015).

Joined-up services

Intervention to support children with complex needs or in care often involves multiple agencies. Clear cross-agency coordination and collaboration is needed to provide the necessary range of support and to agree access to services, costs and funding (Lenehan, 2017). International examples of joined-up services and integrated responses include the UK's Sure Start and Bristol's Think Family. Think Family is the approach used by the Troubled Families programme to encourage services to deal with families as a whole rather than responding to each problem, or person, separately. Troubled Families helps families who struggle with complex needs such as debt, homelessness, mental health issues, domestic violence, poor parenting, illness or substance misuse. The programme was stimulated by crime prevention and has a no-wrong-doors, whole-family philosophy, where services are built on family strengths and support and are tailored to need (Scott, 2009).

There is little easily accessible information on the 'Think Family' initiative effectiveness. The Troubled Families programme 'Final Synthesis Report' in contrast did state that "the key finding from the impact evaluation using administrative data was that across a wide range of outcomes covering the key objectives of the programme – employment, benefit receipt, school attendance safeguarding and child welfare – we were unable to find consistent evidence that the Troubled Families programme had any significant or systemic impact." However, families in the Troubled Families group did report they were "more likely to report managing well financially; knowing how to keep on the right track, being confident that their worst problems were behind them, and feeling positive about the future, when compared with a matched comparison group." (Laurie Day, October 2016)

Lenehan (2017) highlights the Gloucestershire early intervention model, Graduated Pathway of Early Help and Support, as a good model with broad eligibility criteria and a families-first approach. Early Help includes many agencies that deal with children and young people, including the National Health Service, schools, learning providers, the voluntary sector, policy-makers, and housing providers. It seeks to provide support as soon as problems emerge or when there is a strong likelihood that problems will start in the future; it provides help at any and every stage of a child's life from pre-birth to adolescence. Support might include increases in the levels of universal services or locally provided or commissioned services.

In Victoria, Australia, a partnership between Monash University and seven non-governmental child and welfare organisations was examined to understand how cross-agency collaboration could reduce the over-representation of young people leaving OOH care in the youth justice system (Mendes, Baidawi, & Snow, 2014). Based on 77 key stakeholder interviews and focus groups, it was found that offending was associated with variability in responses by both child protection and youth justice systems, with the limited utility of leaving care plans, and with the availability of a range of preventative and diversionary programmes. The researchers concluded that there is a need for formal interagency collaboration on intensive interventions in custody and post discharge (Mendes et al., 2014).

In relation to care and youth justice, McFarlane (2008) notes that major justice policy platforms are often not appropriate for those in care – for example, the importance of maintaining and preserving family contacts. She emphasises the need for programmes to break the welfare-justice nexus (McFarlane, 2008).

While the importance of a families focus is repeatedly recognised in the literature, child-centred approaches should also be considered. Munro (2011) recognises children and young people as individuals with rights, including the right to participate in decisions about themselves according to their age and level of maturity.

Wrap-around services

The wrap-around model is a highly tailored and team-based care coordination strategy for children and young people with complex behaviour issues. As Burnside (2012) points out, it is a coordination model that involves a trained care coordinator and family member partner and that requires cross-sector and cross-agency collaboration in advance in order to ensure necessary services are provided. Schurer Coldiron, Bruns and Quick (2017) also identify that wrap-around services promote community-based care management for youth with multi-system involvement.

The wrap-around model is still relatively new, and requires extensive training and sector collaboration. However, it is considered to be a 'promising' (Burnside, 2012) and potentially cost-effective model (Schurer Coldiron et al., 2017). According to Schurer Coldiron et al (2017), at least one controlled study as well as a number of grey literature studies found that the wrap-around approach provides substantial returns on investments. Further controlled studies with formal cost components are needed to support these claims.

Out-of-home care is a legitimate response to complex needs, and appears to improve the welfare of children in care

Institutional care and foster care are themselves a therapeutic response to complex needs. In addition to some of the negative aspects of historic approaches to institutional care, which the literature has highlighted, institutional care can be more costly than other options. Browne (2009) reports that institutional care can be up to six times more expensive than social services provided to vulnerable children or voluntary kinship/foster care.

There is conflicting evidence on the long-term effects of institutional care. According to Browne (2009), early institutional care is, overall, detrimental to a child's development. He acknowledges that some children who enter care at a very young age can catch up and make a rapid recovery, but this is conditional on their first emotional attachment. Some studies have found that institutional care is preferable to, and is no more or less harmful than, other interventions (for example, McKenzie, 1999 and Whetten et al., 2009 as cited by Dozier et al. 2012b). However, other reviews suggest that even with the modernisation of institutional care there are still negative effects on a child's development

(Dozier et al., 2012). Dozier et al. (2012) contend that institutional care is structurally and psychologically at odds with what young children need and that alternatives need to be developed. Over time the use of residential and institutional care by national care systems has declined, and accordingly there has also been less research on it (Forrester et al., 2009).

The evidence on OOH care, whether via adoption, kinship or foster care, is more clear-cut. Studies find that OOH care generally improves welfare (Dozier et al., 2012; Forrester et al., 2009; Tarren-Sweeney, 2017). OOH care appears to maximise the potential of those with complex needs (Forrester et al., 2009). The mechanism for success is often that the child is no longer living with their birth parent. In a study of 186 children who had parental misuse of drugs or alcohol, the biggest predictor of positive welfare outcomes was removal and not living with their birth parent (Forrester & Harwin, 2008 as cited in Forrester et al., 2009a). The research also reminds us that adoption should be treated as a realistic and viable option (Dozier et al., 2012; Forrester et al., 2009).

Despite this, governments in the UK have historically focused on preventing care or increasing the use of permanent alternatives. Forrester et al. (2009) notes that this policy has led to the UK providing less public care and having proportionately fewer children in care than Sweden, Norway, Denmark and most countries in Europe. The German, French and Scandinavian approach treats care as an extension of family support for those with the greatest difficulties, rather than an option of last resort (Forrester et al., 2009).

By way of example, the Norwegian approach is illustrated and contrasted well in an online cross-country survey that compared the responses of frontline child protection workers to a vignette about two children who might come under the jurisdiction of a child welfare agency (Berrick, Dickens, Pösö, & Skivenes, 2017). The 1,027 frontline workers who responded were employed in child welfare systems in England, Finland, Norway and the US. The study found that the large majority of workers, except Norwegians, would not consider the intrusive action of separating the children from their parents (through signalling a possible care order or child removal). The researchers speculate that Norwegian workers trust their child welfare system and the OOH placements it provides and see this level of intervention as supportive. Normative dimensions and standards within Norway are provided as an additional explanation – that is, "children are not supposed to do poorly, and if the child welfare system can do something, it should – even though it brings with it a removal with very uncertain outcomes" (Berrick et al., 2017, p. 315).

In determining whether institutional or OOH care is an appropriate response, the literature continues to highlight the importance of intervening early, ideally in the child's first year of life (Browne, 2009; Department of Social Services, 2015; Frederick & Goddard, 2008).

Attachment-based models of care are the primary approach to managing complex needs in care

The international literature discusses and advocates for models of attachment-based care for those with complex needs (Frederick & Goddard, 2008). This model of care is particularly relevant for kin, non-kin and adoption-based care. Suitability assessments of carers are an important precursor and part of attachment-based care (Browne, 2009).

However, it should be noted that the body of evidence on the success or otherwise of these different models is relatively scant (Dozier et al., 2012; Stinehart, Scott, & Barfield, 2012). Attachment therapy, or 'holding' therapy, is particularly controversial, and commentators continue to emphasise the lack of an evidence base on its use (Dozier et al., 2012).

Bucharest Early Intervention Project (BIEP) model of foster care

The Bucharest Early Intervention Project (BIEP) conducted a series of randomised control trials comparing the development of children in residential care with non-institutionalised children and those who had left institutions for foster homes. The model of foster care is attachment-based and encourages foster carers to invest psychologically in the child and to love them as their own (Dozier et al., 2012). The model also encourages carers to provide structure, routines, language stimulation and behaviour management. Children in foster care in this study had regular visits and contact with a social worker.

It was found that children placed in foster care performed better than those who continued with institutional care on almost every measure, supporting conclusions reached in correlational studies (Dozier et al., 2012).

Multi-treatment Foster Care (MTFC)

Multi-treatment Foster Care (MTFC), also known as Intensive Fostering (IF), is based on social learning theory (Action for Children, 2014). Intensive support is given to the young person in a solo foster placement, supported by a multi-disciplinary team, with each team member having a clearly defined role and set of responsibilities. The intention is to change behaviour through promoting positive role models.

During placement, the young person's behaviour is closely monitored and good behaviour is rewarded by a points-based system. Young people are placed with a specially trained foster family, who positively reinforce appropriate behaviour. Family therapy is provided for birth parents, and they are taught the same MTFC strategies in preparation for reuniting them with their child.

Oswald et al. (2010), in their review of the literature on mental health and maltreatment in the foster care population, found that prevalence of trauma and maltreatment are high. They recommend referring foster children to interventions like MTFC and trauma-based cognitive behaviour therapy as these have been found to be effective for those experiencing trauma and maltreatment. Similarly, Turner and Macdonald (2011) in their review of MTFC found that it is generally a useful intervention for children and young people with complex emotional, psychological and behavioural needs. However, they preface their conclusions by noting that few studies (only five) reached the threshold for eligibility for their review; they note that the evidence base is not as robust as it could be and that more research is required (Turner & Macdonald, 2011).

Specific research recommendations made by Turner and Macdonald (2011) include settings outside of the US (they note ongoing studies in the UK and Sweden), use of randomised control trials, and collection of data on a range of core outcomes regularly and over a long period. Other recommendations were to include more diverse groups of young people (in age, ethnicity, location and specified needs profiles) and to improve the independence of research teams.

Attachment and Biobehavioural Catch-up (ABC)

Attachment and Biobehavioural Catch-up (ABC) targets regulatory issues, attachment quality, indiscriminate sociability, and frightening behaviour. Indiscriminate sociability presents as lack of reticence with unfamiliar adults, willingness to approach and engage strangers, and failure to maintain proximity to attachment figures in unfamiliar settings. This is often exhibited by children with complex needs in care, particularly institutionalised children, as they do not have an attachment to a primary caregiver (Zeanah et al., 2005 as cited in Dozier et al., 2012b).

ABC is a 10-session home visiting programme that was designed to target issues that are especially challenging for infants who experience inadequate or problematic parenting. The model asks carers (kin or non-kin carers) to behave in a synchronous manner with their child in a 'serve and return' manner. Carers should also behave in a nurturing way, and are encouraged to have strategies to discourage indiscriminate sociability (Dozier & Bernard, 2017). They are also encouraged to avoid behaving in frightening ways, including yelling, grabbing roughly and intruding in the child's space, as this behaviour is believed to undermine children's ability to develop organised attachments and develop regulatory capabilities (Dozier & Bernard, 2017).

Studies find that ABC is effective in high-risk birth children and in foster children (Dozier et al., 2012). A randomised control trial in a lab environment supports the effectiveness of ABC for children of international adoptions and foster children (Dozier & Bernard, 2017; Dozier et al., 2012). ABC has been found to enhance secure and organised attachments, cortisol regulation, and behavioural outcomes (Dozier & Bernard, 2017). In adoption situations, increasing parental sensitivity has been shown to be successful in enhancing attachment security, with more sensitivity being associated with more attachment (van den Dries et al., 2009).

Community-based systems and place-based care

Dozier et al. (2012) states that in order to abolish institutional care, which is structurally and psychologically at odds with what young children need, the establishment of an alternative community-based system is required. This means a child welfare infrastructure that incorporates family support and a system of kinship and foster care. Whānau Ora is a New Zealand example of such a system. Dozier et al. (2012) recognise that in many cases reducing the disincentives for establishing community-based programmes is a critical step. In many jurisdictions community-based programmes are established and funded within local government, and it is therefore important to examine the extent to which national government provides support for community-based programmes and reduces the disincentives for establishing place-based care (see Moore and Fry (2011) for an overview of place-based approaches used in child and family services).

Research shows the association between personal and broader relationships on the one hand and wellbeing outcomes on the other. This suggests that community-based systems, which can provide comprehensive and accessible support and a focus on personal and social networks, would be effective in achieving better wellbeing outcomes (Frederick & Goddard, 2008).

Since 2007, Indigenous and Northern Affairs Canada/Indigenous Services Canada[2] have adopted a prevention-based funding approach, focusing more on prevention, early intervention and alternatives to traditional institutional or foster care, such kinship care in a community setting (Indigenous Services Canada, 2017). As such, there has been a gradual decrease of First Nations children in foster care and institutional care, and an increase in kinship care placement. Kinship care placements have increased from zero in 2007 to 16 percent of First Nations children in care in 2016.

Implementation evaluations of this approach find that while there are funding, capability and capacity challenges (and challenges associated with the negative perceptions of Child and Family Services), the flexibility to develop locally relevant and culturally tailored programmes have facilitated the achievement of outcomes (Aboriginal Affairs and Northern Development Canada, 2014).

[2] In August 2017, Indigenous and Northern Affairs Canada was dissolved and replaced with two ministries – Department of Indigenous Services and Crown-Indigenous Relations and Northern Affairs.

Agencies have developed programmes through community consultation and participation of elders to ensure that services are targeted to address the needs of each community.

The evaluation of the early intervention Cradle to Kinder programme, and the Aboriginal Cradle to Kinder programme, in Australia suggests that its strengths-based approach, long term nature of the programme (four years of consistent support) and connection with other services and the community, influenced the programme's success (Australian Institute of Family Studies & Murdoch Children's Research Institute, 2017). The children and families who participated in the programme were less likely to be in long term OOH care or to have permanent care and protection orders from the Victorian Children's Court. Families involved in the Cradle to Kinder evaluation had a range of complex needs and histories. Many had a history of trauma, financial and housing instability and were also coping with mental health issues, substance use and family violence.

The Aboriginal Cradle to Kinder programme is specifically tailored to provide a culturally competent, sensitive and respectful service for Aboriginal families. This includes working with children, parents and extended family members to strengthen connections to family, community and culture. Service providers identified that one of the benefits of the programme was strengthening ties to Aboriginal culture and the role of strong kinship connections and networks, and the ability to adopt a collective model of parenting (Australian Institute of Family Studies & Murdoch Children's Research Institute, 2017).

However, the majority of Aboriginal clients were accessing non-Aboriginal Cradle to Kinder programmes. Evaluation interviewees suggested that Aboriginal families choosing to access mainstream services may be due to the complexity of kinship networks and relationships whereby there might be a reluctance to engage with some groups; not wanting others in their community knowing their business; and families may already be accessing similar services and wish to stay with the same provider (Australian Institute of Family Studies & Murdoch Children's Research Institute, 2017). The evaluation recommends including an Indigenous or Aboriginal-specific worker at Cradle to Kinder sites to help develop and build cultural competence and understanding within the mainstream programmes, and to improve outcomes for Aboriginal and Torres Strait Islander families, whichever model they choose (Australian Institute of Family Studies & Murdoch Children's Research Institute, 2017).

A youth justice-focused programme in Queensland, Australia which targets indigenous youth with complex needs has had some success. It is based on social control theory with a panel service that focuses on developing the young person's attachment to family, community and school. The programme evaluation found that participants improved their behaviour, had better family relations and were more willing to seek help (Stewart, Hedwards, Willis, & Higgins, 2014). A review of the evidence on policies and programmes that reduce offending by Indigenous youth in Australia finds that interventions which have the following characteristics tend to be more successful (Richards, Rosevear, & Gilbert, 2011):

- focuses on issues of specific relevance or concern to Indigenous communities. Helps address the issue and secures support from the community
- involvement from members of Indigenous communities in crime reduction strategies may help strengthen cultural and social structures and optimise self-determination
- provision of intergeneration, family and cultural support (or mentoring) mechanisms within Indigenous communities
- focusing on younger juveniles to maximise early intervention in potential offending trajectories
- utilise community-based strategies
- builds on existing strengths

- addresses offending through collaborative approaches
- addresses the multiple issues that lead to offending (such as drug and alcohol abuse, unemployment and lack of education).

Aftercare

A number of issues may need to be considered when children and young people leave care (Forrester et al., 2009). These can include returning to family where abuse or neglect took place, discontinued access to physical and mental health services that were previously freely available while in care, and young people wanting to make decisions for themselves (for example, discontinuing medication) (McMillen & Raghavan, 2009).

In a study conducted by the Australian Institute of Family Studies, professionals working with Aboriginal and Torres Strait Islander children in OOH care identified aftercare as a significant gap in the care continuum – both for the young person leaving care as well as for their birth parents and family, as many children will return to their families before or after turning 18 (Higgins et al., 2007).

When instituting change in the care system it is important to consider the implications for, and interrelatedness of, individual performance, organisational settings and the wider policy context

Scott (2009) provides a useful framework for identifying what needs to change within the care system in relation to complex needs. She argues that there needs to be a paradigm shift in the currently child-focused workforce, towards the primary unit of attention being the parent-child relationship. The framework illustrates that individual practitioner performance occurs within an organisational setting, which sits within a wider policy context. All three of these interrelated levels plays a critical role in facilitating and enacting change.

More research is required to provide a better understanding of 'what works' and the interaction between complex needs, risk and protective factors, models of service, and welfare outcomes

More broadly, the research provides a call to action for more evaluation and research on the interplay between complex needs, risk and protective factors, services, and welfare outcomes (Dozier et al., 2012; Forrester et al., 2009; O'Donnell et al., 2008; Tarren-Sweeney, 2017). In particular, more randomised control trials and longitudinal studies are required.

Tarren-Sweeney (2017) isolates the key questions well; that is, the research question is not whether OOH care is harmful or therapeutic but rather:

- what is it about care that promotes or sustains development, and what is it that is harmful?
- for which children is care therapeutic, and for which children is it not?

His longitudinal study found that there does not appear to be a uniform, population-wide effect of long-term OOH care – instead there appears to be several distinct trajectories (Tarren-Sweeney, 2017). Within the care population there is wide heterogeneity.

While the research does not appear to have caught up with the prevalence of children in care, the prevalence of complex needs, and changes in international approaches to the care system, researchers are keen to acknowledge that foster carers, social workers and residential carers work tirelessly to advance the wellbeing of children in care (Forrester et al., 2009). Indeed, they have found

a relationship between positive service experience and involvement in the justice system – that is, youth who reported consistently positive service experiences early on had lower levels of involvement with the justice system than those who reported inconsistent or consistently negative service experiences (Sanders, Munford, & Liebenberg, 2013).

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