Placement Stability in Residential Out of Home Care: What is Good Enough Stability?

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Abstract

The research in this thesis aims to explore the concept of stability in residential care. Placement instability has been found to correlate with problematic outcomes in a number of areas, including mental health, criminal behaviour and sexual behaviour. Conversely, the existing empirical literature has not found close links between placement stability and positive outcomes.

To date, stability has been examined via the paradigm of measuring placements over time, meaning that the continuity of a placement has been used as an operationalisation of stability. Therefore, counting placements and examining outcomes has typically been the vehicle for examining the impact of stability on outcomes for the young person. However, in this thesis it is argued that a paradigm of placements over time does not take into account the internal experience of the placement, nor the many moving parts in residential care, including a staff team that may change significantly despite the placement itself continuing.

The research question addressed herein is "*How do young people, who have lived in residential care, and residential care workers define, understand and explain placement stability?*"

The research has two distinct aims. The first is to:
   a) Understand the experiences of placement stability or instability for the young people and staff involved.

Secondly, with this data the researcher seeks to:
   b) Develop a multi-dimensional operationalisation of stability for young people in residential care, taking into account that stability may comprise more nuancing than placements over time.

This study provides an exploratory, qualitative examination of stability in residential care, based on semi-structured interviews with participants who had lived and worked in residential care in the state of New South Wales, Australia. Eight young care leavers and 13 residential care staff, who currently work or previously worked in varying levels of residential care, including youth workers, clinicians and managers, were interviewed regarding their experiences of stability and instability to ascertain the essential elements of stability.

Both groups of participants largely identified similar elements that contribute to stability. These elements included a consistent care team, consistent rules within the house, a low level of casual workers, a sense of safety within the placement, a perception that the staff genuinely care for the wellbeing of the young people, that planning and communication are effectively employed to smooth the impact of any changes that occur, a recognition of the need for considered and appropriate matching of residents, and the application of principles of trauma-informed care when working with young people.

Additionally, two discrete principles were raised separately by staff and young people. Staff identified that they required support from management in order to do their jobs well, including ongoing supervision and training and the need to 'push back' against inappropriate referrals with the funding bodies. The young people identified the need for ongoing staff contact once they left care, and the need for staff to support peer relationships, both within school and outside of school.

This research has highlighted the critical importance of relationships as being the central tenet of placement stability in residential care. Both staff and young people identified, throughout the interviews, that the young people's relationships with the staff and their peers–either in the house, in school or in the community–were the main drivers of their feeling stable. Without close and meaningful relationships, particularly with the staff members, the continuity of a placement was insufficient to bring about a sense of stability, either internally within the young person or externally in the placement.

A model of stability was developed that draws together the key components identified by the participants as being central for positive outcomes. The major implications of the research are that stability can be achieved within residential care, and stability can provide healing for young people who have experienced trauma.

Acknowledgements

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This thesis is dedicated in honour of my mother, Peta Bollinger, the finest woman I have ever known and the one person I aspire to be more like every day that I live.

Thank you for your love, your support and my very life.

Peta Bollinger
22.12.1951-17.12.2020

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List of Acronyms

AASW: Australian Association of Social Workers

ACES: Adverse Childhood Experiences

ACT: Australian Capital Territory

AIFS: Australian Institute of Family Studies

AIHW: Australian Institute of Health and Welfare

AOD: Alcohol and other drugs

ATSICPP: Aboriginal and Torres Strait Islander Child Placement Principle

CAFAS: Child and Adolescent Functional Assessment Scale

CANS: Child and Adolescent Needs and Strengths

CBCL: Child Behaviour Checklist

CFC: Child and Family Characteristics Form

DCJ: Department of Communities and Justice NSW

DHHS: Department of Health and Human Services Victoria

FACS: Family and Community Services

ITC: Intensive Therapeutic Care

NDIS: National Disability Insurance Scheme

NEET: Not in education, employment or training

NGO: Non-government organisation

NHMRC: National Health and Medical Research Council

NSEC: National Statement on Ethical Conduct

NSW: New South Wales

NT: Northern Territory

NTRCWG: National Therapeutic Residential Care Working Group

OOHC: Out of Home Care

POCLS: Pathways of Care Longitudinal Study

PTSD: Post-traumatic Stress Disorder

QLD: Queensland

SA: South Australia

TAS: Tasmania

UK: United Kingdom

USA: United States

VIC: Victoria

WA: Western Australia

Glossary of Terms

Out of Home Care

Throughout this thesis, 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".

Overseeing funding body

In New South Wales (NSW), the funding body for out of home care (OOHC) has undergone a name change over the course of this research. Therefore, the funding body will be referred to by its name at the time of writing the document to which was being referred. At various times, the funding body will be referred to as Family and Community Services (FaCS) or Department of Communities and Justice (DCJ).

Residential 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: 42).

Sanctuary Model

The Sanctuary Model was developed by Bloom and Farragher (2013) as a means of connecting trauma and attachment theories within a framework for working in residential care and other mental health systems. It is based on the premise that within 'sanctuary', individuals are able to think, create and be physically, psychologically and morally healthy; are able to relate in emotionally healthy ways; each person contributes to the whole and that individuals are able to plan for and work towards a positive future.

Therapeutic Residential Care

In 2010, Australia endorsed the definition of therapeutic residential care that was reached by a consensus of the National Therapeutic Residential Care Working Group (NTRCW). This definition states:

> Therapeutic residential care is intensive and time limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and developmental needs. (NTRCWG, 2010)

Ainsworth and Hansen (2015) proposed that a different definition should be endorsed that does not include references to it being time limited and only inclusive of statutory care. They proposed that the definition put forward by Whittaker, del Valle and Holmes (2014) is a superior one.

> Therapeutic residential care involves the planful use of a purposefully constructed, multi-dimensional living environments designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with the full spectrum of community based and informal helping resources. (Whittaker, del Valle & Holmes, 2014, p. 24).

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Chapter One: The Introduction

1.1 Introduction

Overview of Residential Care

Within Australia, the responsibility for child and family welfare is held by the individual states and territories, which determine the legal framework governing out of home care (OOHC) - including residential care (Family and Community Services [FaCS], 2019). While the majority of young people in the broader OOHC system live in foster care or kinship care, 7% of children are placed in residential care. According to the most recent data, this equates to 3032 children in residential care across Australia (AIHW, 2021). Those in this type of care are typically older, with 82% aged over 10, according to the Australian Institute of Health and Welfare ([AIHW], 2016).

Residential care forms part of child protection and child welfare systems in most developed countries (Ainsworth & Thoburn, 2014). Within Australia, OOHC is governed by the individual states and territories, with non-government organizations (NGOs) often responsible for the day-to-day management of the young people in their care (NSW Ombudsman, 2014). Across Australia, since 2007, there have been 16 independent inquiries into OOHC[1]. These inquiries have consistently reported that the individual states and territories are ill-equipped to provide the care needed by the young people living in OOHC. The inquiries largely concluded that the young people typically cared for in residential care have complex and extreme needs, and require safe and stable placements, for which there is insufficient funding. In some of the reports of the inquiries it was argued that residential care should be gradually phased out (e.g. Nyland, 2016), while in others the case was made for putting greater focus on developing positive residential care (e.g. Morton [WA], 2015) and implementing therapeutic care placements (e.g. Geary [Vic], 2015; Siewert et al, 2015 [Commonwealth]; White & Gooda [NT], 2017). Taken together, the various findings suggest that while residential care is a necessary component of the OOHC system, it needs to be significantly improved.

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[1] Bamblett, Bath & Roseberry, 2010; Carmody, 2013; Cummins, Scott & Scales, 2012; Donnelly, 2017; Doyle, 2014; Farmer, 2019; Ford, 2007; Geary, 2015; Gentleman, 2014; Morton, 2015; Nyland, 2016; O'Halloran, Groom, Petrusma, White & Wightman, 2011; Siewert et al., (2015); Tune, 2016; White & Gooda, 2017; Wood, 2008.

Internationally, the degree of reliance on residential care in child welfare systems varies considerably. According to Ainsworth and Thoburn (2014), Armenia (95%), Japan (92%), Israel (80%) and the Czech Republic (72%) had the highest percentages of their OOHC populations in residential care. The lowest proportions were in Australia (6%), Ireland (8%), England (14%) and the USA (15%). Despite the varied ways that OOHC is provided, the outcomes for care leavers internationally appear to be markedly similar. According to Mendes (2011), young people transitioning from all types of OOHC experience multiple adversities, including: negative pre-care experiences, which necessitated their removal into the OOHC system, often sub-par experiences in care; accelerated transitions to adulthood, requiring independence at an age far earlier than most young adults in the Western world; and a lack of ongoing support once they turn 18 years of age. A combination of these factors contributes to their poorer outcomes. Research (e.g. see Mendes, Pinkerton & Munro, 2014; Stein, 2006) has suggested that those leaving OOHC experience worse outcomes in a variety of domains, including social exclusion, poorer educational attainment, difficulties achieving a stable career, lengthy periods receiving income support payments, difficulties with police and mental health difficulties.

McLean (2019) provided an overview of residential care in NSW and found that residential care facilities in NSW have a median number of four young people in the home with between five and nine regular youth workers rostered on, with a rotating roster. Commonly, staff work eight hour shifts, 12 hour shifts or 24 hour shifts with a staff member either asleep (passive) overnight, or rostered to be awake (active) overnight. Based on her findings, most organisations running residential care have homes in metropolitan, regional and rural areas and generally homes were small suburban homes located in the community. It is noted that internationally the sizes of residential care facilities and staffing ratios may vary, as is reflected in chapter 3.

Complexity of Findings for Residential Care

Despite universally worse outcomes for care leavers compared to their non-care peers, there is an assumption in the field that those in residential care fare particularly poorly,

compared to those in other types of care (e.g. Geary, 2015). Empirical evidence, however, does not necessarily support that assumption. According to existing research, there is either little difference in outcomes between residential and foster care, or some more positive effects found for those who have been in residential care (e.g. see Gallagher & Green, 2012; Strickler, Mihalo, Bundick & Trunzo, 2015; Thompson, Duppong Hurley, Trout, Huefner & Daly, 2017). A number of studies have found that residential care can be a positive environment, particularly for those displaying more complex needs (e.g. Knorth et al., 2008; Lee & Thompson, 2008; Lyons et al., 2009; Portwood et al., 2018). The empirical evidence appears to suggest that residential care is not, in and of itself, the conduit of poorer outcomes once residents leave care.

1.2 Definitions of Stability in the Research

Young people in residential care experience some of the highest rates of placement instability in terms of the number of placement moves (Siewert et al., 2015), and are generally considered to be the most vulnerable, behaviourally disordered and attachment disordered young people in the country (Delfabbro, Osborn & Barber, 2005). A number of researchers have examined the outcomes associated with placement instability, when operationalized as numbers of placements, and have found that the higher the number of placements, the worse the outcomes (e.g. Fawley-King & Snowden, 2013; Newton et al., 2000; Rock et al., 2015; Ryan & Testa, 2005).

There is not, however, any particular consensus on how stability or instability are measured. In 2007, a review was completed examining studies internationally that investigated, in part, the measurement of stability in foster care. Findings included that, across 43 studies, stability was measured in multiple and different ways, for example: setting cut-off points of stability, such as one or two placements, with anything above that being considered unstable; comparing categories of placements such as comparing young people who had experienced one to two placements to those who experienced three to four placements; and examining the continuum of placements that were experienced. This approach to measurement can be considered a paradigm of placements over time. The impact of the differing measurement approaches is twofold. Firstly, studies cannot be directly compared because differing approaches to measuring were used. These may

not lead to the same outcome. Secondly, this measurement approach cannot take into account any elements of the quality of the placements. Therefore, by ignoring the quality of the placements, what is potentially being measured is not stability *per se*, but rather a period of time in which a young person has not changed placements. This may not be the same thing, particularly given Devaney, McGregor and Moran's (2019) argument that stability can be considered as "children's feelings of connectedness and belonging that are characterized by steady emotional attachments to adults and members of peer networks" (p. 635).

Placement instability, as measured by a placements-over-time paradigm, has been found to lead to a host of negative outcomes for young people, particularly in mental health, attachment difficulties, behavioural problems, sexual and general offending and executive functioning difficulties (see Fawley-King & Snowden, 2013; Lewis, Doxier, Acherman & Sepulveda-Kosakowski, 2007; Pritchett, Gillerg & Minnis, 2013), which include the abilities to plan, set goals and inhibit behaviours.

Having multiple placements has been found to be linked to greater use of mental health and psychiatric facilities in childhood (Fawley-King & Snowden, 2013) and increased anxiety and depression (Pritchett et al, 2013). According to Newton and colleagues (2000), placement instability can lead to externalizing behaviour difficulties, such as aggressive behaviour or property damage. These authors found that over a study period of 18 months, behaviour problems increased as placements increased. Further, multiple placements have been found to reduce individuals' executive control, which relates to the ability to self-regulate emotions and behaviour (Lewis et al, 2007), while other researchers found that as foster placements increase, a child's ability for inhibitory control decreases (Pears, Bruce, Fisher & Kim, 2010). Therefore, as placement moves rise, it appears that young people can become more behaviourally dysregulated and have less capacity to inhibit problematic behaviours or regulate their emotions.

General and sexual offending have also been linked to placement instability. Simply being in OOHC, regardless of placement numbers, increases the risk of delinquency for girls; even worse, for boys, increasing the numbers of placements appears to double the

risk of delinquency (Ryan & Testa, 2009). Other researchers have further found that those who have experienced greater instability have greater rates of contact with the police (e.g. Barn and Tan, 2012; Cusick, Courtney, Havlicek and Hess, 2010; Jonson-Reid and Barth, 2000; Taylor, 2006). Researchers have produced two significant studies examining sexual behaviour problems and found that placement instability was an independent predictor of sexual behaviour problems (Prentky et al., 2014; Tarren-Sweeney, 2008b).

According to Prentky and colleagues (2014), instability was the only independent predictor of offence persistence. They added that instability negatively correlated with self-control, which also related to the findings regarding executive functioning. Tarren-Sweeney (2008b) also found an additive effect of placement instability and having had a history of sexual victimization. Thus, both placement instability and a history of sexual victimization predicted sexual behaviour problems, however, having both these factors increased the risk.

There is fairly robust international evidence that instability leads to negative outcomes, in multiple domains. There is not, however, robust evidence that stability has any particular effect. For example, Tarren-Sweeney (2008a) reported that in a sample of mostly stable placements in foster and kinship care, there was little to no change in mental health ratings over a seven to nine year follow up. He argued that, for many young people in OOHC, a stable placement may merely lead to less deterioration than may have otherwise occurred, rather than improvements (Tarren-Sweeney, 2008a). It is possible, however, that the lack of strong findings regarding stability relate to the measurement approach of the placements over time paradigm. Given that counting placements only provides detail about the number of placements a young person experiences, rather than the quality of the placements or the quality of the interpersonal connections, what appears to be stability actually equates to a time in which a young person has not changed placements.

1.3 Methodological Frameworks and Methods

The current research responds to the research question "*how do young people, who have lived in residential care, and residential care workers define, understand and explain placement stability?*" This question interrogates what has not previously been explored in the literature, that is, what is observed and experienced as stability in a complex, multifaceted environment with many moving parts, including a rotating roster of staff, co-residents and a management system including team leaders, managers, caseworkers and psychologists.

The research question is inherently exploratory as firstly, stability has not, to date, been examined as a construct in the literature, and secondly, stability has not been considered specifically in relation to residential care. Therefore, a qualitative approach was taken in order to undertake in-depth interviews with key personnel involved in residential care to understand the intricacies of how stability may work within such a complex environment. To do so, 21 semi-structured interviews were conducted. They included 13 with residential care staff, including youth workers, managers, clinicians and senior management staff, and eight with young residential care leavers who were aged between 18 and 25 years.

1.4 Research Significance

In order to answer the research question, which, to date has not been examined in the literature, interviews were conducted with staff and young people who have worked and lived in residential care, respectively. Within the extant literature, this approach has not typically been taken, thus providing a unique insight into how residential care works according to staff members at various levels of organizations, from youth workers to directors, as well as the experience of being in residential care, heard from the young people. A particularly notable and significant finding, which discussed in Chapter 8, is that both staff and young people identified remarkably similar elements that constituted stability.

These concurrent views provide significant evidence that there are elements that are integral to a young person experiencing a placement as stable that extend beyond simply being in a placement for an extended period of time. This finding has policy and

procedural implications for organizations providing residential care programs. Organizations in NSW will be able to directly apply the findings so as to prioritize the factors that contribute to stability and minimize the factors that contribute to instability. Such implementation should have long-term positive impacts on the mental health and well-being of young people in residential care. Organizations in other jurisdictions will be able to consider whether the findings are applicable in their particular context and circumstances. Given the research findings regarding the impact of instability, approaches that are able to minimize this by proactively supporting elements of stability may be able to minimize negative outcomes. Further research is needed to examine the impact of this approach.

Based on the overarching theories of attachment and neurodevelopment, an assessment of placements over time fails to take into account the need for developmentally attuned, attachment-oriented approaches to caring for traumatized young people. In the approach of placements over time, it is assumed that a young person remaining in a single placement is, in itself, sufficient for the young person's needs to be met so that it could be used as a proxy for stability. It also fails to take into account the possible reparative impact of close attachments developed within the residential care sphere. These impacts, however, may take more time and a more nuanced examination than the research has previously taken into account.

Therefore, this research is significant in that it is connecting these two theories with a population that has not regularly been studied through these lenses to develop a multi-faceted operationalization of stability. This may significantly impact the policy and practice in this area, to not merely measure stability as a 'check box', but also to promote, in line with Cashmore and Paxman's (2006) notion of felt security, the development of attachment stability as a priority, alongside a continuous placement over time.

1.5 Researcher Rationale

This topic is the result of the researcher's experiences working in residential care, both as a youth worker and as a psychologist over many years. My interest in this specific

topic began while working as a psychologist for a residential care provider. I observed placement decisions being made in a mostly ad-hoc, reactionary way with limited guidelines on how best to make decisions. This included when to move a young person, how to move someone into a placement, and how to handle staffing decisions. Furthermore, I had interactions with one particular young person who appeared to thrive in their first placement. However, after a number of moves, in part due to organizational changes, the young person experienced a surge in problematic and risk-taking behaviour. Once the decision was unilaterally made that no further placement changes, regardless of behaviour, would occur for this young person unless it was court-ordered, they settled and were able to thrive in a placement once again. Observing the direct impact of placement instability and subsequent stability significantly influenced my thought process around how decisions are made for and about young people, particularly without research evidence to support those decisions.

My work experience, alongside my experience with mentors who have travelled with me on my journey, taught me about attachment and brain development, both of which led to selecting the organizing theories for this thesis. I become aware of the impact of trauma on the developing brain and attachment systems and how these affect the individual's ability to function. This explained a great deal of the behavioural and emotional difficulties experienced by young people in residential care. My understanding of these theories formed the backbone of my therapeutic work as a psychologist in a clinical practice and informed the therapeutic relationships I developed with my clients.

My experience of understanding the impact of trauma on these systems and the subsequent difficulties in day-to-day functioning provided a framework for working that resulted in extremely positive outcomes with individuals who have experienced trauma. I have had profound experiences of clients healing as a result of the stable attachment relationship within the therapy space, resulting in a greater capacity for working, for engaging in friendships, for being assertive and for being less likely to use problematic coping strategies such as alcohol or self-harm. The experiences I have had within my working life have guided me to this research, which has been undertaken out of a need to answer this particular question and many more that will subsequently stem from it.

The research is also motivated by a love for a population that has not received the care and attention that it deserves and has a right to.

1.6 Thesis Structure

This thesis takes the following format:

Chapter 1 is this introductory chapter, which contains brief background information and some policy context regarding residential care within Australia. It also provides a brief rationale for the study itself, alongside the researcher's rationale and overview of the thesis structure.

Chapter 2 is the theoretical overview that provides the lenses through which the study has been conceptualized. The theories utilized are attachment theory and neurodevelopmental theories, which shape how the literature is examined and how the data have been gathered and interpreted.

Chapter 3 comprises an examination of the relevant empirical literature over three major sections: a discussion of residential care within Australia and internationally; the empirical evidence internationally regarding residential care and the associated outcomes; and finally, a discussion of the international research on stability in OOHC. This chapter provides details regarding the research to date, as well as the significant gaps in knowledge that lead to the current research. The chapter concludes with a connecting section that draws together the theories that were discussed in the theoretical overview (Chapter 2) and the literature, alongside some case studies that demonstrate the need for the current research.

Chapter 4 details the overall methodology of the study, including the epistemology and ontology that shape the methods chosen to answer the research question. In this chapter, I set out details of the methodological rigour required to conduct the research. I also discuss the ethical approaches, sample, data collection and analysis, and limitations of the study.

The study findings are presented in Chapters 5, 6 and 7.

Chapter 5 is a brief chapter in which the demographics are presented of the young people who participated in the research, and some analysis into the differing presentations and subsequent experiences of their placements in residential care. These young people and the stability or instability they experience is the core focus of the study. Therefore, their specific demographics are considered to be especially relevant for understanding the findings. Four particular participants are discussed in detail as their residential care experiences are polar opposites. Two participants had the smallest number of placements, the other two had some of the highest numbers of placements in the study. Yet, their respective perceptions of residential care were not as might be expected. The reasons why these unexpected findings emerged are discussed.

Chapter 6 consists of details of the findings from the staff participants, including their demographics. This chapter provides detailed information regarding the staff members' responses and the significant themes that emerged from their interviews.

Chapter 7 is an outline of the findings from the youth participants, in which brief tabular demographics are provided. In this chapter I set out detailed information regarding the young people's responses and the significant themes that emerged from their interviews. Some comparison to the staff members' themes is also made, however, only briefly.

Chapter 8 is the integrated discussion and conclusion, where I compare and contrast the findings from the two different groups discussed in Chapters 6 and 7 and align the findings with the extant literature, where possible. The overarching theories are drawn into the discussion to explain many of the findings within a framework of attachment and neurological development. In this chapter I present the model of stability that was developed as a result of the research. I also include summaries of the key areas for future research, the strengths and limitations of the study and the policy and practice implications.

Chapter Two: The Theories that Shape the Research

This thesis is predicated on a theoretical understanding of the nature of attachment and trauma on a developing brain. For this reason, this chapter is presented first to contextualize an understanding of the research in residential care generally and in placement stability specifically.

In residential care, those children and young people are looked after who have experienced trauma and maltreatment to the extent that they are unable to be looked after by their families. Any discussion of this cohort must take into account the impact of such maltreatment. In the case of young people in residential care, this maltreatment led to a placement out of home care and subsequent exposure to possible placement instability, potential poor in care experiences and difficulties transitioning to adulthood. These life events must be considered at a structural level (i.e. the impact on the developing brain and the developing attachment systems). The following section is an exploration of the impact of early maltreatment on both the attachment and brain development of young people and how these later affect adjustment, particularly as that may relate to an ability to maintain a stable placement and the effects of instability. Adjustment in this case relates to general functioning and the development of social and cognitive skills. In the following chapter, links are identified among trauma, attachment and residential care

that, to date, have not been explored in the literature. As such, theoretical connections are made nature, rather than those supported by specific, population-based data.

Australian Institute of Health and Welfare data (AIHW; 2021) provides information on the extent of notifications of risk of serious harm made to the Department of Communities and Justice, the New South Wales (NSW) government's department administering child protection. Notifications can be made by mandatory reporters (such as teachers, psychologists, medical staff etc.) or concerned individuals within the community, such as neighbours or family members who have concerns for the safety of a child. In NSW in 2019-2020, 14.8% of notifications related to physical abuse (nationally, 14.1%), 14.8% related to sexual abuse (nationally, 9.2%), 34.5% related to emotional abuse (nationally, 53.9%) and neglect accounted for 35.7% of the notifications in NSW (nationally, 22.5%; AIHW, 2021). These were not sub-classified for various types of out of home care (OOHC) and included notifications for children and young people who were not in OOHC.

These numbers, importantly, reflect the known experiences of maltreatment that precipitated children's and young people's entries into OOHC. It is understood and well documented that young people in OOHC generally and residential care specifically have likely experienced abuse and neglect, which resulted in them being removed from their family's care (Salazar, Keller, Gowen & Courtney, 2012). A key element of these specific forms of trauma (i.e. physical, sexual, emotional abuse and neglect) are that they are relational (Schore, 2001). That is, the abuse occurs within the context of a relationship, rather than as a random event occurring separately to a relationship (such as a natural disaster, war, car accident or an arbitrary attack). As a result, this can significant influence that individual's capacity to manage interpersonal relationships, as well as leading to ongoing difficulties with emotional regulation (Schore, 2001). This is discussed further in Sections 2.3 and 2.4. Firstly, this discussion is grounded with reference to its theoretical underpinnings in attachment theory.

2.1 Attachment Theory

Attachment theory describes the interpersonal functioning related to the urge for infants to seek strong bonds with specific others (Bowlby, 1977). The theory was originally developed to describe the infant-caregiver bond. The theory states that an infant's behaviour is regulated through a distinct, goal-oriented evolutionary and behavioural system with the primary goal of the nurturing caregiver maintaining the infant's proximity and fundamentally aimed at promoting infant survival (Bowlby, 1982). Bowlby (1973) proposed that the quality of the infant-caregiver attachment relationship was predominantly determined by the caregiver's emotional availability and responsiveness to the child's needs. The resulting attachment bond refers to the degree of security experienced by the child, in other words, the child's belief that the world is safe (Bretherton, 1985; Sroufe & Waters, 1977).

A *secure attachment* is determined to exist when the caregiver is available and responsive to the infant, such that an infant's normal resources are sufficient to attract and maintain the attention of the caregiver (Ainsworth, 1989; Mikulincer & Shaver, 2007). This is done by behaviours such as crying, reaching out to the caregiver or becoming restless. An *insecure attachment* forms when the caregiver is unpredictably responsive or non-responsive to the infant's cues (Mikulincer & Shaver, 2007). In this situation, infants will adjust their attachment-seeking strategy to elicit a response from the caregiver, through attention seeking or protest behaviour, or they will give up trying altogether. Bowlby (1982) suggested that, over time, these variations in attachment bonding and behaviour can lead to individual differences in attachment patterns and interpersonal functioning, which can have an impact on adult relationships.

Research examining the individual differences in attachment system functioning tends to revolve around the concept of *attachment style*. This important addition to attachment theory was made by Ainsworth, Blehar, Waters and Wall (1978) who used a procedure known as 'the strange situation' to explore the differences in infant-caregiver attachment relationships. Using this experimental paradigm, they observed the infant's pattern of responses to separations and reunions with their mother, and from the observations they identified three distinct attachment styles: secure, anxious/ambivalent, and anxious/avoidant. Ainsworth and colleagues found that during the strange situation procedure, secure children demonstrated exploratory behaviour and used their mother

as a secure base, whereas anxious/ambivalent children were inconsistent in their attempts to gain the mother's attention and avoidant/ambivalent children actively avoided their mother.

A fourth category of attachment style is *disorganized attachment*, which was developed to explain a pattern of behaviour that did not fit with the other categories. This pattern tended to display behaviours such as freezing, staring at the wall, head banging and other behaviours that appeared to mean that the source of comfort was also the source of fear, typically in the context of child abuse and neglect (Schimmenti & Caretti, 2016; Van der Kolk, 2014). It was found that infants with this attachment pattern had the highest heart rate of the various attachment groups and this pattern was found in over 80% of maltreated infants (Carlson, Cicchetti, Barnett & Braunwald, 1989). Carlson and colleagues (1989) also noted that this particular attachment pattern arises because infants necessarily seek their parents or caregivers out for comfort when distressed. When, however, the parent or caregiver is the source of distress, this is an insurmountable paradox for the infant. Schimmenti and Caretti's (2016) work is theoretical in nature and built upon understandings of neurodevelopment, attachment relationships and their impact on the development of dissociation. The authors argue that the early experience of attachment trauma, whether involving overt abuse or neglect, or simply a subtle means of "overrid[ing] or ignor[ing] the infant's needs and attachment signals but without overt hostility" (Dutra, Bureau, Holmes, Lyubchik & Lyons-Ruth, 2009 p87), results in a disorganized attachment system including elements of dissociation. This leaves the individual with difficulties developing a consistent sense of self, understanding and responding to their own emotions and bodily sensations, poorer emotional regulation strategies and difficulties with managing interpersonal relationships (Schimmenti & Caretti, 2016).

Research into attachment styles in OOHC broadly and residential care specifically indicates greater rates of disorganized and insecure attachment styles (Bifulco, Jacobs, Ilan-Clarke, Spence, & Oskis, 2017; Oskis, Loveday, Hucklebridge, Thorn & Clow, 2011). Disorganized attachment has been linked to trauma and abuse (Schimmenti & Caretti, 2016, Van der Kolk, 2014). Therefore, it follows that those in OOHC would be more likely to have a disorganized attachment style. Maltreated children are likely develop

insecure and disorganized attachment styles, meaning that they struggle to safely and successfully seek care and proximity to their caregivers. This could be because it is a frightening prospect, they cannot predict the outcome of their approach or they have learned to avoid seeking proximity and safety from their caregiver. This has implications for later relationships in adolescence and adulthood, when young people, particularly in residential care, need to seek care and safety from individuals they may not know well.

These attachment styles are believed to reflect the underlying organization of the attachment system, which gives rise to *internal working models* that permit the individual to generate relational expectations and a context in which to interpret these relationships (Bowlby, 1973). The consolidation of these accessible working models is believed to be the psychological process that accounts for the continuity of one's attachment style across one's lifespan (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000).

According to Schore (2001), this attachment relationship is predominantly encoded in the right hemisphere of the brain, which is the location where neurological activity occurs associated with encoding and responding to socio-emotional cues (See also Schore, 1994, 2000; Siegel, 1999). It has been argued that impairments to this part of the brain impact on an individual's capacity to regulate their emotions and develop effective coping strategies (Aideuis, 2007; Davies & Frawley, 1994; Tronick & Weinberg, 1997; Van der Voort, Juffer, Bakermans-Kranenburg, 2014). In a meta-analysis of 80 studies, those with insecure attachment had poorer social competence, which is often linked with poor emotional regulation (Groh et al., 2014).

Attachment theory contends that *stressful situations* should elicit a person's attachment-related behaviour, which normally lies dormant in non-stressful contexts (Bowlby, 1982). That is, in the event of an 'activating' situation such as a job loss, a person's secure attachment is believed to function as a buffer against the potential to experience psychological problems, thus, permitting them to rely on others for comfort and support. In contrast, however, an insecure attachment style is thought to lead to poor coping and maladjustment to the stressor (Shaver & Hazan, 1993). Should there be a lack of attachment security and if a significant attachment relationship were to break down,

this 'activating' situation would likely trigger a cascade of attachment responses that are designed to either keep the attachment figure close or keep them at a distance. This can be contextualized for residential care when key relationships break down to the extent that a young person either has new caregivers or is moved to an entirely new placement. Therefore, the cascading effects of the activating situation eliciting such attachment responses may lead to further traumatization, such as emergency services being called as a result of self-harm or aggressive behaviour; or a further shutting down of those attachment systems. Given Hazan and Shaver's (1993) finding that problematic attachment styles would lead to poor coping and maladjustment, this would likely impact a young person's capacity to settle into a new placement.

2.2 Attachment in Adolescence

During adolescence, there is a period of structural change within the brain (Siegel, 2014). At this time peer relationships take on even greater significance, with mental health and wellbeing depending on positive peer relationships (Narr, Allen, Tan & Loeb, 2019). Furthermore, as Siegel (2014) identified, the experience of close friendships in adolescence, provided they are buffered by close relationships with adults, can provide essential wellbeing and happiness throughout the lifespan. He noted, however, that the absence of positive adult relationships during this time may lead to increased risk-taking behaviour because of the lack of adult reasoning to temper adolescent novelty seeking. In agreement with this, Landstedt, Hammarstroem and Winefield (2015) noted that the best predictors of adult mental health were positive peer relationships and positive parental relationships at age 16. In residential care, the majority of young people are in their adolescent years, living with peers with whom they may or may not have good relationships. The importance of positive peer and adult (here, staff) relationships is likely to be paramount in the development of positive mental health.

It should be noted that one of the concerns regarding residential care is the element of "peer contagion" (Mendes, Snow & Baidawi, 2014 p. 55). Peer contagion refers to the influence, in a closed environment, of some people on others to engage in particular behaviours, due to social modelling. Based on the authors' review (Mendes et al., 2014),

they argued that some young people in residential care were influenced to engage in criminal behaviour as a result of mixing with peers already behaving in such a way. Peer contagion is an important consideration when it comes to matching young people to live together in residential care, given the need for peer relationships, adolescents' inherent movement towards their peers (Narr et al., 2019), and the associated risks. As mentioned by Siegel (2014), however, appropriate adult supervision can assist with mitigating some risk.

In the following section, a discussion is presented of the negative relationship between insecure and disorganized attachment and an ability to regulate one's emotions and enjoy relationships.

2.3 Attachment Theory and Emotional Regulation

Two elements of secure attachment are particularly significant with regard to emotional regulation. Firstly, via their attachment to their caregiver, a child learns to regulate their emotions through the process of their emotions being regulated by their attentive caregiver (Perry & Szalavitz, 2007). Secondly, they develop an ability to enjoy relationships with others, which promotes prosocial behavior (Perry & Szalavitz, 2007). These will be discussed in turn.

The process of an attuned caregiver regulating an infant's emotions, a process called co-regulation, forms the basis of developing an independent ability to regulate one's own emotions (Perry & Szalavitz, 2007). The absence of co-regulation can lead to difficulties recognizing and appropriately responding to one's emotional cues. Being unable to identify emotions and being unaware of how to respond to them can lead to behavioural instability and emotional dysregulation (Van der Kolk, 2014). The inability to regulate emotions would likely significantly blemish a young person's capacity to successfully manage a residential care placement. In studies of neglect, Tronick and Weinberg (1997) identified that infants are incapable of returning themselves to homeostasis (baseline level of arousal) once they become dysregulated, and while dysregulated, they are unable to focus their attention on learning new skills or learning about the world

around them. As such, they require ongoing support from an attuned caregiver to assist them to return to homeostasis. This was stated succinctly by Schore (2001) when he wrote, "infants who experience chronic relational trauma too frequently forfeit potential opportunities for socio-emotional learning during critical periods of right brain development" (p. 209).

Davies and Frawley (1994) further indicated that emotional dysregulation as a result of abuse by the caregiver is of such significance as to leave the child feeling as though their very survival is at risk; so impairing their ability to build a sense of trust and safety with caregivers. The impact of relational trauma on a child's attachment system affects the individual's later ability to see themselves in a positive light, as underscored by Bowlby's (1973) theoretically posited internal working models. Indeed, Balluerka, Muela, Amiano and Caldentey (2014) noted that young people who have experienced early trauma and abuse develop an internal working model of themselves as incapable of giving and receiving affection and safety, as well as developing a view of the world as unsafe and unpredictable.

2.4 Attachment and Relationships

The second significant element of a secure attachment is that a child learns to enjoy the company of others. A child can learn that adults are safe and that people can be trusted (Van der Voort, Juffer & Bakermans-Kranenburg, 2014). In the absence of a secure attachment, such as with an attachment style that is insecure or disorganized, the child cannot consistently view those in caregiving positions as safe and predictably available (Hesse & Main, 2006). This can have profound effects on a child's ability to form a worldview that is consistent with adaptive and prosocial behaviour. Secure attachment also forms the rudiments of prosocial behavior because the child or young person seeks to please those individuals they feel close to, and can feel devastated if they displease the attachment figure (Perry, 2001). If a child's needs are not responded to, they may simply learn that they must rely on themselves and may not find any particular pleasure in being around others (Perry & Szalavitz, 2007). These individuals may appear to lack

empathy and social skills as a result of the underdevelopment of their attachment system (Perry & Szalavitz, 2007; Van der Kolk, 2014). This is frequently observed in young people who have had multiple placements and multiple broken attachments; they become quite detached and uninterested in forming bonds with safe adults. They can then be hard to connect with, hard to bond with and hard to care for (Tarren-Sweeney, 2008b).

As noted in Section 2.1, stressful situations are likely to activate an individual's attachment system (Bowlby, 1988). Such situations likely include new placements or placement breakdowns. More disrupted attachments lead to poorer emotional control, and poorer emotional control gives rise to a greater number of placements, with further disruption of the developing attachment system (Barber & Delfabbro, 2003). Barber and Delfabbro (2004) identified that in South Australia up to 20% of youth in foster care experience significant placement instability. The authors noted that this group of children, over a two-year period, experienced between 15 and 30 placements compared to the population average of five.

> Young people brought into care following neglect or abuse by their caregiver have often suffered a double insult; firstly, the damaging effects of unresponsive, inconsistent or frightening parenting, and secondly the often sudden loss of [those] attachment relationships (Hollingworth, 2014, p. 24).

These researchers' findings shed further light on high placement turnover undoubtedly impacting on young people in OOHC's attachment system, given the constant activation of a negatively framed internal working model, as discussed by Bowlby (1988). It likely follows that insecure attachment styles and significant placement instability are linked, possibly via problematic behaviours that lead to placement breakdowns and further reinforcement of insecure attachment.

2.5 Attachment in OOHC

It has been established that the attachment system is developed via the ongoing, repetitive input of caregiving. When that input is attuned and responsive, secure attachment develops, which results in the person who is cared for developing a relatively positive view of themselves and the world around them. When, however, that input is not attuned, not responsive or not safe, attachment styles develop that reflect the world as being unsafe and the self as bad. This section comprises an examination of the four different studies of attachment profiles as exhibited by those who are currently in OOHC or care leavers, and the impact of this on their capacity to manage their relationships, emotions and general functioning.

There has been specific research examining the attachment profiles of young people in residential care (Bifulco et al., 2017). Bifulco and colleagues (2017) reported that, in their sample of 118 young people in residential care in the United Kingdom (UK), based on the instruments of Attachment Style Interviews (George, Kaplan, and Main, 1984), and Vulnerable Attachment Style Questionnaires (Bifulco, Mahon, Kwon, Moran & Jacobs, 2003), there were far higher rates than in the general population of disorganized-insecure attachment (50% versus 5%), with the vast majority of the sample identified as having insecure attachment styles of all types. The authors posited that this was consistent with other studies in the UK and through Europe (Oskis et al., 2011). They also contended that attachment experiences of those in residential care may be linked with high levels of placement instability (Bifulco et al., 2017). The authors commented that placement stability should be a primary goal for young people in residential care, particularly those displaying insecure attachment styles, as the absence of a stable base denies them the opportunity for a second chance at developing a secure attachment style (Bifulco et al., 2017).

Graham (2006) wrote a theoretical paper regarding different strategies used by young people in residential care to get their attachment needs met and the strategies that care staff can use to assist these young people with re-writing their internal working models. This has the ultimate goal of shifting to more successful attachment patterns in seeking comfort and safety from safe people. In doing so, the insecure attachment styles may have that "second chance" to be revised within residential care via the support of care staff (Graham, 2006, p 1). This notion was also discussed by Schofield, Larsson and

Ward (2017), in their qualitative study of 20 residential care leavers in the UK (aged 17-26) who were involved with a transitional team. The authors noted multiple different themes regarding identity development through the participants' experiences in residential care and noted that those who had more positive outcomes were able to identify the staff as a secure base for them, regularly referring to the staff as "like a mum" or "like a dad" (pp. 787-788) which allowed an ongoing connection into adulthood, even once they had moved out of the placement. The authors further opined that residential care could offer a sense of permanence for young people, with the staff offering a sense of stability, acceptance and connection with the young people by remaining in contact once they had left care. McPherson and colleagues (2021) also noted that the quality of the relationships with the staff in residential care provided additional support for young people to participate in decision-making activities such as case reviews.

Hollingworth (2014) examined 30 care leavers, compared with 35 age and gender matched peers who had not experienced OOHC who were also undertaking higher education, to examine whether there were links between attachment insecurity, emotional regulation and social cognition. Social cognition was defined as the ability to make inferences about the emotional and cognitive states of others (Hollingworth 2014, p. 33). He found that care leavers (who had graduated from various forms of OOHC) experienced greater rates of attachment insecurity, poorer emotional regulation and poorer social cognition than these peers. The author proposed that poorer emotional regulation and poor social cognition were linked, with those with poorer social cognition over-interpreting social cues, leading to negative and difficult to manage emotions. This accords with findings in neurobiological research that suggest that those who have been exposed to trauma are more likely to be attuned to negative stimuli and to interpret stimuli as negative (McCrory, Gerin & Viding, 2017). Hollingworth (2014) found that care leavers had higher rates of insecure attachments, which appeared to be linked strongly to poor emotional regulation and poor social competence. This is consistent with the relationships between attachment and emotional regulation described in Sections 2.3 and 2.4.

Further research into the attachment styles of those in OOHC yields similar results. According to Cyr, Euser, Bakermans-Kranenburg and Van IJzendoorm (2010) who undertook a meta-analysis of ten studies including 456 maltreated children, those who had experienced maltreatment were more likely to develop an insecure or disorganized attachment than those without maltreatment. The authors did not identify the location of the research papers used in the meta-analysis. This evidence further supports Bifulco and colleagues' (2017) work on residential care alumni, where the majority experienced insecure attachment with 50% of the sample experiencing disorganized attachment. This correlates with Schimmenti and Caretti's (2016) supposition that a disorganized attachment style leads to difficulties with understanding and responding to one's own emotions and bodily sensations, emotional regulation and managing interpersonal relationships, all of which are considered to be typical of residential care alumni.

Cashmore and Paxman (2006) undertook a study of young people in NSW who were due to leave care and subsequently followed them up on three occasions, the last being four to five years later. A total of 47 young people was interviewed initially, with a final sample of 41. In this study, the group of young people who reported feeling more secure had, on average, far fewer numbers of placements, with an average of 2.3 placements and those reporting a lack of felt security having, on average, 9.5. Furthermore, 'felt security' - the feeling of being stable, cared for, belonging and having needs met - was found to coincide with the young people's belief in their ability to remain in the placement after they turned 18 (Cashmore & Paxman, 2006). The authors speculated that stability of placement was a necessary but not sufficient condition for felt security, as stability provided a system by which a young person could develop consistent schooling, relationships and a local community. These researchers further argued that it was the "meaningful and trusting relationships that are likely to matter most to these young people" (Cashmore & Paxman, p. 238). They indicated that stability is an important condition for attachment relationships to develop. There may also be an alternate relationship between these variables, that those who had less disorganized attachments were more readily able to build attachments within the placements, which enabled those placements to be relatively successful and facilitated the young people in developing a sense of belonging, feeling cared for and having their needs met (Cashmore & Paxman,

2006). Within this thesis, the factors that influence stability are explored, including the importance of relationships with staff and other young people in the placement.

Attachment theory provides a lens through which to view an individual's approach to the world around them and others with whom they have relationships. In the context of residential care, this would relate to a multitude of complex and unusual relationships including birth family contact, relationships with the residential care staff and other young people with whom they reside, and any other involved staff including caseworkers, psychologists, medical professionals and school teachers and students. A child's attachment develops through the early experiences of being cared for. At the same time, a child's brain is also developing. The following section offers a discussion of how early trauma impacts on the brain and how that links to development.

2.6 Neurobiology of Trauma

Over the past three decades, research into the impacts of trauma on the developed and developing brain has grown dramatically. While it is difficult to assess causality, particularly with specific brain regions, research into animal models assists with drawing some causal conclusions. The validity of causal findings is increased with such experimentation because the animals can be randomly allocated to various conditions, which eliminates the possibility that pre-existing brain abnormalities can increase the likelihood of brain changes as a result of maltreatment, or personality characteristics that may lead to an individual maltreating the child (Anda et al., 2006; Teicher et al., 2003). In the following section what is known about how trauma impacts the developing brain and how this affects an individual's functioning are discussed. Finally, this will be linked to the research on attachment to draw conclusions about early trauma, the development of attachment systems, and connections with the brain. This is then related to the behaviour of young people in residential care.

Approximately 90% of brain development occurs in the first four years, however, the final 10% is not completed until the individual is in their 20s (De Bellis et al., 1999;

Perry et al., 1995). The organization and capacity of the brain depends on specific inputs at specific times (called 'critical' and 'sensitive periods') to achieve optimal development (Perry & Pollard, 1998). As a result, however, the brain's development is vulnerable to extreme or repeated stressors at those critical and sensitive periods, potentially leading to changes to its normative development.

Critical periods are times during development when certain input is required for development, for example prior to the age of three, care and nurturing are critical. Sensitive periods, however, are times when the neurodevelopment is more sensitive to particular input, such as language development; these are points at which development can be maximized (Perry, 2002). Perry (2002) identified that in the first three years of development, nurturing is *critical*. If a child does not receive adequate nurturing in that time, positive experiences after this may be insufficient to repair the damage that was done to the brain's organizing system. In a similar vein, Kaplow and Widom (2007) found that those exposed to stress between three and five years of age developed more severe post-traumatic stress disorder (PTSD) in adulthood, reinforcing that this early period is sensitive to maltreatment.

Those in residential OOHC have experienced trauma and abuse and a lack of protective behaviours in response to that trauma, hence their removal from their families. Research in the United States has indicated that those in OOHC have between two to three times higher rates of PTSD than the general population (Keller, Salazar & Courtney, 2010; Pecora, White, Jackson & Wiggins, 2009; Salazar, Keller, Gowen & Courtney, 2013), than those in the general population with similar demographics.

While it may seem like a flaw in natural selection that a brain takes such a long time to develop and is so susceptible to change as a result of stressors, this may actually be a strength. Teicher, Samson, Anderson and Ohashi (2016) proposed that this was more likely to provide a significant genetic advantage to those whose brains developed in response to traumatic events. Teicher and colleagues (2016) argued that stressors in childhood alter the brain regions in an "experience-dependent plastic manner, to facilitate survival and reproduction in what seems, so far, to be a threatening and malevolent world" (2016, p. 653). For example, the shortening of the lifespan of up to 20 years can

be interpreted as a biological adaptation as it typically would bring about precocious puberty and early childbirth. This has a clear adaptive benefit in a malevolent world to ensure that genes are passed on (Teicher at al., 2016). Research has demonstrated that those in OOHC are likely to have more children younger (Dworsky & Courtney, 2010; Hook & Courtney, 2013), and some more recent research in Sweden has suggested that those who have experienced an OOHC placement in adolescence have a higher mortality rate than the general population (Gao, Brännström & Almquist, 2017). These findings would suggest that those in residential OOHC experience similar experience-dependent changes to adapt to their environments.

A large-scale study was completed in the United States - the Adverse Childhood Experiences Study (ACES; Felitti et al., 1998). This correlated the presence of adverse childhood experiences (ACEs), such as living with the threat of or actual physical abuse, sexual abuse, parental mental health problems, domestic violence, parental drug and alcohol addiction or parental imprisonment, with later health outcomes. The authors found that experiencing ACEs increased the individual's risk of a number of health conditions, such as heart disease, diabetes, suicide attempts, drug use (particularly intravenous drug use) and depression, based on a sample size of 9,508 (Felitti et al., 1998). These researchers also identified a significant dose-response relationship, meaning that the higher the number of ACEs, the greater the risk for these health conditions. For example, for suicide attempts, individuals with one ACE had 1.8 times the risk (compared to the population average) of ever attempting suicide, while those with four or more ACEs had 12.2 times the risk.

Ahrens, Garrison and Courtney (2014) found that those in foster care had a greater risk of cardiovascular conditions and multiple, chronic health conditions. Further research into ACEs in youth in foster care identified that, similarly to the large-scale population studies, those who had greater ACE exposure had worse outcomes in adulthood, particularly in regard to homelessness, mental health difficulties, gang affiliations, substance use problems and risky sexual behaviours such as trading sex for money (Rebbe, Nurius, Ahrens & Courtney, 2017).

Neuroplasticity, the idea that the brain can continue to change with additional input (Doidge, 2015), is fundamental to the premises on which therapeutic and trauma-informed care are based. Doidge (2015) contends that with additional input, at specific times, the brain's neural pathways can change, which results in changes in a person's day-to-day functioning. This was suggested earlier by Perry and Szalavitz (2007) who contend that specific inputs (such as dance, yoga and music) in a patterned, repetitive way can change neural pathways, resulting in improvements in functioning, particularly when engaged with the caregiver.

A discussion of the precise functions of the various brain regions is beyond the scope of this review, however, some review of two specific regions is relevant: firstly, the amygdala which is the fear centre of the brain and secondly, the pre-frontal cortex, which controls our executive functioning, such as impulse control, understanding the consequences of actions and goal-directed behaviour.

Amygdala

The limbic system contains a number of structures including the amygdala and hippocampus. It is typically associated with the development of emotional regulation (Teicher, 2002). The amygdala is responsible for the emotional component of memories and, interestingly, can also act as a metaphorical smoke detector. The amygdala is a central system for emotional functioning (Davis, 1992) and for detecting and responding to information that is potentially threatening, such as facial cues (Anda et al., 2006; LeDoux, 1993). This particular brain region is responsible for determining the level of threat associated with various stimuli. Individuals who have experienced trauma may lack connections between the amygdala and the pre-frontal cortex (Schore, 2001). As a result, the pre-frontal cortex is unable to effectively downgrade the perception of the threat, leaving the individual in a persistent state of alarm rather than being able to calm down (Morgan & LeDoux, 1995; Perry et al., 1995).

Teicher and colleagues (2016) reported that early stress produces an enlargement of the amygdala and simultaneously sensitizes it to further stress. They posited that brain

changes in the limbic system result in enhanced threat detection and enhanced responses to threat due to more advanced pattern recognition. That is, the brain is more aware of elements in the environment that have led to threat in the past (i.e. triggers). They argued that while these developments are beneficial in a malevolent world, in a world that is benign, these attributes increase the risk of anxiety and depression and contribute to the development of PTSD. It is also likely that advanced threat detection skills may make living in an OOHC placement difficult, as individuals with these would likely identify signs of threat often. Further, if their responses to the threat are associated with problematic behaviours such as aggression, this could lead to disconcerting outcomes such as placement changes or even contact with the law.

Pre-frontal Cortex

The pre-frontal cortex is responsible for a number of executive functions such as goal-directed behaviours, planning, working memory and motivation (De Bellis et al., 1999; Teicher & Samson, 2016). The development of this part of the brain is somewhat delayed and continues into the third decade of life (Goldman, 1971; Teicher & Samson, 2016). It has been posited that the pre-frontal cortex has two periods of heightened stress sensitivity and development, in the infancy period to early childhood and in late adolescence to early adulthood (Teicher & Samson, 2016).

Of note is that the pre-frontal cortex is involved in the extinction of fear responses (De Bellis et al., 2002). When this is impaired, fear responses are not extinguished to the same degree, resulting in ongoing hyperarousal and fear responses. Damage to the pre-frontal cortex has been linked to poorer executive functioning and attention (Beers & De Bellis, 2002). Such damage has also been implicated in addiction, through disruptions to the ability to inhibit actions or behaviours, as well as reduced ability to feel rewarded from certain events. The ACE study alluded to earlier (Felitti et al., 1998) also found significant links between maltreatment and drug use. In a residential care population, it is reasonable to conclude that maltreatment may have resulted in a less well developed pre-frontal cortex, so that persistent hyperarousal and fear responses are more likely.

2.7 Neurodevelopment, Attachment and Behaviour

A number of behavioural correlates of brain changes are apparent in the residential care population. They include high levels of impulsivity, poor capacity to delay gratification, poor emotional regulation and poor behavioural control including aggression, substance misuse, early intercourse, sleep difficulties, distractibility and hyperactivity, depression, anxiety, self-harming and trauma spectrum disorders, reduced cognitive ability and difficulties with memory and learning (Anda et al., 2006; Beers & De Bellis, 2002; De Bellis et al., 2002; McPherson et al., 2021; Perry & Szalavitz, 2007; Ziegler, 2009). To date, as far as this researcher is aware, no specific examination of brain changes in an OOHC population has been uncovered. However, we can extrapolate from the data on brain changes and the behavioural difficulties associated with young people in residential care to form the hypothesis that the brain changes discussed in Section 2.6 are likely to apply to a population of young people in residential care.

To summarize the above information, attachment and brain development are intrinsically linked. Early experiences of being cared for provide the required input for optimal brain development at critical and sensitive periods, while also allowing a secure attachment to form, through the experience of touch, eye gaze, rocking and patting. In the absence of attuned caregiving, infants and children will lack the input needed for optimal development at the optimal times, either due to neglect or to traumatic experiences which disrupt both neurodevelopment and the development of attachment. As discussed earlier, a stressful situation will activate an attachment style in an individual which is not secure. In the context of young people in residential care, the experience of placement change is stressful. Moving from one placement to another and being unfamiliar with the staff and/or young people in the new placement will likely activate a young person's insecure attachment behaviour. This could take the form of an anxious/ambivalent, anxious/avoidant or disorganized attachment style. An understanding of the behavioural dysregulation associated with early exposure to trauma and neglect will also provide some insight into the complexity of behaviours associated with young people in residential care. Such complexity includes difficulties managing their emotions, illicit drug use, hyperactivity, sleep difficulties and cognitive difficulties, as discussed above. A young person's difficulty forming attachment bonds with a safe other

(i.e. staff) will be exacerbated by the abovementioned behavioural difficulties if the staff do not understand the impact of trauma on the attachment system and brain development and how this can be ameliorated through techniques which foster the development of a secure attachment system. As such, knowledge of the impact of attachment rupture on the developing attachment system and the changes to optimal brain development is crucial.

2.8 Conclusion

Attachment and neurodevelopment are related. The development of a secure attachment system links to the capacity for more sophisticated emotional regulation skills. Further, a secure attachment system will both lessen the likelihood of maltreatment and reduce its impact. This occurs as there is a consistent and attuned caregiver, which makes it less likely that serious and repeated harm would come to a child, and, if harm did come, there is a consistent and attuned caregiver present to assist the child to cope with the traumatic event. Therefore, a consistent and attuned caregiver not only allows for a secure attachment to develop but also increases the likelihood of healthy neurodevelopment over time.

The absence of such a caregiver, particularly in the case of those in residential care, can inhibit secure attachment and emotional regulation skills from being developed. Placement stability is one area of focus that can assist with this. In contrast, instability ensures that the young people experience ongoing attachment trauma. This happens firstly, as they do not have safe attachment figures on whom they can rely, and secondly, as they cannot therefore be assured of some predictability of carers and co-residents. Because of these two mechanisms, with placement instability, the young person remains in a state of survival, rather than healing.

It would be remiss not to examine the impact of early childhood trauma on the typical development of a child or young person when examining the impact of residential care

and stability. Given the very real structural changes that take place in response to inap-propriate early stress, the subsequent repeat of traumatization, including ongoing placement instability, may have a disproportionally greater impact on their functioning.

Chapter Three: The Literature Review

In this thesis, the overarching research question is "How do young people who have lived in residential care and residential care workers define, understand and explain placement stability?" This question holds importance because stability in residential care has never directly been examined by researchers, and because the operationalisation of stability in the extant literature sheds doubt on whether stability itself has been measured, or rather an approximation of it. Instability for a young person in placement has historically been understood as a young person experiencing multiple placements and has been measured as such. Stability, on the other hand, has been considered as the opposite; the experience of few discrete placements. This researcher will undertake to identify the difficulties with this operationalisation and then examine the experience of stability in residential care. This is the first attempt to conduct such an investigation of this kind.

Residential care is given a lesser focus than the more populous types of OOHC, foster care and kinship care. In Australia, 6.4% of children within the OOHC system are in residential care, and within NSW, this is even lower, at 3.1% (AIHW, 2020). This figure equates to 517 young people in residential care in NSW compared to 7101 in foster care or 8966 in kinship care (AIHW, 2020). Given the discrepancy, the relative lack of research into residential care is explicable, however, young people in residential care experience some of the highest rates of placement instability (Community Affairs Reference Committee, 2015), and are generally considered to be the most vulnerable, behaviourally disordered and attachment disordered young people in the country (Buchanan, 2020; Delfabbro, Osborn & Barber, 2005). Residential care has been referred to variously, as a "last resort" (Ainsworth & Hansen, 2015 p 343; McPherson et al., 2021, p. 2), as something that should be abolished, as being damaging for young people and as housing young people with the most "complex and extreme" needs (Carmody, 2013 p xxi). Therefore, in this research, an investigation is made into the institution of residential care, in an attempt to address the extreme needs of a highly complex group of vulnerable young people.

Placement instability has been linked with a number of negative outcomes, including higher rates of psychiatric emergency services use, poorer mental health, poorer behavioural outcomes and greater difficulty with executive functioning, which includes tasks such as the ability to inhibit behaviour, the ability to consider consequences before acting and the ability to take more than one perspective (see De Bellis et al., 1999; Fawley-King & Snowden, 2013; Newton et al., 2000; Ryan & Testa, 2005). Stability, however, has not been found to be related to positive outcomes. Tarren-Sweeney (2017) stated that for many very complex young people, a positive outcome may simply be a lack of deterioration. Therefore, the provision of stability may not lead to overtly positive outcomes, rather it may provide a buffer against negative outcomes.

Research studies have evaluated instability by counting placements over time (Unrau, 2007). Cashmore and Paxman (2006), in their qualitative study of felt security, identified that *feeling stable* is an important element of stability for young people in OOHC, and highlighted the link between feeling secure in the placement and later outcomes. The authors implied that stability as a construct may not be effectively measured through the strict measurement of placements over time. In this thesis, it is argued that using the number of placements as a measurement of stability actually only examines a point in time in which an individual has not had a placement move. However, the notion of stability likely involves a subjective experience of stability which encompasses safety, connection and potentially the sense that the current placement will not end prematurely.

In this literature review firstly, an overview is provided of the residential care system, its differences and similarities among Australian states and territories, and also among selected countries. Following this, an in-depth discussion is given of the evidence in the extant literature to identify whether the residential care population has extreme needs with high complexity, and whether residential care does damage to young people. Then, an investigation is undertaken to discover what is currently known about placement stability. The review concludes with a section consolidating the reviewed research and research theories into a cohesive whole.

3.1 Residential care: Within Australia and internationally

Residential care forms part of child protection and child welfare systems in most developed countries (Ainsworth & Thoburn, 2014). Its formulation and application however, differs between countries and, in Australia, even within states and territories. In order to make meaningful comparisons and draw valid conclusions on interstate and international data, it is important to understand the differences and similarities in how residential care is implemented. This section comprises an overview of such differences and similarities across the different jurisdictions in Australia, and also in some other nations, in order to provide a context for international and (Australian) state-wide evaluations regarding the functions and utility of residential care.

Residential care will be compared across Australia, Israel, Norway, Germany and Ireland for a broad review of international standards from various countries that have vastly different welfare regimes. It may be expected that such dissimilar welfare regimes provide their child protection and OOHC sectors in disparate ways, which may lead to different residential care experiences and therefore, varied outcomes. The selected countries provide a basis for a comparative discussion across the three major welfare regimes, based on Esping-Andersen's (1999) typology. Australia and Ireland would be considered liberal, Norway falls under the social democratic style and Germany is a conservative welfare state (Mendes, 2017). A liberal state is based on the provision of services to those who need it, with a greater focus on economic stability and efficiency. According to Mendes (2017), a liberal state is based on "selective, residual benefits" (p. 111). A social democratic regime is designed to provide access to services for all, based on principles of equality and rights of access. Mendes (2017) describes this as being based on "universal benefits and a large degree of benefit equality" (p. 111). A conservative model is built around equality, with support given to existing structures (Harder, Zeller, Lopez, Koengeter, & Knorth, 2013; Mendes, 2017). This type of welfare regime is based on status being linked to employment type, with negligible redistribution of resources (Mendes, 2017). I also include Israel, which, unlike the other comparison countries, has a far greater residential care population than most Western countries. The Israeli research findings arguably offer an alternative perspective to the widespread presentation of residential care as only an option of last resort (e.g. Nyland,

2016). While alternative jurisdictions would have provided additional comparative information, it was judged that the benefits of comparing vastly different regimes, such as those in the global south, would not provide significant benefit to contextualise residential care in Australia. Furthermore, given the constraints of time and language barriers, regimes were determined based on availability of English language peer reviewed literature.

The United Nations guidelines for the alternative care of children (2010) outline the primary needs of children to be cared for, safely in a supportive and nurturing environment. While the guidelines explicate that children should be supported to live with their families of origin, if children need to be removed and particularly placed in residential care, this should be done with consideration for the needs of the child and whether a residential care placement is suitable, necessary and constructive for that individual. Furthermore, the guidelines specifically state that "due regard for the importance of ensuring children [have] a stable home" that provides a "continuous attachment to their caregivers with permanency generally being a key goal" (p. 4). The guidelines informed key reviews, such as the Lancet commission into deinstitutionalisation (Boyce, Godsland & Sonuga-Barke, 2020), which also sought information from Zeanah, Fox and Nelson's (2003) work on the Bucharest Early Intervention Project, which examined the impact of placing young, institutionalised children between the ages of six and 31 months of age in foster care and assessing the impact on their development. Both Boyce and colleagues (2020) and Zeanah et al's (2003) work argue that institutional care is inappropriate when compared with family-based care, particularly for infants. The lack of attachment rich relationships and attuned, stimulation rich environments have significant and long-term consequences for development, as discussed by Perry (2002), in section 2.6, that in the first three years of life nurturing is critical for brain development. In NSW, however, residential care is not provided for such young children, with the exception of large sibling groups being kept together, which is also an exception argued for in the United Nations guidelines on alternative care (2010).

Residential care in Australia

In Australia, residential care has been utilized as a "last resort" (Ainsworth & Hansen, 2015 p. 343). 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 & Hansen, 2005). Today in Australia, residential care is typically reserved for young people who have either had multiple failed foster care placements, or those who entered the care system later in life (Victorian Auditor-General, 2014). 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 difficulty in finding them safe and consistent housing in other forms of OOHC (Ainsworth & Hansen, 2005; Barber & Delfabbro, 2004).

In Australia, as in many countries, the Indigenous population is over-represented in the OOHC system (AIHW, 2020; Gatwiri, McPherson, Parmenter, Cameron & Rotumah, 2019; Landers, Danes, Harstad & White Hawk, 2017; Washington, Gleeson & Rulison, 2013). According to AIHW data (2020), Aboriginal and Torres Strait Islander children were 11 times more likely to enter OOHC than non-Aboriginal or Torres Strait Islander children (Gatwiri et al., 2019 To best support them, the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) was developed. The ATSICPP proscribes, firstly, that Aboriginal children be placed within their extended family. If this is not possible, the next preferred option is to place them within their community. The third option is to place them with an Aboriginal carer from a different community. The final option is to place them with a non-Aboriginal carer who is willing and able to maintain a connection to the child's culture (Australian Institute of Family Studies [AIFS], 2015).

Table 1 outlines the various legislation that govern child welfare in Australia and the proportions of children in the states by foster, kinship and residential care.

Table 1: OOHC in Australia by state-based legislation

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Legislation	Children and Young Persons (Care and Protection) Act, 1998	Children, Youth and Families Act, 2005	Child Protection Act 1999	Children and Community Services Act, 2004	Children's Protection Act 1993	Children, Young Persons and their Families Act, 1997	Children and Young People Act, 2008	Care and Protection of Children Act, 2007
% in FC (n = 17,415)	42.1	18.7	51.3	41.0	37.5	54.1	39.5	29.2
% in KC (n = 23,490)	53.1	73.3	36.8	51.1	37.5	39.0	54.2	27.9
% in RC (n = 2,876)	3.1 n = 517	5.4 n = 455	11.8 n = 960	3.7 n = 174	14.9 n = 567	6.4 n = 71	5.7 n = 40	8.7 n = 92

(Sourced from AIHW, 2020)

(Key: NSW- New South Wales, VIC-Victoria, QLD- Queensland, WA- Western Australia, SA- South Australia, TAS- Tasmania, ACT- Australian Capital Territory, NT- Northern Territory). Please note, these numbers do not necessarily add up to 100 as there are other placement options not listed in this table.

Differences between Australian jurisdictions

Some significant differences exist in how the states and territories manage young people in the care system. It is apparent from Table 3.1 above that differences in the numbers of children and young people in residential care exist across the states, varying from 14.9% of the total OOHC population in SA and 11.8% in Queensland (QLD), to 3.1% in NSW and 3.7% in WA. While not explicated in the table, there are also differing proportions of Aboriginal and Torres Strait Islander (Indigenous) children and young people in residential care across the jurisdictions, with the highest proportions in the NT (89.7%) and WA (54.7%) and the lowest in Victoria (VIC) with 25.7% (AIHW, 2020). This is likely related to different proportions of Indigenous Australians in different states. According to 2016 statistics, VIC had the lowest rate of Indigenous people at 0.9% of the total population, and the NT had the highest with 30.3% of the total population being Indigenous. QLD fell roughly in the middle at 4.6% (Australian Bureau of Statistics [ABS], 2018). Indigenous children are greatly over-represented in the OOHC system and in residential care generally, in all states, as only 3.3% of the wider population identifies as Indigenous (ABS, 2017).

3.2 Residential care across the states and territories

The table below provides a summary of the inquiries that have been undertaken in the various states and territories, and their findings and recommendations concerning residential care.

Table 2: National and state-based inquiries into OOHC 2007-2019

Jurisdiction	Inquiry	Focus	Notable findings	Recommendations

| Common-wealth | Community Affairs References Committee: Out of home care, 2015 | Developing an understanding of OOHC across states and territories to facilitate positive outcomes for youth in care. | OOHC system was under-resourced and under-funded. The committee noted that residential care expenditure accounted for more than half of the total expenditure for OOHC.

It was noted that stability was "one of the most important" elements for good outcomes.

Possible benefits of a professional-ised foster care industry, which may bridge the gap between foster care and residential care. | Placements should be determined based on the needs of the child, not "bums in beds".

Best practice evaluations should be conducted to transition young people in residential care to therapeutic care.

Mandatory training should be implemented for residential care workers. |

NSW	Wood Commission 2008	Investigate the child protection system including reports on entry into OOHC, juvenile justice, homelessness, domestic violence and the over-representation of Aboriginal and Torres Strait Islanders in the system.	There is a shortage of high quality placements available.	No specific recommenda-tions were made.
NSW	Tune Report 2016	Create a long-term strategy for OOHC; identify the drivers of the unsustainable growth of numbers of children in OOHC; understand the over-representation of Aboriginal and Torres Strait Islander children.	Aboriginal children were over-represented.	Personalised support packages should be trialled.

There should be a commission to oversee OOHC. |

NSW	Report into Child Protection 2017	Examine the child protection system, the processes and risk assessments in place and funding allocations.	Those in residential care had higher rates of placement instability.	Reforms should be developed to reduce the numbers of children under 12 in residential care.
VIC	Report of the Protecting Victoria's Vulnerable Children Inquiry, 2012	Develop recommenda-tions to reduce the impact and incidence of child abuse and neglect, as well as inquiring into the current child protection system's policies and procedures.	Children in residential care were nine times more likely to be cautioned or warned by police. Children in residential care were 12 times less likely to meet the family and social relationships objectives than those in home-based care.	There is a need to increase therapeutic residential care funding. The use of residential care should be reduced. Those working in residential care should be up-skilled.

| VIC | Auditor-General's report 2014 | Determine whether children's needs for safety, stability and personal development are met within residential care and whether the residential care system is subject to sufficient and appropriate oversight. | Outcomes for young people in residential care tend to be poorer than for other types of care.

The system is functioning above capacity. | Complaints avenues for children and young people should be actively promoted.

Performance measures should be developed for residential care.

Residential care staff should have adequate training.

Forecasting approaches should be improved for determining likely demand and appropriate funding thereof. |

VIC	"As a Good Parent Would", Fyffe & Wolverton 2015	Evaluating and reporting on safety within residential care, particularly as it relates to sexual abuse within residential care.	Government's strategy involves converting most residential placements to therapeutic ones within 5 years.	Increase therapeutic placements. Ensure placements feel more home-like. Cease punitive and restrictive practices. Improve consistency and training of staff.

| QLD | Taking responsibil-ity: A roadmap for QLD Child Protection; Carmody, 2013 | Review the implementation of the previous reviews on the basis that the child protection system is not supporting those in its care sufficiently.

Determine recommenda-tions for legislative and operational reform. Further, develop strategies to reduce over-representation of Aboriginal and Torres Strait Islander children in the OOHC and child protection systems. | Higher levels of residential care can be attributed to more Indigenous children in remote communities.

Children and young people in residential care in QLD are described as having "complex" or "extreme" needs.

27.6% of young people in residential care had been charged with placement-related offending, such as property damage.

Residential care is an appropriate placement | All residential facilities should have a therapeutic framework.

Staff should receive support, training and ongoing professional development.

Implementation of a state-wide therapeutic framework.

A need exists to increase the skills base of the residential care workforce.

Certain groups are suitable for residential care, including those with complex behavioural needs. |

			option for some young people. Currently there are four thera-peutic residen-tial care facili-ties being trialled.	

| QLD | Supporting families, changing futures 2019-2023 | Review at the halfway point from the 2013 review. | Those in residential care have greater difficulty with accessing activities than those in family-based care ('activities' were not specified).

Hope and Healing Framework implemented across residential care. | Investment be made into connecting those in residential care to their kin and community.

Provision of funding through TAFE QLD to support young people in residential care to complete their education. |
| WA | Ford report, 2007 | Review the organisational arrangements, functions and activities of the Department in charge of OOHC to ensure that child protection remains the focus, particularly in light of the death of a baby in care. | Many young people in residential care had been "rejected by the rest of the system... because they are too difficult to manage".

Adopt the Sanctuary Model state-wide. | Three-tiered model of residential care.

Increase staffing and capacity of the staff through further training. |

WA	Strategic directions, 2015	Evaluate the reforms recommended by the Ford report (2007) and subsequently put in place .	Strategies have been implemented to increase availability of appropriate services.	Focus on developing residential care.
SA	Royal commission report into the child protection system in SA, 2016	Examine the laws, policies and practices in place to protect children from harm in OOHC. This was prompted after a residential care worker was convicted of serious sexual assault charges perpetrated against children in his care.	13% of children and young people who had left all forms of OOHC had experienced more than 11 different placements. Multiple references made to very young children and babies being looked after in residential care facilities. Indigenous children were 19 times more likely to be in the child protection system.	Residential units should be closed down. No child under 10 should be in residential care. Implement therapeutic frameworks.

TAS	Select committee on child protection, 2011	Identify early intervention strategies, strategies for integration of services, legislative reform, and actions to address the causes of child abuse and neglect.	Residential care has been outsourced to Centacare. The Australian Childhood Foundation provides services to train staff and to assess and offer treatment to children and young people in care.	Government department outsources its caring responsibilities to NGOs.
ACT	Strategy report, 2014	Develop a plan for ensuring quality OOHC placements.	Therapeutic assessments and plans will be developed for each child and young person in care. A trauma recovery centre has been developed for children in OOHC.	Mandatory recording of the participants' views as well as a computer-assisted self-interviewing program. Residential care should be a short-term service to stabilise young people.

NT	Growing them strong, together report, 2010	Make recommenda-tions to improve the child protection system. This was prompted by adverse public reactions to tragedies and public complaints regarding inadequate responses from child protection services.	87% of the children in OOHC are Aboriginal, making it difficult to place them in line with the ATSICPP. Only one Aboriginal agency provides residential care, for only five children.	Thorough investigation needed, including evaluating the quality of services and accurate statistics on the number of young people in residential care.

| NT | Royal commission into the protection and detention of children in the NT, 2017 | Examine the youth detention and child protection systems following the Four Corners TV program "Australia's Shame" that revealed footage of young people in detention in NT being abused. | Two thirds of Aboriginal children were not placed with Aboriginal carers.

Difficulties finding suitable home-based carers leads to a greater reliance on residential care, with NT having one of the highest proportions of young people in residential care.

90% of the reportable conduct incidents submitted to Territory Families (NT's oversight body for OOHC) between July and December 2016 were made regarding residential care facilities. | Find ways to overcome the issues of remoteness and difficulties locating home-based carers to reduce reliance on residential care.

All OOHC providers must provide therapeutic support in trauma-informed environments. |

			The NT has engaged the Australian Childhood Foundation to develop a therapeutic residential care model.	

The above table summarises the key findings and recommendations made by the various commonwealth and state-based inquiries into OOHC since 2007. For each jurisdiction, the following sections present the governing legislation and any related regulations; the consideration of residential care in those legislations; and any frameworks guiding practice for residential care, with a discussion on inquiries into OOHC that have been conducted.

3.2.1 Commonwealth government

A national parliamentary inquiry was announced in 2015 examining OOHC across Australia. This review was advertised in *The Australian* newspaper as well as on the committee's website, inviting submissions. Seven public hearings were held from 16 February 2015 to 17 April 2015. A total of 259 submissions were received from individuals, organisations, foster carers and young people, among others. Regarding residential care, the investigators made a number of observations, including that the OOHC system was under-resourced and under-funded. The committee noted that residential care expenditure accounted for more than half of the total expenditure for OOHC, despite only accounting for approximately 5.5% of the population of OOHC. In addition, due to the funding models, placements were often based on availability rather than suitability. This was referred to as "bums in beds" (p. 81). The committee accepted a submission from Anglicare Victoria which noted that this principle ignores the needs of the child, alongside their development, preferences and vulnerabilities, which should supersede the need for simply filling a placement.

The committee further noted the importance of stability for young people in care. The review included that this was "one of the most important" elements for good outcomes (p. 88) and that placement instability was often linked to disrupted schooling, with

those in residential care typically reporting more school changes. In the review, the potential benefits of therapeutic residential care were also noted. Preliminary reviews have demonstrated benefits, with the Verso (2011) review of the therapeutic placements in Victoria cited. The committee also touted the benefits of the US-based model, Jasper Mountain, which was considered the gold standard for therapeutic care. It should be noted, though not commented upon in the review, that Jasper Mountain regularly provides therapeutic support to much younger children (from ages three to 13; Jasper Mountain, 2019) thus it is not directly comparable, as within Australia, residential care is typically provided for young people aged 12 and over.

3.2.2 New South Wales

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 Department of Communities and Justice (DCJ) sector of the state government. Most residential care facilities and the case management of the individual children and young people are outsourced to NGOs for the day-to-day running of the facilities. This is typical across the states and territories.

The Wood Commission (2008) into child protection in NSW investigated the child protection system, including reports on entry into OOHC, juvenile justice, homelessness, domestic violence and the over-representation of Aboriginal and Torres Strait Islanders in the system. This report was commissioned after of the deaths of a 5 year old and a 14 year old in care in the preceding year. The review was conducted with 10 full time staff from various departments, including the departments of health and child protection, and legal advisors. Advertisements were placed in major newspapers inviting submissions between December 2007 and February 2008. Public forums were held in Sydney and other regional areas. A website was set up to receive submissions. 147 key agencies were contacted to make submissions. 669 submissions were received. Between March and May 2008, regional meetings were held and specific meetings were held with two organisations, UnitingCare Burnside Family Services and Barnardos. It is unclear why these particular organisations were chosen.

Within this report, no specific recommendations were made regarding residential care, as the report focused more on the model of OOHC in NSW in the lead up to the state's care system changing from government-managed to case management by NGOs. This report did, however, include some favourable statements regarding residential care. Its lead author (Wood, 2008) noted that, as a result of decreasing the availability of residential care, there is a shortage of high quality placements, but that evidence suggests that residential care with a therapeutic component can have beneficial effects for young people. A further comment was that the "continuity of attachment ties is essential for the overall development of a young child" (p. 684). Attachment theory provides the lens through which to view the impact of placement instability and the lack of ongoing attachment security.

A second review was commissioned in 2015 by the NSW government and was subsequently published, and commonly referred to as the Tune report (2016). This was designed to develop a long-term strategy for OOHC in NSW; understand the difficulties within the system and develop solutions for these problems. This report did not include an outline of the methodology for conducting the review. It was noted that Indigenous children were over-represented, with 7.1% in the OOHC system, despite representing only 1% of the general population. The report further noted that the budget allocated for OOHC and the actual cost of OOHC are not aligned, particularly since the transfer of case management from Family and Community Services (FaCS) to NGOs. It was estimated that for FaCS to case manage a child costs $27,000, whereas for an NGO, it costs $41,000 (Tune, 2016).

Specific reference was made to young people in residential care and trials were recommended of personalised support packages for specific groups within residential care. These comprised younger children who may be better suited to other types of care, older children who are already parents or are likely to become early parents, and children who are likely to return to their birth families after leaving care. One recommendation was that these packages would include components such as education services, restoration services and mental health services, among others. There was no reason men-

tioned why these groups were particularly significant. Nor were any particular specifications made concerning other vulnerable groups within residential care, such as those with intellectual and physical disabilities, or those with complex mental health needs.

The Tune report also recommended a new approach to OOHC with a specific commission developed to implement OOHC reforms, with a single Minister overseeing it. This has been developed through the *Their Futures Matter* platform, which implemented a number of these recommendations. These include a single commissioning entity being responsible for the implementation of the reform, individualised packages to support families and children, and applying an 'investment' approach to ensure that needs and supports are aligned (NSW Government, 2019). In 2018, a progress report was published by *Their Futures Matter* in which the progress to date was outlined. This included the development of an integrated data set. In this progress report, there was no mention of residential care services or any update concerning these (NSW Government, 2018).

In 2017, a wider review into the overall child protection system was conducted by a committee appointed by the NSW Legislative Council (Donnelley, 2017). The terms of reference were determined by the committee. In conducting this review, 139 submissions were received, with 13 supplementary submissions. Three public hearings were held in Sydney with a fourth on the Central NSW Coast. A private meeting was conducted with Indigenous community members.

This particular review involved discussion of residential care and some of the issues facing the young people therein. Comments, particularly by Legal Aid representatives such as Mr Wong, suggested that those young people in residential care had higher rates of placement instability and were subject to a casualised workforce, meaning there is a lack of training and education of staff leading to a lack of meaningful relationships between the staff and young people. This particular review focused heavily on the inappropriateness of children under 12 being in residential care. Two contributors (Association of Children's Welfare Agencies and Ms Cheers, CEO at Barnardos Australia) both shared their view that the risk to children of that age was "unacceptably high" (p. 106),

however, did not cite any further supporting evidence. The committee writing the report made only one recommendation in regard to residential care, which was to develop reforms to reduce the numbers of children under 12 in residential care.

In 2018, policy changes were made to the enactment of residential care, with the intention that, over the following two years, all residential care would be converted to therapeutic placements (FaCS, 2018). The intention behind the new program, named Intensive Therapeutic Care (ITC), is that young people would spend less time in residential care in order to be moved into less intensive types of care (FaCS, 2018). It should be noted, however, that these reforms were introduced after the collection of data for the current study, and thus it was not possible use them to inform analysis. Furthermore, many of the individuals who were interviewed had left care prior to these changes being implemented or no longer worked in the residential care field at the time of interviews. Nonetheless, these policy changes will be able to inform further research to determine the impact of the emphasis on therapeutic care.

3.2.3 Victoria

Victorian residential care is governed by both the Children Youth and Families Act (2005) and the Minimum Standards and Outcome Objectives for Residential Care (2001), the former of which has separate guidelines for caring for Indigenous children. OOHC is managed by the Department of Health and Human Services (DHHS), which generally funds NGOs to provide residential and foster care.

The Victorian Children Youth and Families Act (2005) is one of the few that sets out specific requirements for working with young people in OOHC. It sets out an expectation that agencies promote health, emotional and behavioural development, education, family and social relationships, identity, social presentation and self-care skills. The standards expressly require that interventions with children and young people are trauma-informed and that staff working with challenging young people build a strong relationship with them (DHHS, 2001).

These standards for residential care set out, among other things, requirements for managing family contact and maintenance of positive family attachments, and specify that the staff will work with the families to achieve outcomes set in the case plan for each child. The need to view a young person in residential care through the lens of their attachments is a significant step towards reducing the impact of placement instability. The Victorian standards provide guidelines to those working within residential care on what is expected of them when working with traumatised and complex children and young people. However, there is no accompanying explanation of how to go about achieving the standards or how such achievement can be monitored (DHHS, 2001).

A number of reviews have been conducted in Victoria, including a 2012 examination of the performance of the OOHC system (Report of the Protecting Victoria's Vulnerable Children Inquiry; Cummins, Scott & Scales, 2012), contracted and supported by the Victorian government. In this review, 16 public sittings were conducted, with a total of 142 oral submissions, plus written submissions by 201 individuals and organisations. The findings supported empirical research that identified that those in OOHC perform more poorly in terms of education than those in the general population (Smith & McLean, 2013, Wise, 2012). The review (Cummins et al., 2012) also included the observation that children in residential care were nine times more likely to be cautioned or warned by police, or charged with a criminal offence than those in home-based care in Victoria. Additionally, it was stated that children in residential care were 12 times less likely to meet the family and social relationships objectives that those in home-based care.

The underlying reasons for this are difficult to determine without further research. Possible explanations include that these findings may be due to residential care itself. In other words, being in residential care leads to poorer outcomes, regardless of the circumstances prior to entry into residential care. Alternatively, they may be a result of the impact of pre-residential care factors, such as a later entry into OOHC or greater numbers of placements, and as such, further retraumatisation (Ainsworth and Hansen, 2005, Barber & Delfabbro, 2003). Or, it may be a combination of the two. This implies that those who enter care later or have more placement changes or more experiences of trauma, combined with the experience of residential care itself, may lead to the poorer outcomes. The report's primary recommendations for residential care related to, firstly,

the need to increase therapeutic residential care funding which will be discussed further below. Secondly, it was recommended to reduce the use of residential care, and thirdly, to upskill those working in residential care (Cummins et al., 2012).

An Auditor-General's (2014) audit into residential care services in Victoria reviewed outcomes across residential care organisations. This was conducted using reports from various governmental departments and submissions from agencies and individuals. The number of submissions and timeframes for submitting them were not available in the report. It was noted in this audit that the outcomes for young people in residential care tend to be poorer than for other types of care. This was firstly attributed in part due to the system functioning above capacity, with funding for 459 residents, but an actual number of 508 residents on an average day. Secondly, this was partly attributed to the lack of training and skill within the staff teams, which means they struggle to manage the highly complex behaviours exhibited by the residents.

These findings were further supported in the Victorian report *As a Good Parent Would* (Fyffe & Wooltorton, 2015) undertaken by the Commissioner for Children and Young People to investigate the adequacy of residential care services for children and young people who had been subject to sexual abuse whilst in residential care. In the process of this review, submissions from 16 organisations (n = 14) and individuals (n = 2) were received. Again, the timeframes for receiving these submissions were not specified. The review focused on 166 cases of reported sexual abuse in residential care and made recommendations on this basis. While this report does not provide details on measurement or specific statistics, it was stated that therapeutic residential care, which makes up approximately 17% of Victorian residential care placements, has better outcomes. Supporting evidence for this claim is available, however, via the Verso (2011) review into therapeutic care in Victoria.

The report (Fyffe & Wooltorton, 2015) also highlighted that the Victorian government's strategy involves converting most residential placements to therapeutic ones within five years. The improved outcomes when therapeutic care was provided seem to be the product of highly trained staff, and planned matches of young people so the mix is conducive to a sense of safety for the young people and greater consistency in staffing and

programming. A follow up report has not yet been released confirming whether these changes occurred. A specific review of one therapeutic residential care pilot program found positive results, such as reduced externalising behaviours and improved levels of functioning that were, in the long term, cost effective in lowering later costs to the mental health, justice and OOHC systems (Verso Consulting, 2011).

Victoria appears to have had a great deal more focus than other Australian states and territories on investigating what works in residential care and developing strategies for improving the outcomes. Significantly, the implementation and early investigations into therapeutic care may be able to challenge the negative perception of residential care as a "last resort" (Ainsworth & Hansen, 2015 p. 343).

3.2.4 Queensland

Residential care in QLD is based on the Child Protection Act (1999). As in most other Australian states, the state government funds OOHC and outsources the care of the children and young people to non-government organisations (NGOs). An inquiry into OOHC in QLD (Carmody, 2013) was undertaken both to review the entire child protection system in that state and also to develop a plan for OOHC's future. The inquiry placed a significant focus on residential care. In the Carmody report, it was suggested that QLD's higher levels of residential care can be attributed to more Indigenous children in remote communities who may be placed in residential houses to avoid removing them from the local community when local foster and kinship carers are not available. QLD is a large state with many extremely remote areas that are difficult to access. This may have some impact on the extent of young people's needs in residential care in remote Queensland, although specific evaluations have not been completed to compare the cohorts. This 2013 inquiry constructed most children and young people in residential care in QLD as having complex or extreme needs. These include unpredictable physical aggression, property damage, self-harm or suicide attempts, absconding for long periods, abuse of alcohol or other drugs, developmental disabilities or requiring medical or physical care.

This OOHC inquiry (Carmody, 2013) was commissioned to assess how previous inquiries' recommendations had been implemented. The method of review was not outlined. It was noted that there had been an increase in the proportion of young people in OOHC generally, with the median number of placements prior to entry into residential care being four. Median placement numbers, however, were not provided for children and young people who remained in the foster or kinship care sector, making a direct comparison not possible. Multiple failed placements for children and young people in OOHC, referred to as "placement churn" (p. 89) has been referred to in the 2015 Commonwealth inquiry into OOHC, suggesting this is not specific to QLD but is rather an Australia-wide issue (Community Affairs Reference Committee, 2015).

The report included recommendations regarding an increase in the skill base of the residential care workforce, ensuring minimum qualifications. It was also recommended that the following groups be considered suitable for residential care:

> [Those who] have complex behavioural problems and high levels of placement instability;
>
> [Those who] have high support needs, who are part of a sibling group who would otherwise not be placed together, who are moving on to independent living or following a foster placement breakdown; and
>
> [Those who] have emotional, behavioural and psychological problems that cannot be managed in a family-based environment (Carmody, 2013 p. 266).

In 2019, a follow up review was conducted (Farmer, 2019). It was noted that those in residential care have greater difficulty with accessing activities than those in family-based care ('activities' were not specified). As at 2017, a framework was developed and implemented across residential care called the Hope and Healing Framework. Additional reviews will need to be conducted to determine if this was beneficial. One of the main recommendations from the review was that investment be made into connecting those in residential care to their kin and community as well as providing funding through TAFE Queensland to support young people in residential care to complete their education.

3.2.5 Western Australia

Out of home care in WA is governed by the Children and Community Service Act (2004). This act, unlike those in any other states or territories, makes specific references to secure care facilities (as one form of residential care) and their safeguards, including the requirement that the maximum time a child or young person can be maintained in a secure care facility is 42 days. Secure facilities are different to typical residential care facilities in that they are locked. Young people cannot leave without permission and are more greatly restricted. Secure care facilities are available only to children and young people in the OOHC system. The facilities provide specialist input from nurses, doctors, psychiatrists, psychologists and other allied health specialists to address extreme needs associated with a significant risk of the child or young person harming themselves or others. The act also allows for restrictive practices to be used, provided the CEO of an agency has approved the 'authorised person', and also for reasonable force to be used against the child or young person.

In WA, more than 50% of children and young people in care are Aboriginal (AIHW, 2020). This is in contrast to a relatively small total proportion of Aboriginal and Torres Strait Islander people in the state generally (3.8% of the total; ABS, 2011).

In 2007, the Ford report was produced, which allowed for a review of the OOHC services being delivered in WA (Government of WA, 2015). This report was commissioned after the death of a 10-month old child in residential care in 2003. This review was conducted by convening an advisory group which met six times over four months. A call for submissions was put out, resulting in 97; there were additional consultations with NGOs and community groups, discussions with foster carers and some young people in care, and consultations with ministerial advisory committees and governmental departments. Since the Ford report, there a follow up report was written outlining the strategic direction for the OOHC sector (2015). A contributor to the Ford report commented that many young people in residential care had been "rejected by the rest of the system… because they are too difficult to manage" and suffer from "attachment disorders [making them]… unable to tolerate the closeness of relationships involved in 'normal'

family type placements" (Simpson, 2007 p. 105). It is important to note the focus on attachment relationships and the impact of a lack of secure attachments on a young person's ability to remain in a stable placement.

The advisory group made recommendations regarding the structure of residential care, suggesting a three-tiered model. The first tier would be for young people without specifically complex needs but for whom foster care is inappropriate, such as large sibling groups. The second tier would be for those requiring specialised therapeutic approaches before being moved to longer-term placements. The third tier would be for those who are at a high risk of self-harm or harm to others and require intensive therapeutic approaches and/or a secure care placement.

The WA community services sector has made a number of adjustments to residential care, including increasing rostered residential care to 22 homes that house between four and eight young people each, the development of a secure care centre for those with 'extreme' needs who pose a risk to themselves or others, and state-wide adoption of the Sanctuary Model (Bloom & Farragher, 2013). The Sanctuary Model was developed by Bloom and Farragher (2013) as a means of connecting trauma and attachment theories within a framework for working in residential care and other mental health systems. It is based on the premise that within 'sanctuary', individuals are able to think, create and be physically, psychologically and morally healthy; are able to relate in emotionally healthy ways; each person contributes to the whole and that individuals are able to plan for and work towards a positive future. Other Australian states and territories have not adopted specific residential care models.

A specific recommendation of the Ford report was to increase staffing and staff capacity through further training. The WA government's report on strategic directions (2015) does not indicate whether this has been achieved, although the ongoing training may have been achieved through the introduction of the Sanctuary Model. This strategic directions (2015) report was produced to determine whether the implemented reforms from the Ford report (2007) were helpful to the OOHC system, and to advance a for-

ward-going plan for the sector. The methodology for developing this plan was not outlined in the report. However, strategies have been implemented to increase availability of appropriate services and a state-wide approach to residential care.

3.2.6 South Australia

Out of home care in South Australia (SA) is governed by the Children's Protection Act (1993). This legislation makes no specific reference to residential care.

According to the Royal Commission report into the child protection systems in SA (2016), child protection in that state was developed with "little reliance on understanding and developing the evidence base for interventions and strategies" (Nyland, 2016 p. xiv). The report was written on the basis of a review sparked by sex crimes perpetrated by a South Australian residential care worker. In the context of the review, 381 witnesses were heard from, 374 submissions were received, 10,800 documents were examined and 74 stakeholder engagements were conducted. The nature of the reviewed documents was not explained. In the report, the need was identified for an evidence base to be established from which legislation and policies are developed, rather than developing them in a vacuum.

The Royal Commission also found that in 2014-2015, 13% of children and young people who had left all forms of OOHC had experienced more than 11 different placements during their time in care, which accords with findings from QLD on multiple placement changes. The commission also found that an unspecified number of children and young people were either not allocated a case manager, or did not have regular contact with them (Nyland, 2016). There may be a link between the high numbers of placement breakdowns and lack of caseworker contact as without an engaged caseworker, there may have been no-one to identify placements at risk of breaking down, nor anyone to advocate for stability, in the child's best interests. Further, it was reported by one individual whose organisation was not named but who worked as a program manager in residential care, Ms Kelly, that young people in residential care may be disinclined to develop meaningful relationships with staff members because they are aware these relationships cannot continue post-care (p. 260).

In the report, a damning argument was made against residential care. It was argued that residential units should be closed down due to "overwhelming" evidence of the negative effects of residential care (Nyland, 2016 p. xxii), however, the source of this evidence was not specified. The Royal Commission then also recommended that no child under 10 is placed in residential care (except to keep sibling groups together) and that therapeutic frameworks are implemented.

The report appears to be contradictory in its recommendations for residential care, and is not informed by the international evidence base on residential care, which will be discussed in Section 3.8. It is notable, however, that in this particular report, multiple references were made to very young children and babies being looked after in residential care facilities, one such facility being one of the sites where sex offender who sparked this review perpetrated offences against residents.

A separate report into Indigenous children in residential care in SA found that they were 19 times more likely to be in the child protection system than non-Indigenous children, which made the ATSICPP difficult to implement (Office of the Guardian for Children and Young People, 2015). As a result, Indigenous children are over-represented in SA in residential care, and constitute approximately 30% of the residential care population. This is not unique to SA; however, four Indigenous specific residential care houses have been trialled for between three and five residents (despite approximately 120 Indigenous young people in residential care) with culturally appropriate approaches to care. Outcome studies have not been conducted in SA, although research from a Victorian trial has suggested positive outcomes when therapeutic care is combined with embedded culturally-sensitive approaches (Bamblett, Long, Frederico & Salamone, 2014).

Residential care in SA has come under substantial scrutiny in recent years as a result of an extremely troubling case of inappropriate care. The Royal Commission's report (Nyland, 2016) however, appears to be quite reactive in nature, rather than investigating how to improve residential care and its safety for the young people.

3.2.7 Tasmania

Out of home care in Tasmania is managed under the Children, Young Persons and their Families Act (1997). The Act itself makes no specific references to OOHC and its responsibilities. In Tasmania, OOHC is largely governed by the state DHHS. In 2010, an inquiry (Select Committee on Child Protection; O'Halloran, Groom, Petrusma, White & Wightman, 2011) was undertaken to investigate child protection practices. This inquiry was conducted between October 2010 and November 2011. For this, 47 submissions were received and particular individuals and organisations were invited to make submissions. The committee met on 22 occasions and information regarding the inquiry was advertised on the Parliament of Tasmania website and in three regional newspapers. As a result of this inquiry, DHHS appears to have implemented a service reform involving residential care being outsourced to Centacare, with the Australian Childhood Foundation providing services to train staff, and assess and offer treatment to children and young people in care (Children and Youth Services, 2015). These reforms have been designed to meet the needs of a growing body of children and young people in the OOHC system (Children and Youth Services, 2015), although the focus on residential care is minor, given there are fewer than 40 young people in residential care in Tasmania.

The 2011 inquiry committee recommended that ongoing support be provided to young people beyond 18 years of age. In a 2012 statement, it was reported that the state government was looking to establish a visitor and mentoring program for young people aged 15-25, with the express intent of providing ongoing support (DHHS, 2012). There is some evidence, however, that mentoring programs can be damaging to young people who have experienced trauma, particularly if the mentor is not a stable person or the program only lasts for a short time. Currently, researchers have found that mentoring does not have protective benefits if the relationship is ended early (Erdem, DuBois, Larose, De Wit & Lipman, 2016), and given the likelihood that the young people have experienced significant trauma and attachment ruptures, such mentoring programs may have negative side-effects.

Residential care in Tasmania has subsequently been allocated to NGOs for the day-to-day running of the houses (Children and Youth Services, 2015). Further reviews will be required to identify whether this has had positive outcomes for the recipients.

3.2.8 Australian Capital Territory

OOHC in the ACT is regulated via the Children and Young People Act (2008). The Act does not specify how residential care should be managed; however, it makes specific reference to therapeutic protection orders, which allow for young people to be confined for a set period of time to ensure their safety. These are similar to secure care facilities in WA.

In the ACT, non-government agencies have been responsible for OOHC since 2000. The National Standards for OOHC were accepted by the states and territories in 2011. In 2014, a five-year strategy plan was drawn up for the ACT's OOHC sector from 2015-2020. As a result, no outcome measures or evaluations of the new strategies are available at this stage. The data-gathering methodology was not explicated in this document.

In this strategic plan (Gentleman, 2014), it was outlined that therapeutic assessments and plans would be developed for each child and young person in care. These would be linked with various services to ensure that the plans follow the children and young people through their time in OOHC and to reunification (if required) to ensure a continuity of care. A trauma recovery centre has also been developed for children in OOHC in the ACT to address their early trauma. It is designed so that staff work co-operatively with schools, carers, birth parents, caseworkers and any other significant supporters in the child's life, up until 12 years old. Trauma-informed therapies have been demonstrated to be effective to ameliorate the effects of early childhood trauma, provided that they take into consideration the sub-optimal brain development that has likely occurred (see Adler-Tapia, 2008; Shapiro, 2001; Van der Kolk, 2014).

The ACT OOHC sector also aims to be more child-centric to increase the engagement and empowerment of the children and young people. This is intended to be achieved by

mandatory recording of the participants' views as well as a computer-assisted self-interviewing program to allow the children and young people to express their views (Gentleman, 2014). In the strategy plan, difficulties were identified associated with leaving care and it was proposed to make it possible for young people to remain in care until their 25th birthday, although a subsidy to carers for ongoing care would only be paid up until their 21st birthday. Extending the age for leaving care is consistent with international research that has demonstrated improved outcomes for young people who continue to be cared for until they are older (Beauchamp, 2016; Peters, Dworsky, Courtney & Pollack, 2009).

Regarding residential care, in the plan it was stated that residential care is "not a preferred option" (2014, p. 41), however, it is required to meet the needs of 7% of those in OOHC. There was a proposal that residential care should be a short-term service to stabilise young people to be transitioned to kinship or foster care. Research, however, by the Australian Catholic University (Moore, McArthur, Death, Roche & Tilbury, 2016) included a discussion of the role of residential care and safety for children and young people who were in the residential care system. The interviewees were relatively unanimous in expressing that one of the major difficulties with residential care is that it is unstable and inconsistent, therefore considering it to be a long-term option would be more beneficial for residents as it would be designed for their placement stability.

The ACT government has developed a set of intentions for implementing the National Standards for OOHC and best practice guidelines, in terms of the expression of the views of children and young people and specific trauma-informed services for young people in OOHC. Ongoing reviews will need to be conducted to determine the efficacy of this plan.

3.2.9 Northern Territory

In the NT, OOHC is managed under the Care and Protection of Children Act (2007). The Act does not make specific reference to residential care.

A report was commissioned by the NT government in the wake of a negative public perception of the child protection system. *Growing them Strong Together* (GTST) (Bamblett, Bath & Roseby, 2010) focused on the current child protection system and the quality and sustainability of the OOHC system. A number (unspecified) of public forums were held across the NT, resulting in 80 oral submissions. A further 156 written submissions were received. Advice and information was also provided by an expert reference group, made up of local service providers and academics. Dedicated forums were also set up for foster carers and legal practitioners. In the NT, 89.7% of children in the care system are Aboriginal, and as such there is a significant emphasis on the ATSICPP (AIHW, 2020). Here, more so than in other states, there are difficulties with placing a child in co-ordination with the ATSICPP; this appears to be related to very high levels of poverty experienced by 58% of the Aboriginal population (being in the 'most disadvantaged' quintile). In addition, 70% of the Aboriginal population is under 30 years old, making it less viable for the preferred families to look after children in care (GTST; Bamblett et al., 2010). In the GTST report, it was also identified that only one Aboriginal agency provided residential care, for only five children. The coronary of this is that, as all other agencies are non-Aboriginal, they immediately represent the fourth and final option of the ATSICPP.

In the GTST report (Bamblett et al., 2010), a gap was identified in the knowledge about what is contributing to the shortage of residential placements. Its authors recommended that a thorough investigation, including evaluating the quality of services and accurate statistics on the number of young people in residential care, be completed.

In 2017, a report was undertaken after alleged abuses of power in juvenile correctional facilities in the NT (NT Government, 2017). This review was commissioned after a Four Corners television program, *Australia's Shame*, to investigate the treatment of children and young people in detention and OOHC. This review was undertaken via individuals giving evidence, particularly children and young people in OOHC and in detention. The commission further examined manuals, incident reports, CCTV footage, child protection and detention case files and policy and procedure documents. 480 witness submissions were received and more than 400 witness statements were presented at public hear-

ings. The report found that two thirds of Aboriginal children were not placed with Aboriginal carers, despite the importance of the ATSICPP. This was found to be related to difficulties finding suitable carers and partially attributable to the vast remoteness of the state, as found in the GTST report (2010).

It was also discovered that, as a result, there was a greater reliance on residential care, with NT having one of the highest proportions of young people in residential care (Bamblett et al., 2010 p10). Further, 90% of the reportable conduct incidents submitted to Territory Families (NT's oversight body for OOHC) between July and December 2016 were made regarding residential care facilities, alleging inappropriate conduct by staff. In order to reduce the negative outcomes associated with residential care and to increase its therapeutic nature, the NT has engaged the Australian Childhood Foundation to develop a therapeutic residential care model. This was done following one of the reports' recommendations that all residential care facilities should be therapeutic and trauma-informed.

Residential care in the NT is significantly affected by the over-representation of Aboriginal and Torres Strait Islander young people (Bamlett et al., 2010 p. 10), with few services able to meet their needs.

Australia-wide conclusion

It appears to be a common theme throughout the inquiries that the various jurisdictions are ill equipped from a practice and policy standpoint to provide high quality care to all the children and young people in OOHC. Specifically, regarding residential care, the reports from the states' inquiries agree with each other that a particularly vulnerable and complex group of young people reside in residential care and that residential care is being used as a "last resort" (Ainsworth & Hansen, 2015, p. 343). The authors of these reports further concur that there are poorer outcomes for those in residential care than in other types of OOHC. This is likely related to a number of factors. Firstly, there are many young people with complex and extreme needs who require safe and stable placements. This then, secondly, puts pressure on residential services to accommodate those who are without a placement. These services may not be adequately funded to provide the

high levels of trauma-informed services that are required to manage such complex needs.

Despite individual states and territories having discrete legislation to provide OOHC, the recommendations across the inquiries suggest that residential care is run fairly similarly among these jurisdictions, with similar deficits in funding. Deficits exist because OOHC is an expensive form of care that is budgeted for fewer young people than are typically accommodated. There appear to be similar difficulties with caring for a complex group of young people, with a workforce that does not necessarily have the adequate skills and training to provide such care. Recommendations across the states and territories have reflected a desire to reduce or remove the need for residential care.

As is reflected in Section 3.3 on international residential care usage, other countries have much higher proportions of young people in residential care, although, few outcome studies are available for analysis. In the following section, how residential care is enacted in some international countries is explored. As discussed earlier, these countries were selected as they reflect different welfare regimes from Australia's and have differing proportions of young people in residential care. These will allow an international comparison, to examine different styles of enacting residential care.

3.3 International residential care

Residential care forms part of child protection systems in most developed countries. Comparatively, Australia has an exceptionally small residential care sector. Ainsworth and Thoburn (2014) compare international rates of children and young people in residential care. 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%). It is unknown whether it is coincidental that these are Western countries. Ainsworth and Thoburn (2014) suggested that in countries with higher rates of residential care, there are lower levels of behavioural difficulties among the residential care youth. This is likely related to lower thresholds for entry into residential care, resulting in fewer

children and young people with extreme and complex needs and a greater degree of emotional and behavioural stability (Ainsworth & Thoburn, 2014).

In the following sections, residential care in Israel, Norway, Germany and Ireland will be explored with a focus on the numbers of children and young people in residential care, the socio-political framework for child protection, and policies for residential care and leaving such care. These comparisons allow for an examination of how residential care is enacted across countries, and provide evidence on whether or not residential care should be used as a last resort.

3.3.1 Residential care in Israel

Israel has a very high proportion of children and young people in residential care who are in OOHC at 80%, with 20% living in foster care (Rafaeli, Benbenishty, Eliel-Gev, 2013). The majority of children and young people in the OOHC system have been removed by social services for their care and protection (Dolev, Ben Rabi & Zemach-Marom, 2009). The residential units accommodate 12-15 children with a full time social worker for the group. The facilities themselves are much larger, with 80-100 children, separated into the smaller clusters. The reasons for placement out of the family home are similar to those in Australia, with factors including drug addiction, mental illness, abuse or neglect (Dolev et al., 2009). Data are collected using a computer-based system to track the progress of children and young people in the care system (Dolev et al., 2009). The data, however, were not made available to evaluate the outcomes for the youth in residential care in Israel, and some were only available in Hebrew.

The OOHC system in Israel is set up to facilitate ongoing, meaningful contact with birth families, with most children visiting their family homes on weekends and school holidays (Dolev et al., 2009). The families can also participate in activities at the residential centres and can stay at these centres in the visiting quarters. According to Davidson-Arad and Klein (2011), most young people are placed in residential facilities close to their biological families and are able to spend every other weekend with their families of origin. This is designed to enhance the quality of the relationships between the young person and their family, rather than to eventually reunify them. Israeli child protection

services have similar principles to the ATSICPP in Australia, which endeavours to maintain bonds to the community and family with community-based residential centres in the children's communities. The goal is to maintain the child's links with their community, and minimise the need to change schools, doctors and any other major services (Dolev et al., 2009). More recent data were not available on this issue.

The leaving age for care is 18, or at the end of 12th grade (Rafaeli et al., 2013) and the outcomes are similar to what is found in Australia, with a lack of success in managing the transitional period for many care leavers (Zeira, Rafaeli & Benbenishty, 2019). Rafaeli and colleagues (2013) investigated the readiness to leave care in an Israeli population and found that in their cohort, based on staff assessments, fewer than half were assessed as having high level abilities in the majority of domains, with a high proportion needing help in all assessed domains (including acquiring a profession, coping with emotional difficulties, attending university, finding housing, integrating in a workplace, positive relationships, household maintenance, health, avoiding drug and alcohol use and avoiding trouble with the law). These researchers assessed only the expectations of staff and young people related to readiness to leave care. They did not further evaluate how the young people coped with the adjustment. As such, the extent of similarities and differences between Australia's and Israel's data on leaving care remain unclear, although Sulimani-Aidan (2013) reported that self-reported readiness ahead of leaving care was positively correlated with success upon leaving care at the one-year mark.

As indicated above, residential care in Israel forms the major part of OOHC, servicing 80% of those in OOHC. While outcome studies have not been completed or published in English, there appears to be a significant focus on maintaining connectedness to family and community, similarly to the ATSICPP in Australia. Israeli research does not appear to focus on stability and thus information cannot be extrapolated from this population. What is relevant to consider, however, is that residential care has been used to a far greater extent, with a greater focus on maintaining family bonds than is occurring in Australia. Tracking data and outcomes for young people in Israeli residential care will provide significant insights into the benefits and drawbacks of residential care as a system.

3.3.2 Residential care in Norway

Norway's child protection framework is identified as being rooted in 'the best interests of the child', which is congruent with the principles set out in the Australian legislation (Willumsen & Hallberg, 2009). It has been noted that Norway and Australia differ in terms of the styles of welfare, according to Esping-Andersen's (1999) typology. Australia is considered to be a 'liberal' state, while Norway is considered to be a 'social democratic' one. The differences appear to relate to the approach to child protection and child welfare, with Australian approaches being related to minimising risk with an increased forensic focus on child protection, while in Norway the approach is more akin to maximising welfare andequality and promoting child and family wellbeing (Healy & Oltedal, 2010).

The current legislation was introduced in 1993, and in 1992 the threshold for reporting to child welfare services was lowered in order to "lessen the control aspect of child protection work, and to encourage the helping aspect" (Backe-Hansen, Hojer, Sjoblom & Storø, 2013, p. 194). It is noteworthy that these authors identified the varied reasons for children being involved with child welfare services. Three categories were related to the child (child's behaviour problems, child's substance use and child's disability) which made up 10.6% of the involvement. Parental issues (parents unable to cope, parents' substance abuse, parents' mental illness, parents' somatic illness) made up 22.3% of the involvement, while neglect and abuse only accounted for 3.5% of child welfare involvement. The remaining involvement related to other reasons and the situation in the home. This may be linked to the lower threshold for entry into OOHC and these data were not segregated for those who received preventative services only, or alternatively where the children were placed in OOHC. Data on this are not available to the authors' knowledge. A far greater proportion of Australian child protection complaints relate to problematic parenting, including abuse and neglect (AIHW, 2021), however, it is unclear which complaints lead to removal from the family, so direct comparison is difficult.

In Norway, in 2010, approximately 14% of children in the OOHC system were in residential care (Backe-Hansen et al, 2013). It is notable, however, that in Norway, many

children are placed in OOHC on a voluntary basis and almost 17% are aged 18-22 years (Kojan & Lonne, 2012). Residential care generally means being housed in small groups of 5-6 young people, staffed by trained professionals (Backe-Hansen et al., 2013) with most of the child protection workers being social workers or child pedagogues (a specialist social worker), and typically aged over 35 years with at least 5 years' experience (Healy & Oltedal, 2010).

A major focus in the residential care sector in Norway is on interprofessional collaboration, with core group meetings being held among the professionals and the young people on a four to six-weekly basis to discuss the current situation and future plans (Willumsen & Hallberg, 2009). Forming part of the legislation, those organisations providing residential care services are obliged to collaborate with involved services, such as psychiatric, educational and social services, and families.

A recent push has been underway to reduce the reliance on residential care due to fears of the lack of success of young people exiting from residential care, along with factors associated with the cost and the need for more family-based services, as it is purported to be better for the young person (Backe-Hansen, et al., 2013). There has been no specific empirical research cited to explain this shift, with the most significant finding being that those leaving residential care tend to do poorly afterwards (Backe-Hansen et al., 2013; Storø, Sjoblom & Hojer, 2019). Storø and colleagues (2019) reported that care leavers had lower educational attainment, greater reliance on social assistance (welfare payments) and higher rates of unemployment than those who had not been in care. However, these outcomes are not specific to residential care leavers, but rather to care leavers generally. The arguments made for the policy shifts in Norway reflect the arguments made in Australia, where the use of residential care is one of the lowest in the developed world.

Aftercare services are available to young people in Norway until they reach 23, and if they are not provided after the young person turns 18, it is mandatory that grounds for this decision are made available and the young person is able to appeal that decision (Backe-Hansen et al, 2013).

Norway has a considerably higher proportion of young people in residential care than Australia. This may be related to higher rates of adolescents entering the care system, due to more early intervention programs that limit younger children entering the OOHC system, therefore a larger proportion of individuals in OOHC are placed directly into residential care. Despite differences in political ideology, it appears that the concerns around the limited benefit of residential care and the poor outcomes for care leavers are similar.

3.3.3 Residential care in Germany

When considering Esping-Andersen's (1999) model of welfare style categorisation, Germany would be considered 'conservative'. This model means that social rights are allocated on the basis of class and status linked to occupation and employment, and redistribution is negligible (Mendes, 2017). Germany's child protection system is federally run, with the organisation and implementation left to the local municipalities, which delegate the day-to-day coordination to NGOs (Harder et al., 2013).

Similarly to Norway and Ireland (as discussed in Sections 3.5 and 3.7, respectively), a large proportion of the staff involved in child protection and residential care are university graduates (87%), while the other 13% have typically completed a number of years of vocational training (Fendrich, Pothmann & Tabel, 2012). Similarly to Ireland, Germany has a number of models of residential care ranging from intensive therapeutic centres to family group homes to specialised homes for older youth and young adults. There are also a number of secure care placements, about 400 across Germany (Harder et al., 2013). In 2011, a greater number of children and young people lived in residential care than in foster care (65,000 versus 61,000 respectively; Harder et al., 2013). Similarly to Norway, older adolescents (aged 14-18) are more likely to be in OOHC, with the reasons related (like Norway) to greater early intervention programs that provide community-based supports for families with younger children (Fendrich et al., 2012; Harder et al., 2013).

As in the other countries discussed, very little empirical research has been undertaken in Germany to systematically examine the effects of residential care on outcomes for the

young people who are placed there. Two significant studies have examined this issue, the Jugendhilfe Effekte Studie (Schmidt, Petermann & Macsenaere, 2002) and the Evaluation Erzieherische Hilfen (Macsenaere & Knab, 2004). In both studies, beneficial effects of residential care were found in terms of improvement in school achievement and psychosocial functioning over time (Schmid, 2008). These studies were both in German, limiting the author's ability to critically evaluate their findings. Similarly to what has been found in the UK, Australia and the US, German youth in OOHC perform less well at school and have lower educational attainment (Zeller & Koengeter, 2012).

3.3.4 Residential care in Ireland

Residential care in Ireland has been established since the 19th century, with church-based organisations taking on the care of children in need (Gilligan, 2008). It has had multiple reforms over time, and with the implementation of the Child Care Act (1991), has become government-based rather than church-based. Gilligan (2008) identified that a number of allegations of sexual and physical abuse contributed to the reduction in residential care and increased foster care, with residential care generally involving children at the more complex end of the care continuum.

In 2009, approximately 7% of young people in the Irish care system were in residential care, which is very similar to the rates in Australia, and reviews in 1998 and 2000 found that those in residential care had markedly poorer educational attainment than those in long-term foster care (Craig, Donnellan, Graham & Warren, 1998; Emond, 2014; Kelleher, Kelleher & Corbett, 2000). It is notable that Craig and colleagues' estimate of the proportion of young people in residential care is slightly lower than Ainsworth and Thoburn's (2014) assessment of 8%. Furthermore, those in residential care experience greater difficulties securing education, employment or training than those leaving the foster care system (Craig et al., 1998).

The residential care system comprises four tiers: mainstream units, high support units, special arrangements for a single child, and special care units. Generally, residential care units are short to medium term, non-secure, with a high staff-to-child ratio (1-3), and education and therapy provided (Gilligan, 2008). Gilligan (2000) also noted that, at

that time, there was a paucity of data with which to evaluate the Irish care system. By the time of his 2008 review, there did not appear to be a significant improvement in the presence of data. It appears that in mainstream residential settings, therapeutic involvement is not a feature, however, this may be because most staff have relevant tertiary qualifications (82% in 2004), including social work, social pedagogy and psychology (Gilligan, 2008), thus potentially providing more therapeutic input in the day-to-day residential facilities. This is different from Australian residential care workers who tend to have lower level qualifications (Ainsworth & Thoburn, 2013).

It is also notable that in 2012, 42% of children and young people in care were there under a voluntary order (Department of Children and Youth Affairs, 2015), which is similar to Norway. Details of the reasons for placement in care were not available, however, according to the main body (Tulsa) that provides residential care, most children and young people are placed in residential care because of the difficulty managing their behaviours in other settings (Tulsa, 2017).

International Conclusion

Rates of young people in OOHC as a proportion of those in residential care differ markedly across the countries discussed here. According to Thoburn and Ainsworth (2015), this can be partly attributed to cultural differences and differences in implementation of their care models. Their view is that, in Nordic countries, because most young offenders are placed in the OOHC system, rather than a correctional centre, this can inflate the numbers of those in residential settings. Additionally, the focus on early intervention and family inclusion generally offsets children entering the OOHC system early, with residential settings generally being the most suitable placement for adolescents.

It is notable that there are substantial differences in the nature of the child protection/child welfare systems in Australia, Israel, Norway, Germany and Ireland. These international differences occur in relation to the proportion of children and young people in residential care and the qualifications of those working in residential care. However, in all countries, there does not appear to be a strong empirical basis on which decisions have been made to determine which structures will be used. While there appears to be a

significant lack of empirical bases around which residential care is developed, there is a general consensus, often stated, that residential care should be used minimally because it leads to poor outcomes. This makes some sense given the poor social, emotional and educational outcomes associated with the population leaving care.

What is not clear, however, is whether there is a linear link between residential care specifically and poor outcomes. In the following section, the available data on residential care are evaluated, both for Australia and internationally. It is further elucidated whether there is a basis for the "last resort" (Ainsworth & Hansen, 2015, p. 343) approach that many countries, including Australia, apply to residential care.

3.4 The evidence for residential care

In this section, Australian and international evidence is examined concerning the positives and negatives of residential care and specialised therapeutic residential care. This commences with a discussion of whether foster children and those in residential care are comparable and the difficulties associated with research within residential care. Following that is an examination of outcome data for care leavers as this appears to be the evidence base from which the conclusion that residential care is problematic is drawn. Finally, attention will be drawn to key impacting factors such as the length of time in residential care, change over time, relationships and externalising behaviours. Various studies, such as meta-analyses, longitudinal analyses, quasi-experimental studies and qualitative studies suggest a range of outcomes, not all of which are negative.

3.4.1 Residential care residents as different from foster care residents

Almost without exception, young people in residential care have experienced trauma, including neglect and abuse. These young people, within Australia at least, typically have a history of mental health diagnoses, poor school attendance and foster placement instability (Ainsworth, 2017).

It appears that the residential care and foster care populations are different (Ainsworth & Hansen, 2015; Ainsworth & Holden, 2018; Curtis, Alexhander & Lunghofer, 2001). In a nation-wide US review of residential care and foster care youth, Pottick, Warner and Yoder (2005) found that those in residential care had higher rates of dual clinical diagnoses (63% versus 50%), greater rates of attempted or threatened suicide (30% versus 12%) and higher rates of substance abuse (21% versus 10%). In their study of 1082 young people in residential care in the US across 37 agency sites (n = 903) and in foster care (n = 179), Portwood and colleagues (2018) evaluated the young people at baseline, three months, six months and 12 months. The authors used the Children's Global Assessment Scale and the Child Behaviour Checklist (CBCL), both the teacher form and youth self-report form. Their findings supported the previous research that young people in foster care tend to have higher levels of functioning at baseline than did those in residential care.

Further research (Baker, Kurland, Curtis, Alexander & Papa-Lentini, 2007) was conducted in the US in a multi-site and multi-agency study comparing the mental health status of young people in residential care with those in therapeutic foster care. Of the 2274 young people across 22 agencies in 13 states, the authors found that the young people in residential care had significantly higher rates of psychiatric difficulties and behavioural problems, even controlling for age and gender. These conclusions were based on the CBCL and the Child and Family Characteristics Form (CFC) (Baker et al., 2007). They found increased instances of substance abuse histories, criminal behaviour, sexual offending, suicidal behaviour, psychiatric hospitalisations and greater use of psychotropic medication in the residential care population than those in foster care.

Schofield, Thoburn, Howell and Dickens (2007) undertook an evaluation in the UK over 24 local authorities specifically relating to young people who were in the OOHC system for over four years, whom they called 'long-stay children'. The authors found that the residential care sample had higher rates of mental health difficulties and disabilities (80%), with high levels of sexually aggressive behaviour, self-harm behaviour and violent behaviour.

Other meta-analyses found greater evidence for the value of foster care and treatment-focused foster care (Lee et al., 2011) as compared to residential care. One meta-analysis involved comparing residential care to another program: either foster care, therapeutic foster care, or other forms of residential care such as therapeutic care. The authors noted that compared to foster care and therapeutic foster care, residential care had worse outcomes.

What is notable, however, is that all eight studies of therapeutic foster care (multi-systemic treatment foster care, also known as the Treatment Foster Care-Oregon Model) were conducted by author teams that were similar, with the same main contributor (Chamberlain) who is also one of the founders of the model. This arguably has implications for bias in the research, given the research team' association with the model. Additionally, the populations for residential care and foster care are markedly different, thus the comparison between them is not necessarily clear-cut. The more positive results for the foster care cohort may be related to a higher functioning at baseline.

There is little evidence specifically examining the Australian OOHC population, however, internationally it appears to be a fairly robust finding that those in residential care are a different population to those in foster care. Given the Australian governmental reviews discussed in Section 3.2, it is clear that those in residential care appear to be more complex and have more extreme needs than the foster care population. This means that comparisons of outcomes between these two populations may be difficult as it cannot be expected that equivalent outcomes would be forthcoming given equivalent treatments. This point is discussed further below when the evidence for residential care is evaluated.

3.4.2 Difficulties with research in residential care

In general, research in residential care has failed to meet the standards for a strong 'evidence base'. There are many factors at play here. There is a lack of controlled group design studies, and the inconsistent use of a treatment manual administered by clinicians with uniform training, and adherence to the manuals, with outcomes measured beyond

the end of the intervention. The combination of all these factors has typically been considered the gold standard for research (Hair, 2005; Hoagwood, 2003; James, 2015). These flaws have continued over the past decade, with very few controlled studies involving pre-test and post-test results and long-term follow up. A UK review further supported the arguments regarding the methodological flaws inherent in much of the residential care research, including the lack of adequate comparison or control groups (Hart, La Valle & Holmes, 2015).

The value of control groups is to determine whether one intervention, treatment or model can provide benefit over another treatment, or no particular treatment at all. Within the residential care space, many studies may compare those in foster care to those in residential care. However, as described in Section 3.4.1 there are significant differences in the young people typically cared for in foster care as compared to residential care, with respect to their pre-existing mental health and behavioural difficulties. Therefore, adequate comparisons are extremely difficult. These flaws necessarily impact how confident one can be when drawing conclusions from these studies.

However, the lack of control groups and follow up studies does not therefore mean that there is no value to the research. Rather, it means that assumptions and conclusions must be tempered with the understanding that there are elements that have not been examined and cannot be known without more rigorous investigation. In the following section, the research conducted into residential care outcomes in the past decade and a half is discussed. A review is made of the data available in regard to length of time in care, change over time, relationships, externalizing difficulties and finally, specific findings relating to therapeutic care.

While there may be little measured improvement in residential care alumni, this does not necessarily present evidence against the value of residential care. Tarren-Sweeney (2017) identified that in residential care a "successful outcome" (p. 8) may need to be defined as youth experiencing less adversity than they may otherwise have experienced, had they remained in the family home. This view was also expressed by Tomlinson (2008) who stated that no change may actually be a positive outcome, if it indicates a lack of deterioration. It may also be theorised that a lack of improvement in those in

residential care may be linked to other factors, such as the lack of stable and consistent caregivers or a lack of stable and consistent placement opportunities. The adverse impact of a lack of consistent attachment figures was discussed in detail in Chapter 2. However, it must be considered that young people who have experienced marked adversity may require more care than those who have not experienced adversity, in order to demonstrate reparation and healing.

3.5 Outcome data for care leavers

A breadth of research suggests that those leaving care at age 18 fare worse than their age-matched peers who have not been in OOHC. More recent research appears to suggest that when the age of leaving care is raised to 21, outcomes improve (Courtney & Okpych, 2017; Munro, Lushey, Maskell-Graham & Ward, 2012). In a review examining the findings of Australian inquiries into leaving care across the states and territories, Mendes (2019) compared eight public reports. These were completed between 2012 and 2018 and prepared by respective governments, parliamentary committees, an Auditor-General and a Commissioner for Children and Young People. He found that in seven of the eight reviews, it was recommended that support is provided beyond 18 years; in one extending the leaving care age was specifically suggested, in a further six ongoing support until between 21 and 25 years was recommended. In only one report, no specific reference was made to the age of leaving care.

To date, research into care leavers has not been clearly delineated for different care types, making comparisons between residential, foster and kinship care difficult. A significant review of this information is beyond the scope of this thesis; however, a brief overview is provided. According to Mendes (2011), young people transitioning from all types of OOHC experience multiple adversities, including negative pre-care experiences (necessitating removal into the OOHC system), often sub-par in-care experiences, accelerated transitions to adulthood requiring independence at an age far earlier than most young adults in the Western world, and a lack of ongoing support once they turn 18 years of age. A combination of these factors contributes to their poorer outcomes.

Research has suggested that those leaving OOHC experience worse outcomes in a variety of domains including social exclusion, poorer educational attainment, difficulties achieving a stable career, periods receiving income support benefits, difficulties with police and mental health difficulties (Matheson, 2019; Mendes, Pinkerton & Munro, 2014; Stein, 2006). In Victoria, Australia, a longitudinal study was undertaken to evaluate the post-care outcomes for care leavers (Muir, Purtell, Hand & Carroll, 2019).

Muir and colleagues (2019) undertook a significant piece of research called the Beyond 18 Study in which quantitative and qualitative data were collected from young people in care (Wave 1), during the transition from care (Wave 2) and post-care (Wave 3). Wave 3 data particularly provided insights into the outcomes for young care leavers in Victoria. Across all three waves, 126 care leavers completed quantitative questionnaires and 86 young people participated in qualitative interviews. Importantly, 40% of the total sample (n = 51) had been in residential care, meaning that residential care leavers were a significant group in this study so that their outcomes can be considered as a separate group rather than simply as a small subset of the whole. The authors argued that worse outcomes were found in residential care leavers in multiple life domains, including lower levels of education, lower levels of employment, greater rates of mental health issues and self-harming, higher rates of psychological distress and lower levels of life satisfaction in both Australian and international studies (Muir et al., 2019).

84% of the total sample reported some level of financial distress, however, there was no meaningful difference between the placement type subgroups, suggesting residential care leavers were no more likely to experience financial distress than other types of care leavers. Regarding accommodation, those who had lived in residential care were more likely to live in supported accommodation than other types (such as private rentals). Interestingly, it was also noted that supported accommodation tended to be a more stable form of accommodation. Regarding wellbeing, the study found that care leavers generally had higher rates of suicidal thoughts, mental health difficulties and psychological distress than the general population. They noted that those who were not in education, employment or training (NEET) had greater levels of distress. In previous waves, those who had been in residential care experienced lower levels of wellbeing, though

this finding did not appear to be significant in Wave 3 as the levels of wellbeing were more evenly spread.

Muir and team (2019) also reported that those who had experienced greater placement instability experienced more difficulty maintaining trusting relationships and those who had been in residential care reported more difficulty with participating in 'normal' activities in the community, which impacted on their social networks. In general, the Wave 3 study did not find strong associations between outcomes and placement types, suggesting that placement in residential care does not necessarily contribute to worse outcomes for care leavers, particularly over longer periods of time post-care.

The authors did note, however, that young people who experienced high levels of instability, regardless of placement type, were more likely to be in the NEET group, who typically experienced lower levels of wellbeing. This study is significant in noting that, firstly, residential care does not inherently result in more negative outcomes, and secondly, that placement instability, in any type of placement, contributes to poorer outcomes over a number of life domains.

Those leaving care are often grouped together, with little separation according to the type of care experienced. In Victoria, however, a specific aftercare program was developed for those in residential care, called Springboard (Baldry, Trofimovs, Brown, Brackertz & Fotheringham, 2015). Over the four years for which they were initially funded, a total of 448 young people accessed their services. It was noted that 65.4% of the participants had had negative experiences with education, 43.8% had difficulties with literacy and numeracy, 26.6% had difficulties with learning and 46.2% had social difficulties. While the nature of the social difficulties was not explained, the study data included reference to challenges with mental health, drugs and alcohol, anger management, bullying and poor self-esteem. The authors noted that there were many barriers faced by the residential care leavers:

> Current or previous youth justice order (31.9%)
> Custodial sentence or remand (12.5%)
> High risk-taking behaviour (42.2%)

Homelessness or unstable accommodation (53.4%)

Diagnosed or suspected mental health condition (53.4%)

Alcohol and drug misuse (54.2%)

Disconnection from education and training on entry to Springboard (69.9%)

These indicators suggest that those leaving residential care have high levels of complexity and multiple barriers to engaging with education and the workforce.

In the UK, policy changes wrought by legislative changes to extend state care to 21 years (Mendes & Rogers, 2020) have seen the advent of a strategy wherein young people in residential care will move into accommodation "very close" (p. 63) to where their residential house is located with the expectation that the young person would regularly visit the house for meals and activities (Narey, 2016). According to Narey (2016), the young people would not be able to continue to live in the residential house due to concerns around adults (over 18) living with minors (under 18) alongside the prohibitive costs of continuing to provide high level, 24-hour care for an additional three years. There are arguably a number of concerns about this approach to extended care. For example, there is no specification of who finds or funds the accommodation, what support is provided by the key worker from their residential home, how close is "very close" and what provisions will be put in place to allow the young people to visit, should they live beyond walking distance. It is unclear how this extension of care provides greater support than a transition to an independent living program, beyond being near the house they formerly lived in. Within Australia, recent policy changes have occurred in Victoria and Western Australia to universally extend care till 21 years for young people. But currently, there is no concrete approach to enacting such an extenson in residential care (Bollinger & Mendes, 2021).

If negative outcomes could be attributed solely to the deleterious effects of the OOHC system, then extending the age of leaving care might not improve outcomes. It is likely that these outcomes are a feature of multiple pre-care, in care and personal factors, rather than solely related to residential care. Further, it is difficult to identify whether those worse outcomes (should they be the case) are attributable to residential care itself, or because those in residential care typically experience greater adversity and are

identified as more complex and, at baseline, different from those in the foster care system. In the following section, the outcome data that is available internationally is examined in an attempt to identify whether residential care itself is a contributor to poor outcomes for care leavers.

3.6 Outcome data for residential care

In the international literature (e.g. Gallagher & Green, 2012; Strickler, Mihalo, Bundick & Trunzo, 2015; Thompson, Duppong Hurley, Trout, Huefner & Daly, 2017), it has been found that there is either little difference in outcomes between residential care and foster care, or some positive effects for those who have been in residential care. Residential care, however, has received criticism for the lack of evidence base for its efficacy, given its substantial price tag (Thompson et al., 2017). For example, in NSW, it costs between $463,549 and $875,166 annually per child to be in residential care (it was not specified whether this was therapeutic or standard care); compared to nonresidential care, such as foster or kinship care which ranges between $34,634 and $48,985 per child (Productivity Commission, 2019). In the following section, an evaluation is made of the data to date, to examine the outcomes across residential care with regard to the length of time in care, change over time, relationships, externalizing behaviour and, specifically, therapeutic care. This discussion concludes with an analysis of the implications of these results.

Length of time in care

While the results are somewhat equivocal, it appears that shorter stays in residential care produce superior outcomes. Some studies, however, report that longer stays in residential care are associated with behavioural and emotional improvements (e.g. Trout et al., 2010). Lee and colleagues (2011) conducted a two-group comparison meta-analysis of outcome studies. The authors only selected available studies conducted in the US between 1996 and 2009, in which residential care was compared to a control group with an alternative intervention, such as foster care. 19 studies fitted their criteria and the authors calculated the effect sizes for different outcomes. They found that shorter

stays produced superior outcomes than longer stays, although the outcomes themselves were not specified. Hair (2005) conducted a systematic review examining 18 studies between 1993 and 2003 in which outcomes were examined for those in residential care in the US (n = 17) and Canada (n = 1). She concluded that shorter stays of six to eight months were associated with better outcomes for young people.

Strickler and colleagues (2015) completed a study in West Virginia in the US looking at time periods in residential care to examine whether there was an 'ideal' period of time in a residential setting. Theirs was a small-scale study with 50 young people in a 'residential neighbourhood'. The researchers investigated administrative data over a five-year period. They also examined demographic data and pre-test data including the Child and Adolescent Functional Assessment Scale (CAFAS) scored by residential care staff, based on file review, for the 30 days prior to entering the program. Their findings suggested that, in the programs evaluated, changes occurred relatively quickly in all but one subscale of the CAFAS. The authors reported that most improvements were seen in the first one to six months, and after 10 months there was a slowing of improvement, though with a limited decline. These researchers could not provide any hypotheses about the change in effectiveness over time, however, there may be a link with those who require longer stays in residential care displaying fewer or less dramatic improvements.

In their analysis of over 3000 young people in New Jersey in the US, Lyons, Woltman, Martinovich and Hancock (2009) found that residential care could produce positive results within six months. The authors operationalised change via the Child and Adolescent Needs and Strengths (CANS) scale and examined factors such as child behaviour/emotional needs; child risk behaviours and life domain functioning. They reported that measurement via the scale was repeated every three to six months and at transition from the program. These researchers argued, however, that the length of stay is not, in and of itself, particularly significant. Rather, what is significant is the nature of the discharge and the type of location to which the young people are discharged. They argued that the context in which the child leaves the residential program is a better indicator of its effectiveness. Understandably, it is more beneficial, and indicative of the

program's success, for a young person to be discharged to a foster family or independent living, rather than being discharged to a juvenile justice facility or a psychiatric hospital.

It appears that changes wrought in residential care occur relatively quickly. Whether young people are readily able to be discharged to foster or kinship care arrangements would be impacted by the availability of willing carers to look after adolescents, thus potentially rendering residential care a permanent care option.

Change over time

A quasi-experimental, pre-test/post-test design study was conducted by Portwood and colleagues (2018) in the US to compare the baseline functioning of youth in both residential care and foster care (n = 1082). Their findings indicated that, while there was a lower level of functioning for those in residential care at intake, they progressed at the same rate as those in foster care, suggesting that residential care did provide additional benefits for the young people. Furthermore, when matching samples of young people in OOHC and comparing the outcomes across residential and foster care, Lee and Thompson (2008) conducted a comparison in the US using case file data. They compared 716 young individuals in residential care to 112 youth in treatment foster care, run by the same organisation. Data were collected based on problematic behaviours such as substance abuse, aggressive or violent behaviour, use of weapons etc. Maltreatment information as well as family problems were assessed based on parental mental health needs, corrections involvement, substance abuse etc. and used to assess the children and young people in the study. The authors noted that the staff were required to have a "high level of training" (p. 754), however, this was not assessed in the study, nor was the type of training discussed. The groups were somewhat different in demographic terms, such as the mean age at intake, parents with substance abuse issues, domestic violence and the number of prior placements. The researchers speculated that this would put young people in residential care at a disadvantage for positive outcomes, and they were a "slightly more troubled" group (p. 751). They found that, contrary to hypotheses, residential care produced improved outcomes for some young people with greater rates of returning home, greater likelihood of being favourably discharged, less likelihood of a

subsequent formal placement and no more likelihood of subsequent legal involvement compared with those in treatment foster care. The authors identified a number of theories to account for the differences, largely involving factors that were unmeasured, though concluding that there may be youth who simply benefit more from residential care.

Others have also found that, for young people with high levels of complexity and high needs, residential care can be a positive environment (Lyons et al., 2009). Lyons and colleagues (2009) evaluated systematically collected data in New Jersey in the US every three to six months over a four-year period. This resulted in information on 3,170 young people, 9.8% of whom experience over four placements in that time. The authors found that when young people were appropriately matched to residential care (i.e. using it proactively, as opposed to using it as a last resort), the benefits were greater. They also argued that residential care for young people who had "deeply entrenched deviant behaviours" (p. 87) was a particularly appropriate treatment choice.

In the UK, in a longitudinal study, data were collected at age 16 and age 30 on a cohort born in 1970 (Dregan & Guilford, 2012). The authors found that, in the later sample comparing 431 individuals who had experienced OOHC to 10,464 who had not, those in OOHC had worse outcomes, such as greater mental health difficulties, greater rates of alcohol and substance use issues and greater rates of criminal offending. Further, those who had experienced residential care performed worse than those in foster care, on a range of variables such as behaviour and emotional wellbeing. These reserchers suggested that the differences in outcomes may relate to the residential care system not meeting these young people's complex needs. An alternative suggestion was that earlier admission and a greater likelihood of stable placements resulted in better outcomes and this was more often found in foster care than residential care.

While some studies demonstrate worse outcomes for young people in residential care (e.g. Dregan & Guilford, 2012), a significant number with impressive sample sizes have demonstrated the possibility of positive outcomes for residential care alumni. These

findings are important because they demonstrate that there may be flaws in the baseline assumption that residential care should be a "last resort" (Ainsworth & Hansen, 2015, p. 343).

Relationships

In multiple analyses (e.g. Hair, 2005; January, Trout, Huscroft-D'Angelo, Duppong Hurley & Thompson, 2018; Knorth, Harder, Zandberg and Kendrich, 2008; Scherrer, 1994), researchers have pointed to the importance of family contact in improving outcomes for young people in residential care. Links have also been found between participation in therapeutic residential care and improved relationships. Gallagher and Green (2012) cited powerful relationships between staff and young people as contributing to many improvements, such as an ability to trust, regulate emotions and feel safe. One interviewee reported still having (approximately six years later) a piece of artwork completed by a residential care worker when he was approximately 12 years old and that it continued to remind him of the importance of that particular relationship. Other researchers have found links between positive relationships and positive outcomes in the short (Rainer, 2007), medium (Ward, Kasinski, Pooley & Worthington, 2003) and long terms (Martin & Jackson, 2002).

In a US analysis of young people re-entering residential care after discharge, the importance of family and peer relationships was a key theme (January et al., 2018). The authors interviewed young people and a key carer (either a family member or foster carer) to whom they had been discharged from residential care. A notable finding was that positive peer and family relationships assisted with the transition home, but also negative peer relationships or strained family relationships were associated with their return to the residential facility.

In Australia, a qualitative study was undertaken by a team at the Australian Catholic University as a result of the Royal Commission into institutional sexual abuse (Moore, McArthur, Roche, Death & Tilbury, 2017). They interviewed 27 young people in residential care in Queensland, Victoria and NSW aged from 10-17 to identify their experiences

of feeling and being safe or unsafe in residential care. The study was designed to understand their current experiences, rather than to evaluate outcomes associated with residential care. The researchers found some circumstances associated with positive experiences of residential care, including fair rules, an opportunity to have a say, stability and predictability, as well as positive relationships with peers and workers. Other participants, however, identified that residential care felt unsafe, particularly in regards to peer bullying, the dysregulation of peers, feeling they could not talk to the staff for fear of consequences or being blamed, and fear of adults outside of the OOHC system who 'exploit' young people in OOHC. Descriptive statistics were not provided to identify what proportion of young people had positive experiences and what proportion did not, or to what extent there were positives and negatives experienced. As such, it is difficult to draw any conclusions about the pervasiveness of various experiences and, given the small sample size, generalisability cannot be inferred. Nonetheless, it is a valuable addition to the research to identify the lived of positive and negative experiences associated with residential care.

Relationships appear to have a significant impact, both on success after discharge from residential care and within it. Attachment theory provides a lens for reading this information, as attachment relationships provide a buffer against stress.

Impact on young people's behaviour

A Dutch meta-analysis by Knorth and colleagues (2008) examined 27 studies published between 1990 and 2005, involving a total of 2345 young people who had been in residential care. The authors found that some models produce positive short-term outcomes, particularly when family involvement is a focus, as mentioned in the previous section. They further identified that residential care appeared to be more successful with addressing externalising problems (e.g. aggressive behaviour, property damage, criminal behaviour) than internalising problems (e.g. suicidal thoughts, self-harm, anxiety). Interestingly, the authors commented that residential care appears to be more successful than treatment at home with "the same (very) problematic group" (p. 136).

In Sweden, a longitudinal study followed 26 individuals who were in residential care in 1980-1981 (Andersson, 2004). A 20-year follow up was published in 2004. Findings include that 10 of the individuals were considered to have good social adjustment, nine were found to have moderate social adjustment, and seven manifested antisocial behaviour, including drug use and criminal behaviour. Further longitudinal research in Sweden (Vinnerljung, Franzen, Gustafsson & Johansson 2008) identified that more negative outcomes in terms of mental health, criminal behaviour, early parenthood and lower educational attainment existed in the residential care population as compared to the foster care sample. Significant detail on the residential programs was not provided; however, the results were based on administrative data. Given the findings by Portwood and colleagues (2018) that young people in residential care have a greater degree of dysfunction at baseline and improve at a similar rate to young people in foster care, the later findings of being worse off do not necessarily indicate a lack of progress.

Outcomes for care leavers in specific therapeutic settings

Anglin (2015) identified 10 core ingredients of therapeutic care. These include a specific and research based model of practice, whole agency training in the model and a focus on relationships between staff and young people that are appropriate, safe and in the best interests of the child. Supporting these, Bath and Smith (2015) identified five main areas essential for therapeutic care: safe and healthy connections to staff, safe peer relationships, safe and supportive physical environments, a focus on emotional regulation and stability of connection. In a therapeutic care setting there are typically clinical staff (psychologists and social workers) appointed to each residential care house, with greater staffing levels than standard residential care (Jones & Loch, 2015). It is notable that in the UK, guidelines were introduced in 2015 that focused on the importance of attachment in policy and practice related to working with youth in OOHC. These guidelines highlight the centrality of developing interventions that are based on the need for safe and stable attachments.

In some evaluations of therapeutic residential care, positive outcomes have been found for care leavers. These include reduced or ceased substance use, low rates of early

parenthood, no homelessness and better performance than most care leavers academically, though still poorer than the general population (Gallagher & Green, 2012). Gallagher and Green (2013) completed a qualitative study of therapeutic residential care homes in the UK to begin to evaluate the outcomes for these young people. The young people appeared to be broadly similar to those in residential care in NSW, with histories of sexual, physical and emotional abuse and neglect. It was these factors that led the children and young people into the OOHC sector, initially into foster care. But due to problematic behaviours, the placements broke down, resulting in further foster placements or residential care.

The study involved 16 former residents of a therapeutic residential care facility with a mean age of 18.8 years. The therapeutic setting utilized structured therapies including Life Story Work and play therapy with a focus on therapeutic parenting to repair their attachment trauma. The data were retrieved from available file information and interviews with the young people who had completed their schooling. The authors noted that one of their inclusion criteria was that the young people had finished their final school exams, citing that this would mean that the research would have limited ability to impact on their schooling. While this is probably sound, it also likely limits the potential pool of participants to those who were able to complete school. This may reduce the pool (from 117 to 77 potential participants) to include only those who were relatively successful.

Nonetheless, these researchers found that the respondents believed that, as a result of the therapeutic care setting, they had made gains in developing more trust and confidence, generally being happier and less fearful, with greater control over their behaviour. It is also notable that the young people had, on average, left the therapeutic setting at age 12 but were being interviewed, on average, at age 18. The time lag between leaving and being interviewed may impact the links between their current functioning and participation in the therapeutic care environment. Carter (2011) reported on similar outcomes from a therapeutic residential care setting in the UK, called Thornby Hall, with 47 residents. They stated that none of the participants was pregnant while in care,

there were higher rates of educational attainment than the general care leaver population, and greater proportions of these young people were in work or education five years after leaving the facility.

Only one evaluation study of therapeutic residential care has been completed in Australia, by Verso in 2011. Similar results were found, with improvements over traditional residential care in many domains, including the quality of relationships and contact with family, increased community connection, an improved sense of self, reduced risk taking and enhanced mental and emotional health. The researchers identified that the control group in traditional residential care showed little change over the 12-month evaluation period, however, they did not appear to have a worsening of outcomes over that time.

Conclusion

The empirical evidence appears to suggest that residential care is not, in and of itself, the conduit of poorer outcomes for those leaving care. The research to date on multiple domains, including time in care, change over time, relationships, externalising behaviours and specific findings in therapeutic settings, suggest that residential care alumni may have positive outcomes over a range of measures, including mental health, reduced criminal offending and reductions in externalising behaviours. These results are not ubiquitous and multiple studies have found that comparatively, residential care leavers have poorer outcomes than the general public, and also than foster care leavers. As discussed at the beginning of this section, however, care must be taken in comparing foster care leavers with residential care leavers. The differences at baseline suggest that, with the same treatment, the same outcomes cannot be expected. In other words, the outcomes for residential care leavers cannot be expected to be the same as those for foster care leavers. Nonetheless, the findings suggest that residential care, particularly therapeutic placements, may provide positive outcomes for young people, under certain conditions. While the data do not clearly reveal outcomes for care leavers in terms of different OOHC streams, the research into residential care suggests positive outcomes are possible. This conclusion is congruent with the perspectives of both Tarren-Sweeney's

(2017) and Tomlinson (2008), who assert that for young people with extreme complexity and who have experienced significant maltreatment, a positive outcome may be that there is no worsening of their difficulties.

Placement stability has been a major focus within the research literature and policy development arenas. In this section an evaluation has been offered of the evidence regarding residential care more generally, whilst the following section constitutes an examination of the impact of placement instability as well as the predictors thereof. This includes an investigation of the measurement of stability and instability, and concludes with a discussion of whether the common form of measurement is sufficient for an accurate understanding of the impacts of stability and instability. As, to the best of this researcher's knowledge, the current study is the first to directly examine placement stability in a residential care setting, in the following section stability and instability are examined generally, rather than specifically in terms of residential care.

3.7 Placement stability in OOHC

A number of findings have been identified in regard to placement stability in OOHC. Limited research has been undertaken in residential care; therefore, the discussed findings will relate to foster care or kinship care. Within the extant literature discussed below, a number of negative outcomes have been linked to placement instability: mental health difficulties including increases in depression and anxiety and greater use of psychiatric facilities, poor attachment, and difficulties forming and maintaining appropriate relationships. These outcomes adversely affect a young person's ability to regulate and manage their emotions. Problematic behaviours and social difficulties have also been linked to placement instability: behavioural problems, offending behaviour and sexually inappropriate behaviours. In the following section, the available information is outlined concerning placement stability and instability, including the effects of instability that are known, any reparative effects of stability, and the predictors of instability and stability. There is also a brief discussion of failed restorations to the birth family and their subsequent impact on the young person's sense of stability.

A significant piece of research has been completed using Australian data. The NSW FaCS department, responsible for OOHC, began collecting data through the Pathways of Care Longitudinal Study (POCLS). This is the first large-scale prospective longitudinal study to investigate factors associated with children and young people who enter OOHC for the first time. The data were collected on all children and young people who entered statutory OOHC for the first time and for whom final court orders were granted between May 2010 and October 2011. The final sample comprised 2,832 children and young people. Researchers using this data investigated placement stability (Wulczyn & Chen, 2017), analysing data from 1,285 children and young people who participated, with their carers as relevant, in a Wave 1 baseline interview. The authors counted placements, both prior to the Wave 1 interview and after this interview. They then determined the proportions of children and young people changing placements, and which factors were linked to a greater likelihood of placement changes. This study is discussed further in the following sections.

Measuring stability and 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. The author considered papers from the UK (n = 7), Europe (n = 3), Australia (n = 7) and the US and Canada (n = 26) ranging from 1959 to 2004. She found that some of the research papers have used numerical categories (i.e. comparing categories such as 1-2 placements, 3-4 placements, 5+ placements) and continually (i.e. comparing based on a continuum of placements) by looking at how many placements a young person has over a particular period of time (e.g. Koh et al., 2014; Ryan & Testa, 2005). Others have identified stability as being defined by one placement (i.e. no moves) over an 18-month period (e.g. O'Neill et al., 2012). A further method was to have defined cut-off points, generally identifying a point of stability (e.g. one to two placements) and a point of instability (e.g. 3+ placements) over the period in care (e.g. Barber & Delfabbro, 2003).

These decisions about what stability constitutes appear to be somewhat arbitrary and are not consistent across studies. Devaney and colleagues (2019) undertook a qualitative analysis of stability and permanence in Ireland. The authors noted that, tradition-

ally, stability has been measured via placements over time, however, they also acknowledged that stability can be considered as "children's feelings of connectedness and belonging that are characterized by steady emotional attachments to adults and members of peer networks" (p. 635). It is notable that they did not comment on the discrepancy between their acknowledged pre-eminence of emotional attachments in understanding stability, which is not captured in a paradigm measuring stability as placements over time.

Cashmore and Paxman (2006), however, reported that the feeling of security is more significant than a placement period where stability is deemed to represent wherein few or no transfers from one residence to another though these two often co-occur. Within their NSW-based study, felt security was operationalised by collating the feelings of being loved, belonging and having one's needs met within the placement. The authors found that, in general, lower placement numbers correlated with greater feelings of security within the placement. Therefore, the feelings of security are likely to have developed within attachment relationships that have a platform of stability and predictability. The authors further concluded that felt security was a better predictor of positive outcomes 4-5 years after leaving care than is the stability of placements (as measured by counting placements). Furthermore, it was argued that stability is a "necessary but not sufficient" condition (p. 238) for positive outcomes, however, the feelings of being connected and belonging were more significant for the young people's positive outcomes. Notably, it was theorised that the need for stability functions as a way for individuals to form relationships with people that may become secure through the development of positive attachment.

3.8 Impact of stability and instability on young people

Some of the impacts of stability also function as predictors of stability or instability. There is often a bi-directional link between these factors, such that what predicts instability is also brought about by instability.

Studies specifically focused on the effects of stability on outcomes for young people in OOHC are limited. For the most part, researchers in this area examine the predictors and consequences of instability and how this can be defined and measured. In the research, placement stability is generally defined as a child or young person having a consistent place to live over a period of time. There is, however, little agreement about what this 'period of time' should be nor is there agreement about how it should be measured. This means making comparisons across the literature is difficult (Unrau, 2007). With these limitations in mind, a number of negative outcomes associated with instability have been indicated, with some positive effects of stability. In the following section these outcomes are explored in terms of how they relate to mental health, attachment difficulties, behaviour problems, offending behaviour and sexual behaviour problems and how this, in turn, relates to executive functioning, which includes the abilities to plan, set goals and inhibit behaviours. These are each discussed in turn.

Mental health

In multiple studies in the US the link has been investigated between the use of mental health services and placement instability (e.g. Fawley-King & Snowden, 2013; Park, Mandell & Lyons, 2009; Rubin, Alessandrini, Freudtner, Localio & Hadley 2004). Fairly consistently, over large sample sizes ranging from 1362 (Park et al., 2009) to over 19000 children and young people (Fawley-King & Snowden, 2013), the results have demonstrated that placement instability is linked to greater use of mental health services such as psychiatric facilities. Fawley-King and Snowden (2013), with a very large sample size, examined incidences of placement change and emergency psychiatric hospitalisation within the first 90 days of a foster placement. The authors indicated that those who used mental health services more frequently had greater rates of instability. It seems that placement instability may be both the cause and consequence of a child or young person's mental health difficulties (Fawley-King & Snowden, 2013).

Links have been found between placement instability and high levels of anxiety and depression (e.g. Pritchett, Gillberg & Minnis, 2013; Unrau et al., 2008). Tarren-Sweeney (2017) examined mental health outcomes in Australia for those in stable foster and kin-

ship care over follow ups of seven to nine years. Placement stability was neither defined, nor a predictor or outcome variable in this study. He noted that the majority of children (n = 347 children in foster or kinship care in NSW) experienced a stable care trajectory over the study period from the first point (2008a) until the follow up (2017), however statistics were not provided to confirm this. He found that the mental health outcomes were largely unchanged from the initial state to when they were followed up, seven to nine years later, in the stable sample. He theorised that a 'successful outcome' (p. 8) may need to be defined by experiencing less adversity than they may otherwise have experienced, had they remained in the family home. Essentially, Tarren-Sweeney indicated that placement stability may best predict a stable mental health state, rather than an improvement in mental health.

Attachment difficulties

While it is not a strong feature in the literature, Newton and colleagues (2000) commented that children who have experienced multiple placement failures will likely experience difficulties trusting and forming attachments with safe others. They evaluated 415 children and young people in foster care in California over an 18-month period between 1990 and 1991. Each placement change was calculated and outcomes were compared to these numbers. The authors noted that disordered attachment was considered to have contributed to placement breakdowns, but they did not take into account that disordered attachments may have occurred as a *result* of placement breakdowns. Similarly, Rock, Michelson, Thomson and Day (2015) noted attachment difficulties as a predictor of further placement failures, however, they did not evaluate attachment difficulties as a consequence of placement failures.

Behavioural concerns

While it has been found to be a consistent predictor of placement disruption, externalizing behaviour (such as property damage, aggression, sexual acting out) has also been found to be a consequence of placement instability (Newton et al., 2000). Newton and colleagues (2000) found that for 173 children of a total sample of 415, who were ini-

tially rated as having no behavioural problems, the number of placements they experienced across the study period consistently predicted increased internalizing, externalizing and total behaviour problems 18 months later. The authors also found that placement number was a "weak but consistent" (p. 1372) predictor of internalizing and externalizing behaviour problems 18 months later.

Executive functioning

A number of researchers have investigated the impact of placement instability on executive functioning, such as an inability to inhibit behaviour, an inability to consider consequences before acting and an inability to take an alternative perspective (De Bellis et al., 1999; Snyder, Miyake & Hankin, 2015). For example, Lewis, Dozier, Acherman and Sepulveda-Kozakowski (2007) compared 102 children in the US aged between five and six who were in one of three groups: 33 adopted children who had previously had multiple foster placements (based on discrete numbers of placements), 42 adopted children who had previously had one foster placement and 27 children who had never been placed into foster care and were living with their biological parents. The authors found that those children who had experienced multiple placements performed worse on an inhibition task than those who had been in a stable placement. They hypothesised that this was related to the lack of a stable caregiver to assist the child to learn to self-regulate, and concluded that when stability is compromised, this skill is not learned. Furthermore, Pears, Bruce, Fisher and Kim (2010) discovered that as unique foster placement numbers increase, a child's ability for inhibitory control decreases, suggesting that a child's ability to inhibit behaviour, such as taking something that is not theirs or stopping a behaviour that is inappropriate, reduces as placement instability increases.

Offending behaviour

A large-scale US research investigation was conducted into the temporal relationship between placement in OOHC and delinquency (Ryan & Testa, 2009). In a sample of over 18,000 young people identified by the juvenile justice and child welfare systems, findings suggested that being placed in OOHC did not particularly increase the risk for delinquency at the stage of one or two placements. However, for those boys who had three or

more placements, the risk of delinquency doubled from 11% to 23%. The finding regarding instability being associated with delinquency did not hold for girls in the sample, however, merely being placed in OOHC doubled their risk. The authors found that girls who remained in the family home, as opposed to entering OOHC, had a 3% chance of having been arrested or charged but for those in OOHC, the risk doubled to 6%. In this study however, delinquency was defined by contact with the police, so there may be markers, particularly for girls that were missed, such as being exploited. These findings are supported by further research, which has found that those who have experienced greater instability are more likely to engage in offending behaviour or have contact with the police (e.g. Barn and Tan, 2012; Cusick, Courtney, Havlicek and Hess, 2010; Jonson-Reid and Barth, 2000b; Taylor, 2006).

Sexual behaviour problems

Prentky and colleagues (2014) defined inappropriate sexual behaviour as including violation of body space, pulling pants/skirt down, forced sexual acts or sexually explicit orders and threats. The behaviours can range from non-contact, such as peeping, exhibitionism and voyeurism, to contact abuse including fondling and touching with no penetration, to contact abuse including penetration, which may include elements of sadism or humiliation.

Researchers have explored the impact of placement instability and history of maltreatment to determine the differential impact on sexual behaviour problems (Prentky et al., 2014; Tarren-Sweeney, 2008). In both these studies, placement instability was found to be an independent predictor of inappropriate sexual behaviour, even accounting for a history of maltreatment. Prentky and colleagues (2014) examined the impact of placement instability on inappropriate sexual behaviour and aggression, accounting for types of maltreatment histories in 559 pre-adolescent and adolescent males. In this study, placement stability and instability were coded based on discrete placement numbers across all participants. They found a "broad and robust influence of placement instability" (p. 268), with instability being the only independent predictor of offence persistence. The authors also identified that placement instability was negatively correlated with self-control, overall adjustment, motivation for change and accepting responsibility. The sample participants had an average number of 10.4 placements, with a median

of nine placements.

Tarren-Sweeney (2008) noted an additive effect of placement instability and history of sexual victimization on sexually inappropriate behaviour. This suggests that both variables (sexual victimization and placement instability) predict sexually inappropriate behaviours but when added together, are stronger predictors of this behaviour. Tarren-Sweeney's (2008b) research indicates that those who experience childhood sexual abuse are more likely to exhibit sexually inappropriate behaviours. Also, those who did not experience childhood sexual abuse but did experience placement instability were more likely to exhibit sexually inappropriate behaviours. Those who experienced both, however, were most likely to exhibit sexually inappropriate behaviours.

There are a number of negative outcomes across multiple domains associated with placement instability. Placement instability, both short and long term, affects children and young people. This seems to be particularly true for attachment difficulties and various types of behavioural problems, including sexual behaviour problems. The degree to which placement instability is both a cause and effect of poor outcomes, however, can be difficult to determine. Further research is needed to elucidate the effects of placement stability. Researchers and those working in the OOHC sector may theorise that stability would have the opposite effect to instability, resulting in positive outcomes, but findings suggest that this may not necessarily be the case.

3.9 Predictors of instability

In the following section, various factors are identified which are associated with the increased likelihood of stability or instability. It must be noted, however, that factors that have predictive value do not necessarily lead to instability. There are likely to be placements that involve these factors that remain stable over time while other placements with these factors fail. Factors that are considered predictive of placement instability have been found using statistical analyses. In other words, this suggests that placements with these factors have a greater likelihood of failure than ones without. In general,

there appear to be factors associated with the child, the family and the system that affect stability. These domains are each discussed in turn, although it is likely they would often occur together.

3.9.1 Child Factors

Child's age and length of time in OOHC

The child's age and the length of time they have been in OOHC appear to be related to placement stability and instability. Older children and those who have been in OOHC three years or more appear to be likely to experience instability (Crum, 2010; Rock et al., 2015) and as the children age, this likelihood increases further (James, Landsvert, Slymen & Leslie, 2004; Wulczyn, Kogan & Harden, 2003). In the Australian POCLS study (Wulczyn & Chen, 2017), it was found that older children were more likely to change placement. The multivariate models compare each age group to those children less than two years of age. Each age group is more likely to experience a move than those who are less than two, with the exception of children aged two to five years, who are no different than those less than two years. Those six to 12 and 13 and over have more moves than those less than two years old. This is possibly related to changes that occur within adolescence, which is a time of emotional, hormonal and physical changes (Smith, Chein & Steinberg, 2013). McPherson and colleagues (2021) also noted that entry into residential care typically occurs at a stage in life (adolescence and pre-adolescence) when young people are beginning to "explore and exercise agency" (p. 2), which is related to emotional, hormonal and physical changes.

Statistics from the AIHW (2020) indicate that the longer a child is in care, the greater number of placements they are likely to have. Approximately 5% of Australian children in OOHC have more than five placements over their time in care (AIHW, 2020). There appears to be a link between placement changes and later placement changes. Australian POCLS data suggests that individuals who experienced multiple placement changes prior to the Wave 1 interviews were more likely to change placement afterwards (54% as compared to 12% with no prior placement moves).

Child behaviours

Those with more extreme behavioural and emotional disturbances, such as greater rates of aggression, sexualised behaviour and suicidal behaviours have a higher risk of placement failure, and therefore they experience instability as the placement ends; and those demonstrating, particularly, externalising behaviours experience this to a greater extent (Chamberlain et al., 2006; Crum, 2010; Leathers, 2006; O'Neill et al., 2012; Rock et al., 2015). Ongoing behavioural problems may have a cumulative impact on a carer's capacity to continue to parent (Leathers, 2006).

Newton, Litrownick and Landsverk (2000) suggest that while initial externalising behaviours is a consistent predictor of placement changes, in the absence of initial behaviour problems, placement changes predict problematic behaviours. This research is in line with international literature on the impact of trauma on brain development and behaviours (see De Bellis et al., 1999; Perry, 2009; Perry et al., 1995; Teicher, 2002, Ziegler, 2009) as discussed in Section 2.6.

Some limited research has also focused on the role of caseworkers' versus foster carers' perspectives of behaviour problems and the link to later outcomes. Leathers (2006) found in her study that carers' reports of behaviour problems, while not predicting instability per se predicted negative placement outcomes five years later, such as placement in residential care, imprisonment and runaway status.

Child feelings and perspectives

Placement instability has been linked to child related factors of "giving up" on securing stable placements and "disconnecting" from their caregivers (Rock et al., 2015, p. 188; Rubin et al., 2004). This was identified by Unrau, Seita and Putney (2008) in their analysis of placement instability. Their interviewees commented on difficulties developing trust and a disinterest in forming emotional ties. This research confirms that in l Section 2.5 on the link between placement instability and attachment difficulties which arise from not having a stable base.

As discussed previously in Section 3.11, Cashmore and Paxman's (2006) findings highlighted the importance of feeling secure in a placement, and they associated the feeling of security with having fewer placements. Their reasoning was not specifically extrapolated, however, the authors argued that stability is a necessary precursor to developing secure relationships. Furthermore, these researchers suggested that one feature of feeling secure is the belief that one may continue in the placement even when 18 years of age or older. Within residential care, this is currently impossible, given the restrictions on minors living with adults. To be sure, within Australia, a current campaign called Home Stretch aims to extend the care leaving age to 21 years in all Australian jurisdictions. Should this policy be adopted in the future by NSW, the DCJ and the individual agencies will then need to adjudicate how that measure will be applied to young people in residential care.

Child mental health difficulties

The presence of mental health problems appears to increase the likelihood of placement instability. In a study investigating 3483 children in kinship and foster care, differences were examined between those who were considered stable (two or fewer moves in an 18-month period; n = 3223, Koh et al., 2014)) and those who were considered unstable (three or more moves in an 18-month period, n = 260). The authors reported that the stable and unstable groups comprised similar proportions of young people with psychiatric diagnoses at the start of the study. The researchers found that one significant difference between the two groups was the proportion of young people with a psychiatric diagnosis. In their sample, 31.2% of those in the unstable group had a diagnosis as compared to only 5% in the stable group. Interestingly, many of these diagnoses were given during the study period, with the children having no psychiatric diagnoses at the commencement of the study.

The authors suggested that their results may be explained by an insufficient opportunity for the children and young people to receive an accurate diagnosis due to their unstable placements. It can also be hypothesized that instability, and its associated factors, such as disrupted attachments and additional trauma, may have a causal effect on the development of psychiatric diagnoses.

Similarly, in a study involving 19, 351 foster care youth in California, researchers examined the impact of seeking emergency mental health support on placement stability (Fawley-King & Snowden, 2012). Their findings suggested those seeking emergency mental health care were more likely to experience placement instability. Similarly, Park and Ryan (2009) found that young people with a history of psychiatric hospitalisation were more likely to have three or more placements than those who had never been hospitalised.

3.9.2 Family Factors

Parental problems

Limited information exists on factors related to birth parents. In a systematic review completed by Rock and colleagues (2015) in the UK, they found some links between parental substance abuse and poverty, and later placement instability. The authors identified that substance abuse was linked to instability in one out of four studies, while poverty was found in one of two. These researchers did not provide any further detail about these findings. These factors have also been found to be damaging to reunification, which is discussed in Section 3.13.3. However, Delfabbro and colleagues (2014) found that children were less likely to be reunified if there was evidence of poverty or substance abuse, both of which are regularly related to neglect (Fernandez & Lee, 2013; Fernandez et al., 2019).

Reasons for removal

There is very little evidence, either in Australia or internationally, that speaks to this issue. Therefore, only brief comments can be made. Australian POCLS data have suggested that children who experienced multiple maltreatment types changed placement more frequently (Wulczyn & Chen, 2017). Those young people who were in care as a result of sexual and physical abuse appear to be more likely to experience placement changes than those who experienced neglect (Chamberlain, Price, Landsverk, Fisher & Stoolmiller, 2006; James et al., 2004).

3.9.3 System Factors

Carer-child 'fit'

Studies examining carers' perspectives are limited. There has, however, been one Australian research team who examined this issue by interviewing 41 carers about their perspectives and experiences (Withington, Burton, Lonne & Eviers, 2016). They found that a significant predictor of stability was the'fit' between the child and the foster family. This related to the child's ability to form meaningful relationships and participate as part of the family. While this may appear to be placing a somewhat heavy burden on the child to fit in with the carer's family, the participants also indicated that the carers needed to have both the ability and motivation to connect with the child, care for the child and help the child to change their unhelpful behaviour. Researchers in the US also found that stable caregiving predicted stable placements, meaning that when caregivers were able to provide stable and consistent care for the young people, the placements themselves tended to be stable, with reductions in internalising and externalising behaviours over an eight year period (Proctor, Skriner, Roesch & Litrownik, 2010).

Foster family circumstances

Some researchers have suggested that a large proportion of placements end due to foster family related factors. Changes to the foster family's circumstances such as illness, death or birth of a new child can lead to instability (Sinclair, Wilson & Gibbs, 2005). The presence of additional foster children has also been linked to placement instability (Rock et al., 2015). Koh and colleagues (2014) found in their US sample of over 3000 young people that 35.5% of placement changes were attributable to foster family related factors, over half of which were related to maltreatment allegations against the carers, a quarter of which were substantiated. The authors did not provide details on the nature of the maltreatment allegations, or their impact on the young people. However, within residential care, carers can move on to different houses, leave their employment or take leave without it overtly affecting the placement of the young person. The

current research aims to begin investigating whether a change of carers, without a change of placement, has destabilising effects.

Foster carer satisfaction and support

Researchers in Australia (Whenan, Oxlan & Lushington, 2009; Wulczyn & Chen, 2017) and internationally (Mullins Geiger, Hayes & Lietz, 2013; Rodger, Cummings & Leschied, 2006) have found that satisfaction with the fostering role has a significant link to the decision to continue fostering. Satisfaction appears to link to the belief in one's ability to handle children's behaviours, feeling supported by the caseworker and agency, self-efficacy and social support (Mullins et al., 2013; Whenan et al., 2009). Pelech and colleagues (2013) found that increased caseworker contact predicted enhanced stability, with carers having a greater sense of being part of a team. Other factors such as access to sufficient funds and the predictability of ongoing support have a significant impact (Mullins et al., 2013). In Australia, Qu, Lahausse and Carson (2018) w interviewed over 2000 foster and kinship carers, finding that carers often felt supported and satisfied with their role, but there was a need for greater support and greater information pertaining to the young person in their care. They considered that these factors would improve carer wellbeing. Further, Wulczyn and Chen (2017) stated that children and young people living with carers who reported higher levels of stress and lower levels of feeling supported experienced more rapid placement changes and higher numbers of placement changes.

Mullins and colleagues (2013) shed light on the internal factors in foster carers that led to a satisfaction with fostering. They suggested that social support in terms of their family, friends and professional agencies had some of the most significant impacts. They further identified that an opportunity for respite was beneficial.

Specifically identifying factors associated with stability, Proctor and colleagues (2011) found that having a father-figure heavily involved was associated with stable placements. This may be related to, as observed previously, feeling supported by family and friends, as well as the agency, increased the likelihood of stability (Mullins et al., 2013; Rodger et al., 2006; Whenan et al., 2009).

Kin connection to child

Kinship placements appear to be more stable than foster placements (Chamberlain et al., 2006; Delfabbro, Fernandez, McCormick & Kettler, 2014; James et al., 2004; Rock et al., 2015; Wulczyn et al., 2003). According to Rock and colleagues (2015), this appears to be related to kinship carers feeling connected to the children "unconditionally" (p. 194). The stability may also be linked to factors underlying a family's capacity to look after kin, including a more stable extended family, which may make it more possible to care for a child who has been traumatised. Furthermore, placements with siblings appear to be more stable (Rock et al., 2015). This is significant as placements with siblings are also more likely to lead to reunification with a parent (Webster, Shlonsky, Shaw & Brookhart, 2006).

Placement type

It is a fairly consistent finding that kinship placements are more stable than foster or residential care placements, with lower rates of reunification in Australia (Delfabbro et al., 2014). This has also been found in the international literature (e.g. Courtney, 1994; Goerge, 1990; Winokur, Holtan & Valentine, 2009). It has been noted that this is particularly the case with placements with grandparents, likely because it is seen as a form of "pseudo-reunification" as the children are with members of the immediate family (Delfabbro et al., 2014 p. 369).

Residential care

Research has demonstrated that placement failures predict further failures (Chamberlain et al., 2006; Rock et al., 2015). Specifically, those in residential care, on average, are more likely to experience multiple placements (Rock et al., 2015; Ryan, Marshall, Herz & Hernandez, 2008). Using Australian POCLS data (Wulczyn & Chen, 2017), it was found that young people in residential care experienced the highest number of placement changes and the most placement changes per 10,000 days in care (which was adjusted for length of time in care). These data are difficult to interpret, however, because, of the

1,268 children and young people in the study, only 25 were in residential care. There-fore, there is insufficient power in the numbers to be able to provide a great deal of in-sight into this population. Nonetheless, the findings do accord with the general litera-ture. In the US, Ryan and colleagues (2008) examined the placement trajectories of over 20,000 youth in Los Angeles in both foster and residential care. The authors found that 62% of those in residential care had four or more placements, compared to 23% of those in foster care. Webster, Barth and Needel (2000) found that more than one move in the first year predicted further placement instability over an eight year follow up pe-riod in California, US.

Interestingly, Sunseri (2005) examined placement stability in California in the US in dif-fering types of residential care (from least restrictive to most restrictive, such as thera-peutic-based to secure care). The author found that more restrictive levels of residential care had less instability and preferable outcomes in terms of shorter stays and greater rates of returning home or moving into a home-like setting than less restrictive types of residential care. He speculated this may be linked to a better match between needs and service provision and greater therapeutic input for the needs of the young people. Fur-ther, though not speculated in the article, placement stability may be maximised be-cause staff in more restrictive types of residential care may have greater training and more realistic expectations of behavioural difficulties, making placement breakdowns less likely.

Jedwab and Shaw (2017) found that those who had been placed in residential care, once returned home, had a 1.7 times greater likelihood of returning to OOHC than those who were not in residential care. The authors speculated that placement in residential care would suggest greater emotional and behavioural difficulties that could not be accom-modated in less restrictive environments. Similar findings have been produced by Landsverk and colleagues (1996). Esposito and colleagues (2014), however, identified the opposite result, with their sample being more likely to experience reunification than those in other types of care. Their speculations were that either the young people expe-rienced therapeutic care that addressed their needs, or that they may have entered resi-

dential care as an emergency placement and therefore were quickly reunified or, alternatively, that the issues pertained to the child's behaviour problems, which the family may have developed greater skills in managing.

Despite these results coming from North American countries, they are likely to be relevant to Australian circumstances. Western countries appear to have a similar "last resort" (Ainsworth & Hansen, 2015, p. 343) approach to residential care, with low rates of use (Ainsworth & Thoburn, 2014). The conflicting results are interesting because they appear to depend on the cohort and the measurement. This indicates that the assertion that residential care is a negative environment may be in doubt.

Further, Barber and Delfabbro (2003) identified that of those in foster care in Australia, 15-20% have a large number of placements. This has been further supported by Wulczyn and colleagues (2003), with approximately a quarter of children having multiple placements in their US samples. It may be the case that a portion of these spend time in residential care as a result of insufficient foster carers (Withington et al., 2016) and, in particular, a dearth of willing to care for adolescents. As such, those who experience placement instability in foster care are likely to move into residential care, which, in and of itself, is a predictor of further instability.

It is difficult to assess, however, whether residential care is itself a predictor of instability or whether the child factors that contribute to instability are present more in those in residential care. It may be very difficult to safely care for and enhance the stability of those young people, in circumstances where multiple highly traumatised young people reside together. The research presented in this thesis seeks to determine whether stability can be provided and enhanced in such a complex environment.

Failed reunification

Reunification is an essential part of the stability literature. While it would appear, on the surface, that reunification is an end to the OOHC journey for many children and young people, studies based on US samples suggest that approximately 15-30% of reunifications fail and the young person returns to OOHC (Brook & McDonald, 2009; Font, Sattler

& Gershoff, 2018; Wulczyn, 2004). Jedwab and Shaw (2017) compared re-entry to foster care rates in the US for those who had previously had a failed reunification and those who were experiencing their first reunification. Their findings suggested that when a previous reunification had failed, the children had a greater likelihood of re-entering the foster system and girls with a previous reunification failure had a greater likelihood of subsequent reunification failure. They also found that infants had a higher rate of re-entry than older children or adolescents. The authors speculated that this was related to greater child protection involvement due to their vulnerability.

Conclusion

Multiple factors appear to influence instability in foster placements. These relate to the child and how they function within the foster care family, their behaviours and their mental health. Further, their age and length of time in OOHC appear to have an impact on their likely stability. Other factors relate to the family, including the reasons for being removed, the 'fit' between the young person and the foster family, and the circumstances surrounding the foster family such as the carer's health. Many of these can be managed or supported to increase the likelihood of stability.

Placement instability has a number of negative impacts on young people, both short and long term. Short-term effects include further placement instability (Chamberlain et al., 2006; Rock et al., 2015), sexual behaviour problems (Prentky et al., 2014; Tarren-Sweeney, 2008b), and a greater reliance on mental health services. Long term, these impacts include difficulties with executive functioning and decision-making (Beers & De Bellis, 2002), poorer mental health (Fawley-King & Snowden, 2013), and offending behaviour (Ryan & Testa, 2009). These effects appear to hold even when accounting for the type and timing of maltreatment. Placement instability in all forms of care causes significant and long-lasting harm to children and young people. Instability is a significant risk factor for a number of mental health and behavioural difficulties that a young person might experience, including anxiety and depression, contact with the criminal justice system and difficulties with executive functioning.

These long-lasting consequences that span many domains of life may be able to be re-mediated with stability, but to date the verifiable evidence is not available. The reasons for this lack of evidence are discussed in the following section, and provide the rationale for the present study.

3.10 Sufficiency of placements over time

Most of the researchers examining stability do so with the paradigm of placements over time. They may employ cut-offs of stability and instability, or develop categories based on numbers of placements, however, the essence of all of these methods is that the number of placements over a particular period of time is deemed to constitute stability or instability. This broad-brush approach to measuring stability and instability may ex-plain the lack of supportive findings for stability having a reparative influence. In the following section, I delve into this question with greater depth to discuss the ability of placements over time to adequately capture the experience of young people in residen-tial care.

3.11 Putting it all together

The previous chapters have provided a series of building blocks to provide an under-standing of residential care and its associated issues. The aim of this review was to build an understanding of the literature in order to shed light on the importance of this thesis' research question: "how do young people, who have lived in residential care, and resi-dential care workers define, understand and explain placement stability?"

This research is situated in an understanding of the nature of attachment, the impact of negative attachment experiences and the impact of trauma and maltreatment on the de-veloping brain. These theories and understandings allow an exploration of the idea that those in residential care likely have brain development that reflects early maltreatment and an experience of adverse attachment, resulting in behavioural and emotional diffi-culties that can make it difficult to remain in a single placement.

In this review of the literature, firstly, I analysed the residential care system and how it is placed both within Australia and internationally. This allows the reader to situate residential care as part of the OOHC continuum, with its similarities and differences over states and countries. Despite these differences, however, outcome studies across OOHC throughout the international literature demonstrate vastly similar results. Secondly, I detailed the current state of the literature on residential care. This challenged the evidence against the position that residential care is a "last resort" (Ainsworth & Hansen, 2015, p. 343), a position common in many countries. The evidence to date suggests that those in residential care do have the opportunity for positive outcomes and successful in-care experiences. Finally, the review included evidence to date on stability in the OOHC system. It was identified that there are multiple and varied adverse outcomes as a result of instability. What has not been demonstrated, however, are any particular reparative outcomes as a result of residential stability.

Stability has been typically measured as placements over time (Unrau, 2007). Given what is known about attachment and neurodevelopment, particularly in the presence of early maltreatment, it is not necessarily the case that a young person would experience a period of time as being stable, in the absence of the security of knowing how long the placement would last or who would be living in the accommodation with them over time. The attachment relationships that develop over time with the residential care workers are likely to be the conduit of the feelings of stability. Cashmore and Paxman (2006) reported that the feeling of security is more significant than a placement experience of stability, though these two often co-occur. Therefore, the feelings of security likely develop within attachment relationships that have a platform of predictability and consistency.

On the basis that attachment relationships are the conduit for the feelings of security and stability, it is likely that one of the reasons stability, as it is currently measured, is not demonstrating particularly reparative benefits is because stability is not being effectively measured. What is being measured is a point in time during which the young people have not had a placement change. This is fundamentally different to a young person experiencing "meaningful and trusting relationships" (Cashmore & Paxman, 2006, p.

238) in the context of a placement that lasts over time, with predictable caregivers and co-residents.

The following case examples provide an insight into the experience of young people in residential care who would likely be coded as stable by the standards of current researchers into placement stability. The case studies also demonstrate the lack of stability the young people would tend to feel within those placements, despite apparent stability on the placements over time scale. It should be noted that these are composite examples and do not reflect any particular young person in residential care.

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, none of whom he has a good relationship with. It is unclear who will be replacing the team member who is moving to another house. The new team leader, however, is someone he has met on one occasion.

Tallulah, a 16 year old girl, has ongoing difficulties with drug use and aggression. Her staff team have been fairly stable for the past six months, and she enjoys good relationships with them. Prior to this, there was some instability as the organization had restructured, with a shortage of permanent staff. All of the young people living in the house when she moved in, however, have moved out: one because he turned 18, another because she was incarcerated for theft offences and another because of assaulting one of the staff members. Currently, Tallulah is waiting to find out who will be moving into the bedroom next to hers.

Ben is 13 and lives in a house with three other boys, all of whom can be quite aggressive and have long criminal histories. 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, familiar casual staff are hard to get so agency staff are often called in as replacements. For example, Ben may expect that Bill is on shift today, but

there is only a 50% chance that Bill will attend. If he does not, there is about a 70% chance that Ben will not know the staff member who does arrive. 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 during the day or to visit once a week.

These case examples were designed to demonstrate that what may overtly appear to be a stable placement may not feel like a stable placement to the individuals within it. These examples were also designed to form a continuum from more stable to less stable. Understanding stability in residential care requires a detailed examination of many moving parts, and the narrow operationalization of stability by counting placements ignores those complexities.

The purpose of this thesis is to examine stability as a construct in detail. In this research, I argue that the construct of placements over time does not constitute stability, nor does it necessarily allow a young person to feel stable or secure. Therefore, the extant literature examining stability has failed to take into account the importance of attachment, both in terms of the theory of attachment and in the practical sense of forming meaningful attachments. As a result, it makes sense that while instability leads to negative outcomes, to date, stability has not been shown to provide an enriching or curative effect to demonstrate any improvement in outcomes. This is a result of the construct of stability not being effectively measured.

In the current chapter, the extant literature has been examined through an exploration of the varied forms of residential care, both within Australia and internationally, and via an overview of the evidence related to stability within residential care and its associated outcomes. This chapter concluded with a discussion of the relationship between attachment, neurodevelopment and the literature and an exploration of case studies that exemplify the importance of a more nuanced exploration of stability, particularly in residential care. In the next chapter, the methodological approach is discussed of this research to answer the research question: "how do young people who have lived in residential care and residential care workers, define, understand and explain placement stability?"

Chapter Four: The Road Less Travelled: An Exploratory Approach to Residential Care

In this chapter, the methodological approach is explained for the current research, along with the rationale for taking that approach. In this chapter, initially the research question and associated aims are explored, followed by a discussion of the researcher's worldview and an outline of the ontological and epistemological positions that underpin the research. Understanding the researcher's perspective allows the reader to be aware of the researcher's biases and thought processes with regard to the research process. The chapter then moves to the practical 'doing' of the research, where I address the ethical challenges confronted and managed, the research design, sampling strategies, recruitment and data analysis. The overall methodology was informed by previous research, both with respect to the concept and methods, and this is referred to throughout the chapter. The chapter concludes with a brief description of the participant demographics and an assessment of the limitations and strengths of the research design.

4.1 Research question

The question that this study seeks to answer is: *how do young people who have lived in residential care, and residential care workers, define, understand and explain placement stability?*

The research question was designed to be able to achieve the aims of the research.

4.2 Study aims

Given the current limited conceptualization of stability, as being measured by a paradigm of placements over time, based largely on data from foster care, this study has two distinct aims. The first is to:

a) Better understand placement stability and instability in residential care specifically, from the expert perspectives of the young people and staff involved.

Secondly, with this data the researcher seeks to:

b) Develop a multi-dimensional operationalization of stability for young people in residential care, taking into account that stability may comprise more nuancing than a framework of placements over time.

The following diagram encapsulates the study's underpinning framework. It demonstrates the integration of the concepts which have shaped this study. Drawing from Grix's (2002) ideas about the building blocks of research, it is clear that the researcher's worldview shaped the development of the theoretical lens and methodological approach, which, in turn, frames and justifies the data collection and analysis. This chapter offers an outline of each of these elements and how they intersect with each other. As discussed in Section 1.5, the researcher's personal and professional experiences of working in residential care, from a trauma-informed approach, shaped the constructivist approach to this study. The experience of working in residential care provided an understanding of a setting that is inherently changing and changeable, where the experiences of the young people ranged from positive to extremely negative. This led to the conclusion that what the individual experiences was the most significant element for that individual's outcomes. Therefore, the need to understand this individual experience more deeply formed the baseline for the current research.

Figure 1: The researcher's worldview and development of the methodological approach
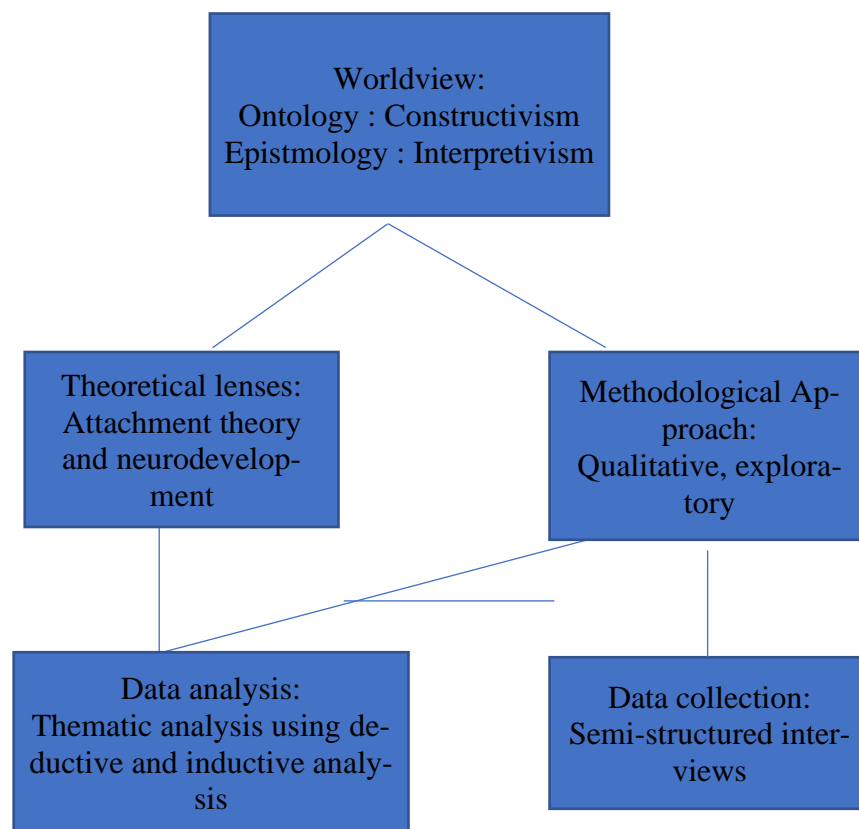
4.3 Researcher Worldview

Ontological position

As discussed by Grix (2002), ontology underpins epistemology, which leads to the development of the methodology, which directs the selection of the methods. In order to understand how the research question and research aims came into being, the ontological and epistemological position of the researcher need to be clearly stated and understood. Brinkmann (2018) identified ontology as the study of being – of what there is to know. Epistemology then follows as a study of how we can know what there is to know; whilst methodology is how we go about the knowing (Grix, 2002).

The author's ontological position is one of social constructivism (Grix, 2002; Protrac, Jones & Nelson, 2014), which asserts that social phenomena are in a constant state of revision as they are constructed by the process of social interaction. According to Derry (1999), in social constructivism, the focus is on developing an understanding of the culture and context that contributes to an individual's experience. Individuals' histories, experiences and cultures shape their experience of the world and their learning within it (Gredler, 1997). This premise aligns with the theoretical underpinnings that have shaped this thesis, of attachment and neurodevelopment. Both theories are predicated on the assumption that an individual's experiences shape their development.

The experience of residential care is inherently related to social interactions, in the form of the day-to-day interactions between staff and young people, and the interactions of the individuals with their own histories. The current research's aim is to understand how individuals make sense of their experiences of stable and unstable placements and relationships to formulate a coherent sense of what elements constitute stability. The model developed as a result of this research is, therefore, inherently the subject of review, revision and redevelopment, as new findings emerge or are clarified. The model forms a guide rather than a rulebook.

Epistemological position

The ontological position of social constructivism lends itself to the epistemological position of interpretivism. Epistemology embodies the study of how we can know what there is to know. In the case of interpretivism, the focus is on developing understanding of the experiences of individuals and groups (Protrac et al, 2014). This position allows the researcher to discover what can be known about what constitutes stability for those in residential care, through understanding the subjective experience of those who have lived experience of residential care. This moves the examination from the focus of the existing literature on a foster care cohort measured at a particular point in time, to exploring a complex interplay of relationships among residents and staff in relationships over time. It takes into account the residents' histories of instability, maltreatment and attachment ruptures.

Interpretivism focuses on understanding and explaining human behaviour and experience alongside how the individuals make sense of that experience (Bryman, 2012). Furthermore, interpretivism tends to include the view that the social world is constructed within an individual's own experience, such as through their interests, emotions and values (Protrac et al, 2014). This approach posits that individuals interpret their experiences based on their histories and, through doing, interpret the intentions and motivations of the self and other/s (Smith, 1989). It is clear that interpretivism is an appropriate epistemological fit for the research question to be investigated and lends itself to the chosen methodology. Protrac et al., (2014) identified that interpretivism has proved to be particularly useful as an epistemological position for the methodology of in-depth interviews which are often appropriate for exploratory research (Flynn & McDermott, 2016).

Given the nature of the current research and the fact that I investigate the concept of stability at the level of definition, the research has to be considered exploratory. The current research is designed to generate knowledge and build from a limited base. Taking an interpretivist approach to generating new knowledge will allow for the research to "say the first word, not the last word" on this novel area of exploration (Flynn & McDermott, 2016 p. 88). Therefore, the fit between the ontological position, the research question and the epistemological position of interpretivism is logical. The conceptual framework also brings a theoretical lens, with two theoretical perspectives as indicated in Figure 1. This is discussed in detail in Section 4.4.

4.4 Theoretical perspectives: Attachment and neurodevelopment

The theoretical perspectives framing this study were discussed in detail in Chapter 2. These perspectives are considered to be so crucial to understanding the nature of the population that they were used as a lens through which to interpret the extant literature. These theories also shape the study's methodology, including ethical practice and methods, as well as the analysis of the data. Patton (2015) describes this type of study as being theory-oriented.

From a social constructionist and then interpretivist perspective, our knowledge of the world is shaped by the act of knowing about it. From an attachment perspective, our interpersonal functioning is related to our early experiences of nurture and care from primary caregivers, which enables us to relate to others and regulate ourselves and our emotions (Schore, 2001). From a neurodevelopmental perspective, early input shapes the later development of cortical structures, with inputs at certain times leading to particular outputs (Perry & Pollard, 1998). The theoretical overview in Chapter 2 provides the grounds for understanding how attachment and neurodevelopment intersect. Attachment provides the comfort and support to promote healthy brain development, which feeds back into the development of age-appropriate self-soothing and skills in interpersonal relationships, all of which is impacted when attachment is disrupted and brain development does not occur optimally. The epistemological and ontological perspectives taken by the researcher have influenced the development of the methodology to answer the research question.

Theory as a guide to understanding and approaching the study population

An understanding of attachment and neurodevelopment also shaped the study's approach to methodology and methods. The ability to garner information relates to how questions are asked, of whom they are asked and the willingness of the person asked to provide answers. The attachment systems that have developed within young people in residential care, due to their early experiences of caregiving, likely fall on the insecure/disorganized spectrum (Schimmentti & Caretti, 2016). It is probable that the young people have had experiences that lead to adaptations, which whilst ensuring early survival, have impaired their later abilities to relate, regulate their emotions and use the power of the cognitive brain (Schalinski et al., 2016).

An understanding of attachment theory and neurodevelopment also informed the approach taken with the young people, which is discussed further in Section 4.5. This involved providing choice for the young people about where and when interviews would be held, explaining the rationale of the research, giving the opportunity for breaks, and maintaining a sensitivity regarding asking difficult questions that the young people may

either be unwilling to answer or unable to answer. For example, a number of young people were unaware of their reasons for entering OOHC, so approaching this question required sensitivity. A plan was developed for managing difficult emotions and any apparent drug or alcohol affects during the interviews.

Theory as guide to shaping the data collection and data analysis

In the current research I rely on these theoretical positions to develop an understanding of stability and instability that draws from the attachment and neurodevelopmental literature. The theories have been utilized, firstly, in the development of the instruments used in the research, that is, the demographic questions and the interview questions, which are discussed in Section 4.11. The attachment and neurodevelopmental literature allowed for an understanding of the importance of relational bonds for individuals generally and for young people who have been exposed to trauma specifically (Schore, 2001). These insights were then used to develop a line of questioning that would explore the impact of relational bonds and the severing of those bonds in a residential care context.

The theoretical lenses have also shaped one aspect of the data analysis, using a deductive process (Braun & Clarke, 2006; Clarke, Braun, Terry & Hayfield, 2019; Linneberg & Korsgaard, 2019). Core theoretical concepts were used to code and analyse the data at a latent level, in order to identify underpinning themes (Braun & Clarke, 2006), such as the importance of consistent relationships and a predictable routine. Braun and Clarke (2013) opined that in developing deductive or researcher-derived codes, conceptual and theoretical frameworks are used to identify the implicit meanings within the data. According to Linneberg and Korsgaard (2019) a deductive approach allows the theory to be relevant from the beginning of the analysis, whilst still allowing for inductive exploration of the data to ensure that the codes and themes that emerge are true to the data. In the current research, the data analysis strategy involved allowing the theoretical lenses of attachment and neurodevelopment to underpin the reading of the data in the initial phases whilst still allowing ideas to emerge through inductive processes. These theories gave a means to understand the responses from the staff participants,

many of whom espoused similar ideas but used different language to communicate them. This is discussed in Chapter 6.

The theoretical lenses were similarly used in an early reading of interviews with the care leavers, who did not use the language of attachment and neurodevelopment. Therefore, the early development of codes was shaped by the theoretical lenses (Clarke et al., 2019). Second and subsequent readings of the data involved an inductive approach, wherein the themes revealed themselves and were coded based on the frequency and significance of the comments. Furthermore, Clarke and colleagues (2019) discussed the use of a latent analysis that allows for developing an understanding of the concepts that underpin the interviewee's words.

4.5 Marginalized populations and sensitive topics

Marginalized populations are groups of people who are often considered to be invisible or stigmatized (Hurley, 2007). Topics are considered to be sensitive based on a number of criteria, such as if participation could result in stigmatization, if results could negatively impact a social group, if the research challenges deeply held values, or, as in the case with the current research, that the research may either induce or exacerbate existing distress (Burke Draucker et al., 2009). Furthermore, Lange, Rogers and Dodds (2013) contended that all research participants have some level of vulnerability, however, some individuals experience 'more than ordinary' vulnerability (p. 336). The authors provided guidelines to determining levels of vulnerability, and when applied to a residential care leaver population, the specific vulnerabilities would be *inherent,* given the participants' ages, coping strategies and attendant social supports and *pathogenic* which are characterized by histories (among other things) of abuse, neglect and/or injustice. These particular vulnerabilities are not necessarily applicable to each individual who has experienced residential care or who participated in the current study. However, they are likely to apply to a large number of the specific population and were therefore used as a guide to ensure ethically defensible practice.

Research with marginalized populations has specific challenges and rewards. In line with the ethical principles of beneficence and justice, working with this population allows for voices to be heard that may otherwise not be (NHMRC, 2018). It also provides an opportunity to advocate for an equitable distribution of resources so that marginalized, stigmatized or 'invisible' populations are also considered when developing policy and practice.

A participant-centred approach (Mudaly & Goddard, 2006) in research seeks to minimize power differentials between researcher and participant in the research sphere. This is important when working with children and other potentially vulnerable populations (Morris, Hegarty & Humphreys, 2012). Despite the current research only involving interviews with adults, given the early life experiences and difficulties experienced by the young adult care leavers, it was a priority to ensure minimal power differentials and the emotional safety of the participants. In the current research, this was achieved through placing the young people as experts regarding their own experience, with the researcher wanting to know about their thoughts and opinions. Furthermore, the researcher also liaised with the participants about the need for breaks, scheduling times and days and locations of interviews to best suit the participants' needs, as recommended by Moore, McArthur, Roche, Death and Tilbury (2016) based on their research with young people in residential care.

Research on sensitive issues requires some significant preparation. Burke Draucker and colleagues (2009) conducted a brief review of the literature on research into sensitive issues such as suicide, trauma and psychiatric illnesses. They identified that two analyses had been conducted, one systematic analysis of 46 studies (Jorm, Kelly & Morgan, 2007) and a meta-analysis with 12 studies (Newman & Kaloupek, 2004). In both of these studies, it was reported that, in general, participants perceived personal benefits from the research: feelings of catharsis, feelings of empowerment and the sense that they may have been able to help others (Burke Draucker et al., 2009). Furthermore, both research groups found that only a small proportion of participants reported any distress regarding their participation (<10%; Jorm et al., 2007), and a small proportion of this reported some regret about it (Newman & Kaloupek, 2004). Furthermore, Burke Draucker et al. (2009) concluded that in general, few participants experienced distress

and those that did were typically distressed prior to research participation. This is further discussed in relation to the current study in Section 4.6.

This sentiment had also been presented in earlier work by Becker-Blease and Freyd (2006), who noted that research findings suggested that only a small percentage of participants who had been asked about stillbirth experienced distress, and of these, the vast majority found participating in the research helpful, despite the distress. This notion is in line with the ethical principle of autonomy (Burke Draucker et al., 2009) which encourages inclusive rather than exclusive approaches to research participation. This principle is that, providing ethical considerations have been addressed (particularly about the research's benefit), and participants are appropriately briefed about what they are likely to undergo during participation and are aware of the possible issues that may be discussed (in this case, a young person's experience of residential care), they should be given the opportunity to elect to participate or not, rather than researchers being over-zealous in their desire to prevent any distress occurring on the part of the participant. Provided participants are competent to consent (or assent in the case of minors), their autonomy should be respected.

In the current research, the sensitivities of vulnerable care leavers discussing their experience of residential care were managed through providing them comprehensive, clearly written and accessible explanatory statements, consent forms that were explained in detail including discussion around the statements contained within as needed, and the protection of their confidentiality through pseudonyms. Further, as discussed in Section 1.5, the primary researcher conducted all the interviews, and has a master's degree in psychology with over seven years' experience in conducting assessments and treatment of individuals who have experienced trauma and abuse. This allowed for an ongoing assessment of the individual participants' wellbeing throughout the interview and the ability to liaise with the participants about how they felt afterwards, including making any referrals as necessary.

4.6 Ethics

Conducting any research requires an awareness of undertaking research ethically. This research was approved by the Monash University Human Research Ethics Committee. See Appendix 1 for a copy of the certificate.

Engaging in ethical research, however, requires more than seeking approval from an ethics committee. In order to ensure that the highest standards of ethical practice were undertaken, the Australian Association of Social Workers Code of Ethics and the National Statement on Ethical Conduct (NSEC) were consulted (Australian Association of Social Workers [AASW], 2010; NHMRC, 2018). It is noted that there is a more recent version of the AASW Code of Ethics (2020), however, this research was developed in line with recommendations from the 2010 version. Ethical research should be based on the four cornerstones of human ethics: autonomy/respect, beneficence, non-maleficence and justice (AASW, 2010; Burke Draucker, Martsolf & Poole, 2009; Declaration of Helsinki, 2018; Hillier, Mitchell & Mallett, 2007; NHMRC, 2007). These are outlined in detail below with reference to the current research.

Autonomy and respect

Autonomy and respect, as discussed by Hillier and colleagues (2007), is not simply the achievement of informed consent. Rather, it encompasses a respect for all participants' autonomy and respect for their wellbeing, including the language used, research design, portrayal of the participants in the write-up phase, as well as ensuring informed consent and participant awareness of how and when they can withdraw their consent. Burke Draucker and colleagues (2009) also take into account allowing participants to decide whether they are able to participate, rather than assuming they are unable to participate, particularly participants who have a reduced capacity for self-protection. Therefore, respect and autonomy are predicated on the assumption that individuals have a right to self-determine whether to participate in research and under what conditions (within the scope of the research). They also have the right to be treated with respect by the researchers concerning how they are talked *about*, in terms of structuring questions and in writing up the research, and how they are talked *to* whilst the research is conducted.

In the current research, the ethical principle of autonomy and respect was upheld through a number of means. Firstly, informed consent was obtained (see Section 4.7 and Appendices 2 and 3). This process (Hillier et al., 2007) involved ensuring the participants were aware of the required undertakings in the research, as well as the possible risks and benefits that may come from their participation. The risks that the participants were informed about included experiencing possible distress, whilst the benefits were understanding stability more effectively, to develop policies and procedures to enhance it.

Secondly, respect and autonomy were ensured by protecting participants' confidentiality with pseudonyms, assigned if not self-selected. This is discussed further detail in Section 4.7. Thirdly, respect and autonomy were ensured by following Burke Draucker et al.'s (2009) advice to have eligibility criteria that were broadly inclusive, so a wide range of care leavers could participate. Burke Draucker et al., (2009) argued further that, in seeking to have 'no risk' of harm to participants, such as by removing any possibility of distress, these individuals are denied the right to participate in research.

These decisions must be balanced against issues such as promoting autonomy: allowing participants to determine whether they are willing to bear any risk of distress gives them the right to participate (Burke Draucker et al., 2009). Based on the theoretical underpinnings, it is understood that young people who have experienced trauma may struggle with considering the consequences of their choices and managing their emotions. As such, the researcher formulated a management plan, based on many years of working as a masters level clinician, with survivors of trauma. Risk mitigation and reduction strategies were implemented, (see Section 4.6) to ensure participants were not excluded unnecessarily. The eligibility criteria are also discussed further in Section 4.9.

Finally, autonomy and respect were ensured by participants choosing the time, day and method of interview best suited to them. For example, one was interviewed over the phone whilst the primary researcher was on holidays overseas because the participant was 38 weeks pregnant, and had three other children in day-care only on certain days, the next of which fell on a public holiday. Therefore, so that she could participate in a

convenient and suitable way, the interview took place over the phone whilst respecting time differences.

Beneficence and non-maleficence

Beneficence is understood to mean "to do good" (Hillier et al., 2007 p. 33). Hillier and colleagues (2007) discuss this requires the researcher to consider what is good, and good for whom? Whilst for the researcher, completing the research is likely a 'good' outcome, this is not necessarily a 'good' outcome for research participants. Therefore, what constitutes good enough beneficence to warrant undertaking the research involved considering the value for individuals and organizations of obtaining the information about a previously unexplored topic. Although non-maleficence, the principle of doing no harm (AASW, 2010; Burke Draucker et al., 2009; Hillier et al., 2007; NHMRC, 2007), is often collapsed with beneficence, they are fundamentally different (Burke Draucker et al., 2009). Doing no harm is not the same as doing good, and in fact, both harm and good can be done simultaneously. Therefore, as ethical researchers, both principles should be considered.

In the current research these principles guided the research. Sensitive topics may induce some distress in participants, particularly as they may be recalling difficult periods. In the current research, beneficence was ensured through two strategies. Firstly, young people who were consumers of the service were engaged, to ensure their voices were heard. These participants were able to convey their experiences and opinions and were held up as experts, with their knowledge actively sought. Secondly, beneficence was upheld by ensuring that something unique was contributed to the literature that may have positive policy and practice implications, for example, an improvement in residential care sector standards.

In addition, and to also address non-maleficence, in line with Burke Draucker and colleagues (2009), protocols were put in place to ensure that any potential risk of harm was minimized. These included: identifying any participants who were assessed by the researcher as highly distressed at interview and offering to reschedule (though this did not need to occur in actuality); monitoring distress during the interview and offering

breaks as necessary; and providing details of services participants could follow up if needed once the research was concluded. The researcher, an experienced masters level psychologist, conducted all interviews and monitored distress levels throughout. Furthermore, former residential care residents were targeted as participants, rather than current consumers of residential care. This is because they were thought to have achieved some emotional and temporal distance from their experience, and were more able to reflect on a past experience rather than discussing their current experience.

In order to ensure the greatest beneficence and least possible maleficence, a distress protocol was established for participants' safety. In line with Burke Draucker and colleagues (2009) and Moore and colleagues (2016), research with children and young people regarding sensitive issues can be safely enacted provided safety protocols are in place. The following is a summarized list of protocols to ensure the safety of the participants:

- A master's level clinician conducted all interviews.
- All participants were given the opportunity to discuss the consent form in detail.
- Participants were clearly informed about their rights to withdraw their consent.
- Participants were monitored for their distress at the start, during and at the conclusion of the interviews.
- Participants were given the option of rest breaks as needed.

Justice

Justice is the fourth and final ethical cornerstone. Justice relates to the "distribution of risks and benefits of research within the community" (Hillier et al., 2007 p. 52). This means that research should not consistently benefit one part of society whilst other echelons are either unable to participate or systematically ignored, either due to difficulty with recruitment or with achieving a powerful enough sample size. This is particularly salient for marginalized or vulnerable populations who may feel that their voices are not heard. Therefore, for justice to be upheld, individuals for whom there are benefits should be able to participate in research.

Justice in the current research

In the current research, in line with the principle of beneficence, young people who were engaged with residential care services were invited to participate in research about their experience. Similarly, staff members at all levels (from youth workers to managers) were invited to participate. Ethical researchers must also undertake to accurately represent the participants' views and opinions. As Stuart (2001) notes, as a researcher, it is important to treat participants with fairness and justice so that the research methods recognize the insights of the participants, rather than researchers simply interpreting and presenting results in line with their own viewpoint.

4.7 Informed consent

Given the sensitivity of the topic and the vulnerability of the care leaver population, a range of issues about informed consent were raised. As discussed by Hillier and colleagues (2007), obtaining informed consent as one way of operationalizing respect and autonomy is a *process* rather than a one-off 'check box' event to obtain a participant's signature. In the current research, this involved a three step process.

Firstly, potential participants were provided with a written explanatory statement (see Appendix 2), that was free from jargon. This was given ahead of the interview, to ensure the participants were aware of what the research involved. Secondly, a written consent form (see Appendix 3) was given for participants to initial or tick and sign at the end, to acknowledge their consent. It was either provided in person, or emailed to the participants for their records. Thirdly, at the beginning of the interviews, the researcher read the consent form with the participant to ensure the participant understood what was involved in the research, to confirm obtaining consent.

As all participants were over 18, and therefore legally able to give their own consent, the researcher had to assess and negotiate whether an individual had the capacity on the day to give informed consent. This included evaluating whether a participant was

affected by drugs or alcohol, or whether there was a sufficient cognitive impairment that they were unable to do so. Under these circumstances, the interview may have been rescheduled, or a support person may have become available for the participant. On one occasion, a participant had been scheduled for an interview, however, had experienced a significant personal stressor the night before. In this instance, the participant assessed himself as unable to participate. The interview was postponed until the following week. To confirm an individual's ability to consent, in line with Hillier and colleagues (2007), at the commencement of each interview, the researcher went through the explanatory statement and consent form step-by-step with the participant, who would be asked to repeat back in their own words what was said and what it meant for them.

Young care leavers were offered a $30 gift card as a token of appreciation. These redeemable at various retail stores, including Big W, Target, Woolworths etc. These were given at the beginning of the interview, so that they did not act as an inducement to participate, should the participant wish to withdraw consent. The consent form itself specified the ability to withdraw their consent to participate either during the interview, or any time up to four weeks after, the right to stop the interview completely, or to stop for a break as needed.

Confidentiality and privacy

Confidentiality is the legal requirement for maintaining an individual's privacy (Declaration of Helsinki, 2018; Morris et al., 2012) and is often found in professional relationships where there is a power differential, such as with a doctor, solicitor or psychologist. In research, confidentiality constitutes the requirement to protect a participant's identity to the extent that is realistic, given the nature of the research. For example, in quantitative research, typically grouped results are presented based on a large number of respondents' answers to various questions. In qualitative research, however, confidentiality is maintained differently, as participants' words are often used as the data. This is sometimes referred to as quasi-anonymity (Keeney, Hasson & McKenna, 2006). Therefore, confidentiality is often maintained by the use of pseudonyms and, as relevant, grouping data, for example in age groups (such as 10-13 years; over 35 years). In

the current research, participants were informed that their confidentiality would be maintained by using a pseudonym, and any identifying information, such as the names of organizations or suburbs, would be removed from any chosen quotations.

Participants were also informed they had the opportunity to read over the transcript of their interview if they wished. In practice, none elected to do this. In line with Stuart's (2001) thinking, the maintenance of confidentiality is paramount. As mentioned above in the discussion of autonomy in Section 4.6, participants were assigned a pseudonym, unless they had selected one. Confidentiality was also maintained through ensuring a pseudonym was linked to any paperwork or recorded interview. Further, documents and recordings were stored on a password protected computer only accessible by the research team.

Managing disclosures

In line with Stuart's (2001) approach, protocols were developed to respond to any allegations of historical or current abuse that may be made by the participants in the interviews. The explanatory statement outlined disclosures that would not remain confidential, such as any threats to harm oneself or another, any allegations about harm to a child, or any serious crimes that may have been committed. It was clarified that, should there be any such disclosures, participants would have a right to have a say in how these were handled, however, they could not remain confidential. If the disclosures were about historical events, such as historical sexual abuse, the protocols for managing these disclosures included identifying the level of support the individual was already receiving, discussing the disclosure with an appropriate support person for the participant and seeking support and advice from the university to develop a plan consistent with the NSW Children and Young People's (Care and Protection) Act (1998).

4.8 Research design

The constructionist-interpretivist approach to research, as discussed previously, lends itself readily to exploratory research (Protrac et al., 2014) because this approach allows

data to be collected that is grounded in the personal experience of the individuals. Exploratory research is typically the entry point for examining a particular topic where there may not be an established 'best practice' approach. Exploratory research, according to Flynn and McDermott (2016), is primarily used when there is little research on a particular topic. The authors explain that such research is aimed at discovering knowledge about an issue and identifying key variables related to the research phenomenon. Typically, data is sourced from 'experts' in the field, with in-depth data collected from those with lived experiences (Flynn & McDermott, 2016). The current exploratory research is an attempt to identify potential variables associated with placement stability in residential care.

In relation to the current study, the issue has been examined in the existing literature, to a vast extent, only in foster care, as discussed in Chapter 3. Therefore, any examination of this issue in residential care is largely exploratory. To add to this, the historical view of placement stability as encapsulated by placements over time is challenged in this research. Therefore, the research is exploratory on two fronts: firstly, to explore this issue in residential care as a largely new setting and secondly, to explore the meaning of stability for participants who have lived and worked in residential care. The purpose of this exploration is to develop a framework for operationalizing stability that captures the complexity of residential care and the development of a sense of stability.

As discussed by Crotty (1998) and Grix (2002), following on from the research question, which is shaped by the study's epistemology and ontology, is the selection of the methods. To answer the research question, a qualitative approach was identified as offering the greatest opportunity to explore the perspectives of individuals who have been service users, staff and service providers in the residential care sector- namely, those who lived in it and those who work(ed) in it. Given this research is exploratory, qualitative methods provide an opportunity to develop an in-depth understanding of the meaning of stability for young people and staff in residential care. Qualitative methods have the ability to capture "theoretically richer observations that are not easily reduced to numbers" (Rubin & Babbie, 2013 p. 40); these are particularly suitable when studying a relatively unknown phenomenon (Rubin & Babbie, 2013).

As discussed in Section 3.1, many individuals are involved in residential care: other residents, rotating staff, managers and those in the overseeing funding bodies, all of whom play a role in the life of a young person in residential care. Merely counting a child's placements and examining their outcomes on that basis fails to capture that complexity. This is because an individual may not experience a vast number of placements, but if the staff and other residents continue to change, the individual's experience of stability may be more akin to a young person who experiences multiple placements. As stated earlier, this research is aimed at developing a specific understanding of what constitutes stability for a young person in residential care. This in-depth understanding of stability (and instability) is best sought through qualitative interviews with experts in their field, consisting of staff and young residential care leavers.

A qualitative approach was considered to provide the greatest depth of knowledge on a topic virtually without focus in the extant literature. To date, research into stability has only been conducted in foster care, where the experiences of young people and their carers were examined (Koh et al., 2014; O'Neil, 2012; Unrau, 2007; Wulczyn & Chen, 2017). Very few researchers have examined what elements constitute placement stability. Therefore, open-ended and semi-structured interviews were considered to provide the most fertile ground to begin to understand this phenomenon.

4.9 Sampling

The sampling strategy for the current study is best described as non-probability sampling, meaning that individuals were selected as "fit for purpose" rather than as representative of the wider population of young people or workers in residential care (Flynn & McDermott, 2016 p. 103). This sampling strategy fits with an exploratory research design (Flynn & McDermott, 2016) and was considered the most appropriate.

In the current research, two approaches were taken to sampling: purposive and snowball sampling (see below). The nature of exploratory research, as discussed earlier, means that specific expert individuals can be targeted to develop an in-depth understanding of the issue to be explored. Therefore, participants were selected on the basis

that they had either lived in or worked in residential care. As such, the views of young residential care leavers and staff across all levels were sought.

As indicated above, in the present study, two types of sampling were specifically undertaken, to reduce the bias of both and increase the likelihood of recruiting sufficient participants. Purposive sampling is driven by the researcher to select cases that may be useful to the study (Flynn & McDermott, 2016). In this case, this was targeted at identifying participants from different organizations who had different work histories, ideally in different geographical locations, to allow for greater heterogeneity. In regard to recruitment of young care leavers, participants were sought who ideally experienced different levels of instability, from different organizations, in different geographical locations. Further, certain groups were deliberately over-sampled (Rubin & Babbie, 2013). This is known as maximum variation sampling (Flynn & McDermott, 2016), a specific type of purposive sampling to ensure that different perspectives were heard. For example, whilst the majority of staff working in residential care tend to be floor staff, management, upper management and clinician perspectives were also deliberately sought.

Snowball sampling involved seeking an individual who fits the research criteria (see below and also Section 4.10), and asking that individual or those initial individuals to identify further participants who meet these criteria (Flynn & McDermott, 2016). According to Flynn and McDermott (2016), this particular approach is often used to access hidden or stigmatized groups. They noted, however, the sample can be somewhat homogeneous because of the connections between the participants. These approaches dovetailed, typically with staff members identifying young people they remained in contact with, and providing the researcher's details to the young people if they wished to participate.

Inclusion/exclusion criteria

The following criteria were developed to guide sampling. In line with the recommendations of Burke Draucker and colleagues (2009), inclusion and exclusion criteria were developed to be as inclusive as possible, rather than limiting the potential pool of participants and thereby limiting their autonomy to self-determine whether to participate.

Two specific groups were sought, to ensure a balanced perspective from both users and providers of residential care: young people who have a lived experience of residential care and staff who currently or previously worked in residential care.

Young people:
Young people were sought who

- had left OOHC in the past decade and had experience of living in residential care in NSW, and
- were fluent in English and did not require the services of an interpreter.

The exclusion criteria for this group were as follows:

- Individuals with current high levels of distress.
- Those who were unable to give informed consent, either due to being affected by drugs or alcohol or an intellectual impairment.
- Individuals who were likely to experience high levels of distress associated with discussing details regarding their experiences in residential care.
- A final criterion that was not universally applied, but constituted a part of the risk assessment, was whether the individual had any support available. If the other exclusion criteria were not met, however, and they identified the lack of a support network, this would not preclude their participation. This criterion simply formed part of the risk assessment for an individual's participation.

Staff:
Residential care staff members were sought who were

- currently working or had previously worked in residential care in NSW.

The experience of distress associated with discussing their work in residential care is likely to be less, given they are not discussing their own potentially traumatic experiences. This would theoretically reduce the likelihood of their experiencing high levels of

distress on participation or as a result of participation. However, if they appeared to be distressed, the interview would be rescheduled.

4.10 Recruitment

Participants who fell into one of two categories were recruited: individuals aged 18-25 years who had left care in the past decade and had experienced residential care in NSW; and individuals who currently or previously worked in residential care in NSW. The specific parameters for the residential care leavers were selected for two reasons. Firstly as the participants would have left OOHC in the recent past, their experiences were relevant to current residential care practice. Secondly, given they had left care, they were also in a position to reflect on their past experiences of residential care with some distance. There was no limit on the shortest time after leaving care for participants' eligibility. Any individuals who indicated an interest in participating but had not yet left care were contacted after their 18th birthday.

The young people and staff were recruited for participation via connections made to the organizations which supported or employed them, respectively. The recruitment was conducted by two processes. Firstly, the research study was advertised through organizations which either employed residential care staff or supported youth in care and young care leavers. These organizations were initially provided with a flyer and explanatory statements regarding the research. The key individuals to be contacted were identified either through publicly available information on organizational websites or through professional networks. They typically worked in managerial positions within the organizations. These individuals then provided details about the study, including the researcher's contact details, to potential participants. Advertisements were disseminated both online via social media and through contacts. Organizations targeted included residential care organizations such as Marist 180, CareSouth, CatholicCare and Lifestyle Solutions, and organizations designed to support young people in care and those who have left care, such as the CREATE Foundation. Key personnel were provided the details via email, with follow up conversations over the phone with the primary researcher.

Secondly, those who participated were asked if they could identify anyone else who met the study criteria and may be interested in participating. Interviewees were then asked to provide the researcher's details to these potential participants, should they wish to contact the researcher about the study. This two-tiered strategy ensured that individuals, particularly young care leavers who are more vulnerable, were not coerced into participating. It also allowed for a greater number of young people to be contacted as this is a population particularly difficult to reach.

There are many challenges when seeking to conduct research with marginalized and vulnerable populations. Furthermore, residential care, as discussed in the literature review, only accommodates a very small subset of the OOHC population. For example, in NSW as of June 2019, there were 517 young people in residential care out of a total of 16,067 young people in OOHC (AIHW, 2020, Table S5.3). Therefore, not only are there few individuals who would be able to participate, those who have been in residential care experience significant adversity, including poverty and homelessness, making it especially hard to recruit from this population. To overcome this, this multifaceted recruitment strategy was employed.

Recruitment of staff members was less complex, with a range of potential participants presenting as willing and available to schedule interviews. Recruitment of young people, however, was extremely challenging. Initially two interviews were undertaken and then it took several months to identify any further individuals willing to participate. All in all, the recruitment of residential care leavers took many months. It required patience and reaching out to multiple organizations for support with recruitment.

4.11 Data collection procedure

Data collection took place in NSW between February 2019 and August 2019. It involved two components:

- collecting demographic information from participants

- engaging in semi-structured interviews (see Appendix 4)

The demographic data collection tool and semi-structured interviews were developed by the candidate based on the literature review, the overarching theories of attachment and neurodevelopment and the researcher's experiences of working in residential care. The tools were then revised following feedback from the doctoral supervisory team, with advice to either reframe, reorganize or add in additional questions. The data collection method was designed to recognize the "insights, experience and knowledge of young people and youth workers" (Stuart, 2001; p 39).

Demographic information

Structured questions regarding the demographics of the participants were administered at the commencement of the face-to-face interview and typically took five to 10 minutes to complete.

For young people, demographic information was collected on the time spent in residential care and OOHC generally, their numbers of placements and their current experiences regarding their mental health, education and living situations. This provided detail about their pre-care, in-care and post-care experiences. Young care leavers, particularly those leaving residential care, have poorer outcomes than their peers who had not experienced OOHC (Baldry et al., 2015). Because of this, understanding the participants' experiences of mental health, education and housing were deemed important so as to compare the current participants to what is generally known about residential care leavers.

Staff were asked for information on their experience working in residential care including their specific work roles and length of time in residential care. This approach established the various amounts of time staff have worked in residential care, and the different roles held by participants meant particular types of experience could be captured.

Interview protocol

According to Cohen and Crabtree (2006), semi-structured interviews are particularly useful when an interviewer will only have one opportunity to interview a particular participant. These authors further argue that semi-structured interviews give the interviewer the freedom to expand on particular topics, adjust the order of questions, or ask questions on different topics to "provide the opportunity for identifying new ways of seeing and understanding the topic" (Cohen & Crabtree, 2006 p. 1). This approach is in line with exploratory research and an interpretivist underpinning, where the aim is to explore previously uncharted territory to develop a beginning familiarity (Rubin & Babbie, 2013).

When considered in light of the current research, much research into placement stability has involved file review data, counting placements and structured tests used as outcome measures. Very few researchers (e.g. Cashmore & Paxman, 2006) have examined the issue qualitatively, taking into consideration the views of those who have directly experienced instability. No research, either in Australia or internationally to date, has been an inquiry into the direct views of both young care leavers and staff who have worked with the young people, specifically in the context of residential care. Conducting research in this mode will provide an opportunity to investigate some of the pre-existing assumptions on what constitutes stability. As the vast majority of research in this field to date has examined the issue by counting placements and inspecting outcomes, the current research will allow for an in-depth understanding of what precisely constitutes stability, as understood by those who have lived or worked in residential care.

Semi-structured interviews specifically, as discussed by Cohen and Crabtree (2006), provide an opportunity to follow the interviewee where they want to go, allowing a conversation to flow, allowing follow up questions to be asked and a more intricate understanding to be derived. Semi-structured interviews also seek to circumvent literacy issues, as questions are asked conversationally, with the ability to rephrase or explain the questions being asked, providing greater ability for individuals to participate, who may be discouraged by needing to read or write. Following up on questions and answers is an important element because, to date, this research has only been conducted in foster care. An ability to remain open to the participants' answers is necessary as they will have experiences and insight that could not have been predicted.

Consent, power and vulnerability can also be more adequately monitored in semi-structured interviews. Being able to attend to the nuances of an individual's demeanour, over time, allows for an attuned interviewer to identify when a participant does not want to follow a particular line of questioning, or wants the interview to end. Being able to observe the facial expressions and changes in tone or body language, gives clues to the participant's state of mind. The interviewer is then able to address any concerns, either by changing the line of questioning, asking directly about the participants' comfort level, offering a break or offering to end the interview.

Interviews give additional information about the participants' state of mind that, when attended to judiciously, provide an ability to protect the participants when they may be unwilling or unable to speak out about their discomfort. Given the young peoples' histories and ethical concerns regarding asking them about sensitive life events, attending to issues of power and vulnerability are of utmost importance. Ensuring that young people who have experienced trauma and abuse are able to fully consent and understand what they are being asked to discuss allows for a meaningful and open dialogue about their experiences and insights.

The application of this approach to both the young people and the staff was used as part of a member checking strategy to identify whether those young people who lived on a daily basis in residential care had similar views to those who observed and worked with them in this context. A shared view would suggest greater reliability of the data, whilst disparate views would have required additional thought and consideration. Both would have provided an equally rich data source.

Previous research approaches

Previous iterations of research into stability have examined the issue in various ways. Some qualitative research has been conducted in OOHC. Cashmore and Paxman (2006) undertook qualitative interviews with individuals in various types of OOHC over four time periods and compiled composite measures from these interviews, such as a meas-

ure of social support and a measure of stability, and compared these findings to outcomes. Their measure of stability was derived by determining whether at least 75% of the time in care had been in a single placement. Devaney and colleagues (2019), who examined stability in foster care youth in Donegal, Ireland, conducted interviews to discuss the young people's, foster carers' and birth families' stories, however, they were not triangulated to be comparable across the participants. These interviews were not semi-structured and themes were derived to identify which elements contribute to stability.

As discussed in Section 3.11, various measures of stability have been employed in the extant literature, all of which operationalize stability based on the number of placements a young person has experienced. For the current research, Devaney and colleagues' (2019) approach was considered to be significant as it did not have a pre-determined set of criteria for what constitutes stability, but rather attempted to determine factors that contributed to stability in a foster care cohort. The researcher sought to replicate this approach in a residential care sample.

Given the exploratory nature of the current research, and that the vast majority of studies to date have presumed an operationalization of stability that is based on numbers of placements rather than alternative factors, a survey approach may have failed to identify the significant elements of stability in residential care. Devaney and colleagues (2019) were able to identify some common themes that contribute to stability in foster care, however, as discussed in Section 3.8, foster care cohorts and residential care cohorts are fundamentally different. The features of residential care, particularly the rotating staff roster, mean that remaining in a single placement does not ensure a continuity of caregiver. Therefore, the question of what constitutes stability in residential care needed to be examined through a qualitative lens to begin to identify these key features. Furthermore, because of some participants' literacy issues, a survey approach may have led to their exclusion.

The semi-structured interviews were all conducted by the primary researcher at a time and place convenient for the participant. For some participants, this meant the interviews took place over the phone, as described with one participant who was 38 weeks

pregnant. The interviews took approximately 45 minutes to one hour, were audio-recorded and transcribed verbatim.

For young people, the interview schedules focused on their experiences of stability and instability, their experiences of positive and negative placements and how these differed, their experiences of staff and co-resident turnover, and the impact for them of the use of casual staff. Young people were asked about what makes a 'good' or 'bad' staff member and the different impact on them of these experiences.

The interview schedule for staff focused on their opinions about and experiences of stable and unstable placements: what contributed to the stability or the instability and the outcomes of both. Further, the staff were asked about the impact of staff and co-resident changes, the impact of casual staff, and how stability could better be enacted.

4.12 Data analysis

There has been less scrutiny regarding the process of thematic analysis, however, Braun and Clarke (2006) Braun et al. (2015) and Clarke et al. (2019) outlined a six-step process for undertaking thematic analysis and this process was followed in the data analysis for the present study to identify and report on themes found within datasets.

Following Braun and Clarke's (2006) process, Step 1 involved transcribing the interviews. For the present study, interviews were transcribed into Microsoft Word and then uploaded into QSR NVivo to assist with data analysis. Step 2 involved initially developing codes based on the theoretical lenses of attachment and neurodevelopment and how these relate to stability in residential care. These codes included "stable attachments", "felt attachment", "child development", "identity development" "belonging", "feeling safe" and "staff skills". Initial readings of the data allowed for the emergence of additional codes through inductive analysis (Braun & Clarke, 2006; Linneberg & Korsgaard, 2019). This iterative process allowed for deep reflection on the data to analyse underlying meanings as guided by the research question (Miles, Huberman & Saldana, 2014).

Step 3 involved collating the codes into themes which emerged from the data, based on the prevalence of the particular codes and how they related to the research question. Some themes included the importance of a consistent care team, the need for planning and organizational support for staff, and the importance of relationships that are based on care for the young people. According to Braun and Clarke (2006), prevalence is not necessarily related to one theme emerging more than others, or in most cases. Rather, the significance of the theme may be measured by its frequency or importance to some, most or all participants.

Step 4 involved reviewing the themes to ensure that they were both significant in and of themselves and that they did not overlap with other themes. For example, the need for consistent staff was raised by virtually all interviewees, though some participants discussed the importance of the staff quality. Step 5 involved naming and defining the themes, which will be discussed in Chapters 6, 7 and 8. Finally, Step 6 involved the production of these three chapters where findings are discussed.

The data analysis involved a repeated back-and-forth process of reviewing the data and synthesizing information to ensure that the analysis presented was true to the raw data and the voices of the participants (Linneberg & Korsgaard, 2019), whilst also contributing something more than descriptive to the literature on stability. The following flow chart (Figure 4.2) provides a visual outline of the data analysis process.

In order to ensure that the data analysis was trustworthy and credible, a number of approaches were used. Firstly, member checking was used, particularly during the interviews, to ensure that meaning was understood and clear, for example, rephrasing what was said and confirming that was the intention of the speaker. This approach was taken with all participants. Secondly, peer review was used by providing the supervisory team with copies of the transcripts and discussing coding approaches. Thirdly, thick description of the research processes and the cases, as discussed in Chapter 5, allowed the reader to assess the applicability of the findings to other settings. Fourthly, purposive sampling and maximum variation sampling were used and driven by the research problem to bring both typical and divergent cases to broaden the range of data gathered.

Figure 2: Data analysis process

Transcribing interviews

Initial code development based on literature (e.g. stable attachments) followed by development of inductive codes from the data

Collating codes into themes, e.g. consistent care team, planning and organisational support

Naming and defining themes

Writing the findings chapters
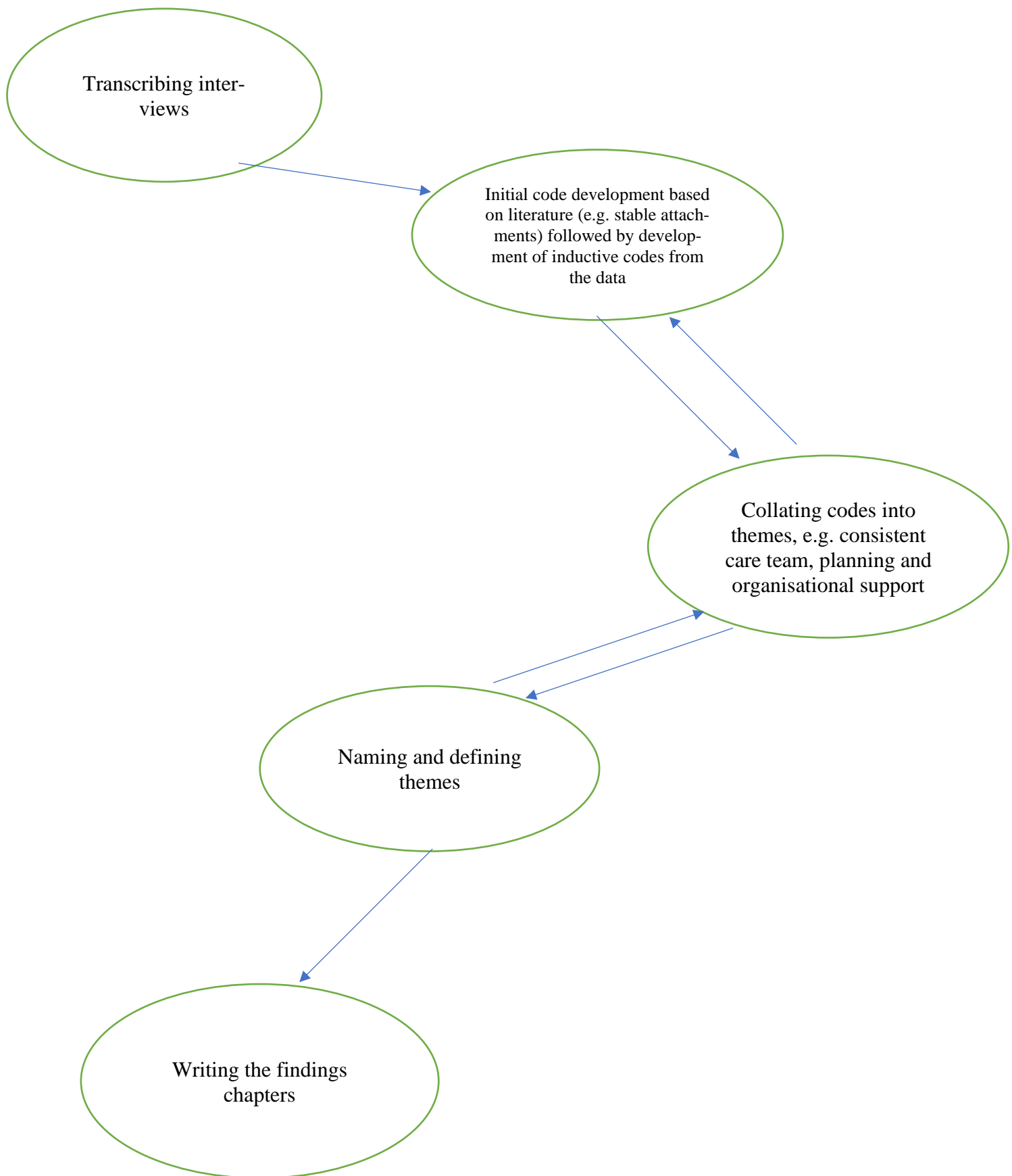
4.13 Conclusion

This chapter has focused on the design and implementation of the study. It highlights the epistemological and ontological world-views that shaped the study and the reasons for taking an exploratory stance. This was done to be able to develop a deep understanding of the experiences of the staff and young people who work and live in residential care. The design of the study allowed for the lenses of attachment theory and neurodevelopment to shape both the development of the questions and the analysis, in a way that allowed the voices of the participants to be heard.

This methodology was designed to answer the research question "how do young people who have lived in residential care, and residential care workers, define, understand and explain placement stability?" This question is important because, to date, examinations of stability have taken a superficial view of what constitutes stability, and have failed to take the principles of attachment and the impact of trauma on the developing brain into account. Therefore, the methodological approach, particularly using an exploratory approach, allowed for an examination of those factors for the individuals who are most affected by it: the staff and the young people.

In order to answer this question and to hear the voices of the participants, a qualitative approach was taken using semi-structured interviews. Participants were guided using an interview schedule but were able to take the interview on tangents that were important for them to discuss. Whilst interviews occurred on a one-off basis, this methodological approach gave time and space to participants to discuss their experiences, opinions and views on a topic that has not received sufficient attention, particularly in this participant group.

In the next chapter, a discussion of the demographics pertaining to the young people who participated in the research is presented. Chapter 5 provides an in-depth examination of who participated, including details regarding their experiences of life prior to and whilst in OOHC and how this related to their experiences of stability.

Chapter Five: Who are the Young People?

5.1 Demographics of the young residential care leaver participants

Residential care leavers are typically considered to be a particularly disadvantaged cohort (Mendes, Snow & Baidawi, 2016). Despite this, no strong dataset exists providing a breakdown of who these young people are, where they came from and where they go once they have left OOHC. In two relevant large-scale Australian studies, researchers have taken a closer look at the young people who have been in OOHC. These are the Beyond 18 Study (Muir et al., 2019; Purtell, Muir & Carroll, 2019) and the Pathways of Care Longitudinal Study, the latter of which has been used for multiple articles (POCLS; Burke et al., 2019; Paxman et al., 2015; Wulczyn & Chen, 2017). For the purposes of this comparison, three POCLS papers are discussed: the Wave 1 baseline statistical report (Paxman et al., 2015), Wulczyn and Chen's (2017) study regarding placement changes and Burke et al.'s (2019) statistical report which focuses specifically on the cohort leaving care who were 15-17 years of age.

The POCLS was conducted using data from FaCS, the NSW governing body responsible for OOHC, with 1,268 children who had entered OOHC for the first time between May 2010 and October 2011 and agreed to be interviewed, 25 of whom were in residential care. The Beyond 18 Study was conducted in Victoria with 126 care leavers, 86 of whom participated in qualitative interviews. 51 of the participants had been in residential care as their most recent placement type. In considering the demographics of the current study, reference is made to these studies to identify how 'typical' the participants are, as compared to other Australian data.

The purpose of this chapter is to examine the occurrence of stability and instability they experienced, in numerical terms. This is then compared to their experiences of care and nurturing. This is done from their responses during the interviews.

Age, gender and Indigenous/non-Indigenous status

For this study, eight young people were interviewed. They ranged in age from 18 to 24, with a mean age of 21.1. Three participants were female, four were male and one identified as a transgender male. Three of the eight, all males, identified as Indigenous. The NSW POCLS study baseline statistical report (Paxman et al., 2015) included fairly equal proportions of male and female participants, similar to this study. Further, 34.3% of their sample identified as Aboriginal, similar to the 37.5% of the current sample. Interestingly, in Burke et al.'s (2019) statistical report on the cohort leaving care, 40% of the residential care population identified as Indigenous. The Beyond 18 Study (Muir et al., 2019) on the other hand, had an over-representation of female participants (69%) and an under-representation of Indigenous participants (11%).

Entry into OOHC and placement numbers

Regarding their entry into the OOHC system, in the current study, two young people went directly from their families to residential care, therefore, experiencing no placements other than residential care. Those young people both reported having two residential care placements: one entered residential care at 13 and the other at 15. The other young people all reported an experience of foster care prior to residential care. These six young people were removed from their families at varying ages, ranging from four to 12 (mean = 8.2 years). Notably, all the young people who experienced foster care (except one who could not recall much about his history and therefore responded with 'unsure' to most demographic questions) reported entering residential care because no more foster placements were available to them. One young person, in particular, experienced 32 foster placements over 10 years before entering residential care.

In discussing the reasons for entry into the OOHC system, two young people did not know why they were removed from their families, three reported histories of domestic violence within the family, one reported having an "unfit mother", another reported "problems" at home and one cited neglect as the precipitating reason for removal from their family. Further details were not sought on these issues for reasons of privacy. According to the POCLS study (Wulczyn & Chen, 2017), young people had entered OOHC for a variety of reasons, however, domestic violence was not one of the options, making comparison between the groups difficult. Burke et al.'s analysis of the cohort leaving

care noted that 60.5% of the participants had risk of harm reports related to domestic violence. This compared to 37.5% of the participants in the current study. This data was not reported in the Beyond 18 Study.

Regarding placement numbers, while in residential care, the mean number of placements was 5.75 (min. 1, max. 28). Prior to entering residential care, the mean number of placements was 8.88 (min. 0, max. 32). The largest number of total placements experienced by one individual was 36, with the smallest being two placements in total, and the mean number of total placements was 14.62. In Burke et al.'s (2019) report on the cohort leaving care, 17% had experienced six or more placements. In this, placement type was not delineated, however, nor were the precise numbers of placements provided.

Education and links to offending and parenting

Four of the participants in this study had completed Year 12, while two others completed Year 10, with another having completed Year 9 and one completed Year 8. Since leaving residential care, six reported that they had engaged in ongoing training; one young person stated they were currently completing Year 12 while in semi-independent living. Only one young person denied undertaking any further training. Regarding school attendance, some young people identified they attended a number of schools prior to entering OOHC (min. 0, max. 5), while two were at or below school age when taken into care. The young people stated that, once entering OOHC, they attended between one and nine schools (mean = 3.5). In the Beyond 18 Study sample (Muir et al., 2019), 28% had completed Year 12 (compared to 50% of the current sample), 41% had completed Year 10 (compared to 25%) and 10% had left school before Year 10 (compared to 25%).

It is notable that, within the current sample, the four participants who did not reach Year 12 all currently have children. Further, three of these four also had juvenile justice involvement whilst in residential care. None of the young people without children had any involvement with juvenile justice. In Wave 2 of the Beyond 18 Study (Purtell et al., 2019), it was identified that in the sample of 126 young people, 60% reported having contact with the juvenile justice system prior to turning 18. In the current sample,

37.5% of participants (three) reported having contact with the juvenile justice system before turning 18. According to Wave 3 of the Beyond 18 Study data (Muir et al., 2019), 19% currently had children. In the current sample, this was vastly higher at 50% (four participants).

Mental health and disability status

It is of further note that all young people in the current study had a mental health problem or a disability. One reported having a disability (intellectual) only, while the other seven all reported mental health problems, with one of these reporting both. When discussing their mental health diagnoses, participants divulge being diagnosed with depression (n = 3), post-traumatic stress disorder (PTSD; n = 4), anxiety (n = 3), attention deficit hyperactivity disorder (ADHD; n = 4), oppositional defiance disorder (ODD; n = 1) and bipolar disorder (n = 1). Of the eight participants, four indicated multiple diagnoses. 17% of the participants in the Beyond 18 Study (Muir et al., 2019) disclosed an intellectual disability; in the current sample, the proportion was 25%. The Beyond 18 Study did not include mental health diagnoses, but rather, the participants completed a scale of psychological distress where 39% had scores indicating high levels of distress. In the current sample, 87.5% (seven of the eight participants) indicated they had been diagnosed with a mental health condition; however, their current levels of psychological distress were not assessed. There did not appear to be significant differences between the groups in the Beyond 18 Study based on placement type (i.e. those who had been in residential care did not appear to have significantly higher distress scores).

Experiences of stability

The young people who participated in this study provided remarkable insight into their experiences of stability and instability. One particular participant, Participant E, provides insight to the meaning of stability through his unusual experiences. This participant was 18 years old at the time of the interview and, remarkably, was engaged in the first year of his university degree. This particular participant is an Indigenous male who lived in 32 different foster homes prior to entering residential care. Once in residential care, he had only one placement for four years. However, he reported that it was a fairly

negative experience for him on account of the staff being disengaged and unhelpful. This particular young person noted that he was given the option of attending boarding school elsewhere or living in residential care, as he had exhausted his options for foster care. He chose residential care as this would give him what was most important - the option to remain at his school. For him, stability came in the form of his school, his friends and his teachers. As a result of this stability, he was able to cope with residential care and go on to complete Year 12 and begin university studies.

The instability of his placements, both in foster care and a disconnected and unhappy time in residential care, were overridden to an extent by the stability of his school attendance and the associated attachments. This allowed him to focus on working towards his goals. Participant E also noted that he was able to maintain a connection to his family of origin, with ongoing contact with his mother and a sense of responsibility for being a good role model to his younger brother.

Two of the participants experienced significantly more instability while in residential care than the others, Participants T and A, both 24. Participant T finished school in Year 10, while Participant A left school after Year 9. Both are young parents and both maintained ongoing family contact throughout their time in care. These particular participants reported positive experiences in residential care, despite the instability, alongside negative experiences. Participant T noted that sometimes she felt unsafe in her placement with regard to the other young people, but experienced significant support from the staff. As a result, she attributed her ability to be a good parent to the staff she had as a young person in residential care.

Participant A noted that, while he did not regret the outcome of his time in care (his son), a number of experiences he had there negatively influenced his life, as a result of the instability he encountered, including contact with the juvenile justice system and drug use. Both participants have ongoing contact with at least one staff member who had worked with them. This may highlight differences between these young people and others who had experienced marked instability.

In contrast, two of the participants with the lowest number of placements, Participants B and E, both 18 years old, had, respectively, two and one placement in residential care. Nevertheless, of the reflections on their time in residential care made by this group of eight young people, they reported some of the most negative. While Participant B had only two OOHC placements, she did not have ongoing family contact. Participant B was completing Year 12 at the time of the interviews; Participant E had begun university. Neither have any children.

Participant B noted that casual staff often worked at her residence and, when they were present, she would isolate herself to avoid having to get to know someone she would likely never see again. She noted that she felt there was no point forging connections due to no consistency in staff members. Participant E observed that the staff involved with him rotated multiple times, with multiple clinicians, managers and even house staff.

Both these young people reported that there were some staff members to whom they felt a connection, and this was extremely beneficial for them. Participant B stated that she felt more inclined to interact with staff and engage in activities when she felt a connection with someone. Participant E remarked that a staff member, not of the house staff, helped him realise his interest in physics.

This comparison is particularly striking because the two individuals with the greatest residential care instability, in terms of numbers of placements, had more positive reflections on their experiences. This was likely related to the close and meaningful relationships they had with some staff members. Participant A even noted that one staff member was present for the birth of his son, while participant T noted that the residential care staff helped her learn how to be a better parent. In contrast, Participants B and E, with the lowest levels of numerical placement instability, but the highest levels of disconnection from the staff members, had far more negative reflections on their experiences of residential care. This highlights the vast importance of the relationships formed with the care staff in mitigating the impacts of instability.

In this chapter I have briefly introduced some of the significant demographic characteristics of the eight young people who participated in this study and compared these general features with those of large-scale Australian studies in an effort to highlight their representative similarities and differences. Some initial seminal outcomes illustrating the importance of stability in terms of relationships over the impact of stability in terms of the numbers of placements have been highlighted. In the following chapter, the findings from the current research are discussed, as well as a brief outline of the demographics of the staff members who participated in the research.

Chapter Six: The Voices of the Workers

"So, I think that the more we start thinking about placements as relationships with carers, we will actually do a lot better in stabilising them, rather than seeing placements as a place" **SM, clinician**

This chapter presents the study's findings with respect to the staff interviews that were conducted. Firstly, there is an outline of the demographic data provided by the participants. This provides an understanding of who the participants were and their experiences. Secondly, an analysis is presented of the significant themes from the staff interviews, with quotes from staff as evidence for these findings. This section seeks to answer the research question: "How do young people who have lived in residential care and residential care workers define, understand and explain placement stability?" This question will be answered with respect to four linked but meaningfully different aspects:

how the staff define stability and their view on external and internal stability;

how the staff understand stability including the organizational requirements for stability to be possible for young people;

what elements the staff see contributing to a placement being stable or otherwise; and how the staff explain stability and its impact on those involved.

This chapter concludes with an initial exploration of whether stability can be reparative and the impacts of instability on young people in residential care.

6.1 Demographics

The following tables provide demographic information about the staff participants. Their levels of education and experience are outlined to provide some background on the individuals in the study who speaking about stability in residential care.

Table 3: Staff demographics

Participant	Age	Sex	Years of experience	Qualification level	Educational discipline	Current role	Previous residential role
WF	26	M	6	Postgraduate	Psychology	Therapeutic specialist	Clinician
JA	40	M	18	Undergraduate	Social work	Family therapist	Manager
AB	42	M	10	TAFE	NA	Youth worker/floor staff	Co-ordinator
WC	37	M	11	Undergraduate	Social science	Not working	Manager
IE	48	M	18	Year 12	NA	Youth worker/floor staff	Youth worker
EF	20	F	1	TAFE	NA	Youth worker/floor staff	Youth worker
JG	34	F	12	Undergraduate	Youth work	Caseworker	Co-ordinator
SH	31	F	5	Postgraduate	Psychology	Psychologist	Co-ordinator
KI	39	F	7	Undergraduate	Not specified	Manager	Co-ordinator

SJ	51	M	12	Postgradu-ate	Not specified	Regional man-ager	Manager
SK	33	M	15	TAFE	NA	TAFE teacher	Co-ordina-tor
NL	42	F	6	Undergradu-ate	Psychol-ogy/criminology	Area manager	Acting di-rector
SM	49	M	20	Undergradu-ate	Social work	Consultant	Clinician

Staff participants had a mean age of 44.4 years (min. 20, max. 51), with eight males and five females participating. As is evident, there is a wide range of experience held by the participants, with the mean number of years of experience as 10.8. Most participants have a degree (either undergraduate or postgraduate) from a range of disciplinary backgrounds including psychology, social work and youth work. It is notable that the sample is highly educated, with nine out of 13 (69.2%) staff participants holding at least an undergraduate degree, and 23% holding postgraduate degrees. Those that hold lower qualifications, such as a TAFE qualification or high school degree, dominated the youth work/floor staff roles. One participant with a TAFE qualification worked as a co-ordinator, however. Those who worked in clinical roles or management positions all held at least an undergraduate degree.

According to a Victorian survey undertaken by the Centre for Excellence in Child and Family Welfare Inc. (2015), which examined statistics about the residential care work-force from over 20 organizations with 1597 staff members, 37% were male and 63% fe-male, 62% of whom held tertiary qualifications, with 14% of these having university qualifications. This suggests that the current sample is more highly educated, with a greater proportion of male staff than is typically found in residential care. Regarding the positions held by the staff, many participants have previously or currently held roles in management at coordinator or manager level. Two participants worked in upper level

management, two held clinical roles and the remaining participants had the majority of their experience 'on the floor' in residential houses. This sample provides a wide range of voices of those who have worked in residential care, concerning understandings of how stability has been enacted, how it has failed and the consequences of both.

6.2 Staff Definition of Stability

Staff who participated in this study define stability in two different but interlinked ways. Firstly, they define it as involving external stability which refers to the environment around the young people. Secondly, it involves an internal stability which is related to the young people's internal worlds. These elements are separate but mutually reinforcing, with stability in one area influencing the likelihood of stability in the other. Therefore, the experience of external stability increases the likelihood of internal stability.

Each of the following elements is made up of a number of intersecting factors and will be discussed in turn. It is important to note that these factors are not discrete and all work together to form 'stability' for young people in residential care.

6.2.1 External stability

Consistency

External stability for young people requires the external experience of consistent, strong staff members who are known to the young people and each other, working in consistent and predictable ways.

> *"...consistency throughout with the staff, with the young people even things like their school, what's expected of them, routine. I tend to find the more that those things can stay constant and stable, it tends to offer young people a bit of reassurance there because so much of their world has been unstable and unpredictable that, from my experience there are placements where there's consistent staff and*

consistent other young people there for a significant amount of time and these placements seem to work a bit better.” **SH, co-ordinator**

“Staffing has to be stable, staff have to be known to each other, you can’t just have strangers, not only strangers to kids but people who are strangers to existing staff. They’ve got to know each other. The staff have got to know each other – it’s important.” **SM, clinician**

“I think any placement will work in residential care as long as you’ve got a really, really strong team willing to support that young person.” **AB, youth worker**

“For me a stable placement means that there are not frequent changes in the staffing and other young people coming and going and their case worker and clinician and other people around them. I think that stability is the people that are involved in their life or constantly there, even if they stay in the house, [change] *is just as unsettling for them as moving frequently, which is a worst case scenario.”* **KI, coordinator**

These comments demonstrate that staff members are aware that young people require consistent caregivers, not just in their day-to-day life, but also in the surrounding organization. They need consistency of case management and clinical staff. The consistency, according to staff, appears to offer an antidote to the chaos experienced in their early lives and possibly their previous experiences in care. This finding is significant methodologically as in previous research, residential care staff have not been consulted on their experiences of stability. Here, the staff begin to highlight the insufficiency of evaluating placement stability with a paradigm of the number of placements over time. Given a young person could remain in a single placement without consistent staff, that placement is unlikely to be experienced as stable.

Casual staff

Conversely, the use and impact of casual staff members can destabilize the day or the placement entirely.

"…casuals just give them [young people] *whatever they want, so the rules aren't followed and they don't have any consistency with things. So, the kids just think 'oh well you don't really care about us' because we're not putting the boundaries there that they're used to having."* **AB, youth worker**

"Yes it really destabilizes them you know, they say for themselves through surveys that we have done with them that they don't like casuals coming through. As much as they say they don't like their team or whatever, when you put casuals through (because you don't have a choice, because people are on leave or whatever) they are very clear on saying we don't want casuals, you know? They will act out, there will be incidents, you know the casuals don't necessarily know, well they don't know about everything the care team knows. They don't know the little things they might de-escalate on, you can't teach all that in a quick handover." **NL, area manager**

"Interestingly, when a staff member did call in sick and there were casual staff who came in, that's when you would tend to see the hiccups and the more oppositional behaviour coming out. To the point where we would know if a casual staff member is coming in, you knew it was going to be a little bit more of a tricky shift to work on. Again it just highlights how much that routine and predictability is important" **SH, coordinator**

The use of predictable and known casual staff, however, can decrease the level of felt instability for the young people and, indeed, the staff, as they are familiar with the young people and the rules of the house.

"So you'd have a larger pool of casuals like most organizations, like a semi-large pool of casuals. For me, it was about identifying some of the ones that work best in your particular programs based on their skillset, what they bring to the table. Then it was consistently using that person - so for the programs I had running well, I had only one or two casuals that would work in each one and it was the same one or two casuals all the time." **WC, manager**

The importance of consistent staffing, even with casual staffing, indicates the significance of the relational element of staffing. Furthermore, the staff identified the difficulty of how the casual staff fit into the residential house and impact the structure and running of the house. Because of their lack of familiarity with the house rules, or the casual staff not following the rules, the young people may feel less cared for than they do with their usual staff. The impact of casual staffing further highlights the insufficiency of using placements over time to measure stability. This is because those young people who are in the care of casual staff are missing their consistent staff and this absence is destabilizing. Ensuring that the staff are known to the young people and to each other increases the likelihood of a consistent approach to day-to-day care, as well as a sense of safety for the young people who are being looked after by individuals who are familiar to them.

Co-resident stability and instability

The staff typically did not immediately raise the issue of co-resident stability as important for stability, though it was considered to be relevant to stability within the house. This particular issue, however, was considered to be less straightforward than stable staffing. The staff identified that there may be positives associated with changes of co-residents, or that it may be a fairly neutral experience.

> *"For example, it might make the other kids feel more stable and feel safer if the presence of that child was making them feel unsafe right? So if that child was a bully and they were feeling unsafe because of their erratic behaviour and so on, then the placement* [of that child elsewhere] *is going to be better for the other kids."* **SM, Clinician**

> *"I think a lot of the young people accept it simply because of the state of play. There are so many transitions that occur in out of home care so kids come and go all the time. So, at the end of the day, it's just another person I used to live with. I've seen a lot of young people make those types of comments. That's fine, its only when the young person transitions on, when they finish care, that there's a sense of happiness for them, that they're able to move out of the circumstances and be able to move*

onto bigger and better things. That's a different feel for the young people that stay behind. But for the most part, they are generally 'who cares?'" **WC, manager**

"They lose their friends, like that's their only family, they're the people that they know." **JG, coordinator**

"I've definitely seen it have a significant impact on some young people and not really bother others and that can be, even if it's the same young person that's moving out of a house. I think a lot of it has to do with the relationship that the young persons had with each other whether that was a close sort of relationship, whether they like each other and whether they miss having that person around or whether they don't. Whether they, just for whatever reason, haven't, don't have that close relationship or don't like them, in that case sometimes they're happy to see that young person out the door." **SH, coordinator**

The staff identified that co-residents' moving in and out may be experienced as positive, neutral and negative for the other young people in the house. The staff were able to explain that young people suddenly moving may be experienced as a positive change as there may have been erratic or dangerous behaviour going on, precipitating the move. They noted it may be experienced as neutral because of their repeated experience of living with different people, so others moving may have less of an emotional impact on them. They also observed that it could be experienced as negative, particularly if they are losing co-residents who feel like friends or family to those left behind. This finding is significant because it suggests that some level of instability may not be destabilizing for the placement; either because the change is experienced as positive or neutral. In order to operationalize stability, the experience of co-resident stability would require further investigation to determine how to incorporate it. What appears to be more significant is the experience of matching the young people together more appropriately in the first place, which will be discussed in more detail below.

Planning and communication

Further, external stability is impacted by transitions into and out of placements being planned and communicated, so that young people know where they will be living, with whom, and they have the opportunity to develop relationships prior to the moves. For these young people, this involves giving them notice that a change of placement will occur, providing time and resources to them to adjust to the change, such as spending time with the new staff and resident young people so as to build relationships ahead of the move. Staff noted a lack of clarity around how much planning is required for a positive transition, however, more time is generally considered to be better. In planning, there is an important need for decisions to be thought through in the best interests of the young people, rather than being made in haste or in response to a crisis.

> *"...Planned is always good, one of my things around planning though is that there's different perceptions of what constitutes a plan and how long a plan is for. A plan shouldn't be 2 weeks, as is the case generally across the sector. Any transition from one program or one service or organization to another is generally done in a 2-3 week period. That's not OK. I think the transition needs to be a 3 month process, lots of sleepovers. It's about building connections first. So if you know a young person's going to be transitioning, from day dot you need to be including the young person in that conversation, including the other organization or service in that conversation. You need to start building relationships from the get go. For me that's the most important thing. And after 2 months or whatever you can start to have sleepovers and things like that and really integrate them slowly so they feel like they're already connected to that space. Too many times I've seen young people transitioned and then 'here's your bed and room, here's your room, mate, enjoy' and it's a bed with a desk and that's all it is. So, but if they can already start to put pictures up and start to bring things over slowly, it's always a much better process."* **WC, manager**

> *"I think it's just everyone having the opportunity to say a proper goodbye and to have any sort of closure and understanding about where the child is going or what's happening for the child leaving. They can get on the same page and make peace with everyone and they get used to having the kids not there, because it's a transition."* **JG, coordinator**

"We found much more placement stability where the transitions were long and the transitions were relationship based. So the child doesn't actually see, doesn't even go to visit the placement until they have a relationship with at least 4 or 5 of the key staff and they have developed a good relationship with both the manager and the clinician. Then they actually meet each of the kids away from the house and then, on their first visit to the house, they all really know everyone that they see. That gets us on the front foot and we found that we always end up with a much more stable placement, much quicker" **SM, clinician**

Predictability, a sense that decisions are being made in the best interests of the child and communication about what is going to happen are of prime importance to providing stability. Staff noted that careful preparation and slowed transitions increase the likelihood of a stable placement for two reasons: firstly, because the young people become familiar to the staff and others in the house and, secondly, because poor matching can become apparent prior to the placement, allowing for changes to be made.

An implicit acknowledgement was made by the staff that placement changes are, at times, inevitable. With this inevitability comes the need to provide as much predictability and planning as possible so that the move can be accomplished in the least detrimental way to the young people. This is done partly by ensuring the new placement is one in which the young people can feel safe, connected, and they can say goodbye and have an acknowledged ending with the previous placement.

Within this is also an understanding that a young person changing placements has an impact on the other young people in the residential home. An individual changing placement has flow on effects to the others in the house that may impact the feeling of stability for everyone. The need for planned transitions that take into consideration their potentially destabilizing effect on the individual and those left behind in the residential home adds an additional layer to the understanding of stability.

To sum up, transitions impact those left behind as well as those moving on. Being able to communicate and plan for a transition to be safe and stable provides some level of stability, with a farewell and a smooth transition to a new placement.

6.2.2 Internal stability

The second element in defining stability, according to staff, involves recognizing the importance of internal stability. This refers to the inner world of the individual young person.

Safety

Internal stability for young people also requires an internal experience of safety. Staff observed that, or many young people, safety is a primary requirement: both felt safety and actual safety. This notion of safety as felt as well as actual relates to the idea that an individual can physically be safe, while feeling unsafe. Examples are the feeling that someone might have on a high balcony overlooking the edge, or in the presence of a feared creature in a safe environment, such as the reptile house at the zoo.

Interestingly, the concepts of perceived and actual safety have not previously been discussed in the residential care literature, however, it has been found that early stress, such as trauma and abuse, sensitizes the amygdala, the fear centre of the brain, to stay in the fear state longer and to become activated more easily (e.g. Pechtel et al., 2014; Schalinski et al., 2016; Teicher et al., 2016). Young people in residential care may not feel safe despite actually being safe. Further, they are cared for by many different people who generally know they themselves are safe adults but the young people do not know them yet, so they cannot yet feel safe with them. This paradox links internal and external stability: the increase in consistent and known staff makes internal stability more likely as the young people know who is looking after them and can, in turn, feel safer. In short, to develop internal stability, a young person needs to both *be* and *feel* safe in the environment.

"Yes, that's the main thing, that they feel safe. Because I've heard young people say that they've been at home and that people have come into the house, broken into the house and there's no one there to look after them. Where here where I've worked, I've had young people come to attack other young people and we've stopped them at the front and they know someone cares about them." **IE, youth worker**

Staff participants observed that this experience of safety allows young people to develop greater connections to the staff members and an opportunity for healing from their traumatic experiences.

"So when a young person feels unsafe, it's not impossible. But it's very hard to have a therapeutic intervention when someone's feeling unsafe because of the hierarchy of needs and that sort of thing. They're not able to engage in a therapeutic intervention because they don't feel comfortable or feel safe in the environment because they're working in primarily a flight or fight mode." **JA, manager**

"Of course, there is a difference [between someone who is internally unstable in a stable placement and someone who is internally unstable in an unstable environment] *because the young person who feels internally unstable and is in a stable placement has more opportunity to heal and more opportunity to then develop internal stability. The one who is moved all the time doesn't have that opportunity."* **SM, clinician**

Safety, according to staff, is of the utmost importance for a young person to feel stable. Without safety, both actual and felt, a young person will be unable to participate in therapeutic interventions and develop internal stability. Therefore, the need for safety is a primary goal in ensuring stability. It is particularly notable that staff highlighted the role of safety in healing for young people in residential care; its absence will make healing from the early trauma difficult if not impossible, while its presence provides a settling environment in which a young person can begin to heal.

While stability does not provide healing in and of itself, it is a key ingredient in making it possible for a young person. Safety adds an important layer to the definition of stability. A placement that is unsafe does not provide a stable environment that allows a young person to healing. Therefore, safety, not just a continuity of placement, is important as an element contributing to form a stable placement.

Increases in connectedness

Additionally, internal stability involves a developed or developing ability to feel a sense of belonging, to regulate one's emotions, and to develop trust and connections. Conversely, the absence of stability does not allow for these key abilities to grow and strengthen. For many young people who have experienced relational trauma, the ability to feel connected to a safe adult needs to be learned, as those who were charged with caring for them failed to do so, to the extent that required them to be taken into OOHC. Therefore, for these young people to form attachments to safe adults and a sense of belonging, this needs consistent input from staff members.

> *"Yeah and the kids, there are so many kids that have far too many placements. By the time they're 15 they're moved 30 odd times. no one likes moving at the best of times when you have a choice and these kids, they have no belongings, their belongings are limited to what anyone's willing to pack for them, no ownership over anything because the beds aren't theirs, nothing is theirs, it's all shared or belongs to an agency. They don't have anything to be proud of or look after, it makes me sad."* **JG, coordinator**

> *"The young people have also have refused to be involved in certain things, because 'it's your job'. It's like if the young people trash the house, you clean it up, it's your job. That's what they believe. So they feel empowered to do these kinds of things and yet at the same time it's a disadvantage to them because they don't have a sense of belonging. That is a big thing for them I believe, that they don't have investment in the place because they know they have a shelf life, at 18 they leave."* ***SJ, regional manager***

"To have a sense of belonging, to something or someone is a standard human need. So if you don't have that you're really missing out on a large component of what it is to be human." **WC, manager**

"*There were lots of things as far as their ability to regulate, self-regulation stuff, self-soothing and at that very basic level, instead of going from zero to a hundred, being able to sit back and feel bad and empathize. And school and things like that, they were engaged in school, they were wanting to spend time with the staff because they had that rapport and relationship there. So they were engaging in those recreational activities on the weekends, which then reinforced that feeling of a family unit, those sorts of positive experiences then also helped in their processing of what's gone on…"* **SH, coordinator**

"If kids feel internally unstable due to the external instability of the placement, they tend to regress, drop out of school, not able to attend. Because they feel more chaotic and less safe. Feeling safe is what is required to regulate the brain stem to be able to think. So just to be able to learn, not only that but just to tolerate the social environment of the school." **SM, clinician**

"[The young people test staff by] *trashing the place, threatening you to see how you respond and how you take it, if you can handle it. Because all their life they've been either abused or let down by family members and people just giving up on them and leaving. So, if they can test you through that way and feel safe with you, that's when they usually trust you. It's about trust."* **IE, youth worker**

*"**…**because they have no safe place or safe person and they don't feel as if…there's nobody consistently around in their life that they're able to vocally speak to about their emotions or they feel comfortable talking about how they feel, or anything really. It's a very rare occasion for staff members to have heart to heart talks with these kids because it takes a really long time for you to build up that trust network for it to happen. So when a child doesn't feel like they have anybody that they can talk to and there's somebody that has gone through probably a fair amount of trauma throughout their childhood it can be quite painful…"* **EF, youth worker**

The connection to staff and feeling as though they belong somewhere or to someone increase the ability of young people in OOHC to self-regulate and participate in important activities like school, friendships and activities within the house. The primacy of safe and consistent relationships is highlighted as young people develop abilities to relate to the staff and feel they belong in the houses. The development of emotional regulation skills and connecting to staff members constitute an additional component to the understanding of stability.

Initially, staff participants identified that consistent staffing was a key component of stability; that staff are known to the young people and each other and that staff are consistently present in their lives. An additional layer was added here, with the staff participants highlighting that there needs to be a connection between the staff and young people, which allows for their healing and learning of skills such as emotional regulation. An absence of connection between the staff and young people impacts on the young people's ability to develop these skills, with a resultant sense of a lack of belonging. Therefore, consistency of staff who are known to the young people and have the ability to build safe connections with the young people, is required for a placement to feel stable.

6.3 Staff Understanding of Stability

In outlining their understanding of the nature of stability, staff participants discussed elements that organizations need to put in place in order to facilitate such stability for the young people. Staff demonstrated an understanding that stability is enhanced or damaged by the organizational management of structures, supports and relationships between the organization and its staff and the organization and its funding body.

Organizational scaffolding

The way the organization functions is an important element of stability, according to staff participants. The organization provides the scaffolding for staff to be able to do

their jobs, by providing training and support, ensuring that the staff feel listened to and empowered to do their work well. When this does not occur, however, staff are more likely to burn out and this creates instability within the team and the house as they use their leave allowances.

> *"It gets to that point when people are just burnt out or people have a genuine fear that this is what they'll be walking into. So they'd rather not walk into it, people refuse to work in certain places. Your regular team, they're obviously taking every privilege that is afforded them so leave, sick leave they'll have. So you would have to back for that with casual staff. Then if you can't get casual staff, you've got agency staff. So obviously if the team is made up of 5 or 6 people, now you have 15 people."* **SJ, regional manager**

> *"Training is helpful as well, of course, like psycho-education for staff to be able to understand, I suppose, that what they're seeing in the behaviours that they're observing and trying to manage, that's actually coming from a place. It's not that a child's just defiant, there are underlying causes for that behaviour, which I suppose in a way it helps other staff develop more empathy and more understanding so that they are a little bit more patient, nurturing, those sorts of things instead of just being reactive to the behaviours that they're trying to deal with."* **SH, coordinator**

> *"Working in residential care is a high stressed environment and it worked very well because the house supervisor or coordinator was always there for supervision and was always available for any kind of debriefs. They were always available just in case we just needed like a 20-minute breather."* **SK, coordinator**

> *"I've got a good manager who makes me feel supported because she's always working hard to keep the team together and she's always working with the team and she has the same goals we have - trying to make it like a family environment as best we can. So, my manager is really good like and the rest of my team are really good but it's a hard struggle sometimes for the team."* **AB, youth worker**

"Probably because the workers are not always underskilled but underpaid, under-valued, there's not a lot of self-care put around them. There's not a lot of oppor-tunity to provide for acute stuff and being subjected daily to vicarious trauma. So when they're not supported by a coordinator or manager, they generally don't stay in the role for very long." **JA, manager**

The need for the organization to scaffold the staff to be able to do their job is highlighted by staff. Staff at different levels of employment, from floor staff to high level manage-ment, noted that managerial support, both in terms of providing support, supervision and training, was integral to ensuring the staff were able to remain in their roles. In de-veloping an understanding of stability, if consistent staffing were a key element, then or-ganizational support and scaffolding form the bedrock beneath the consistent staff teams. For staff members to remain consistent, they require support, supervision and training. They need this to remain both present in their roles and emotionally equipped to cope with the vicarious trauma they are exposed to. Therefore, in brief, for a place-ment to feel stable, the staff also require organizational support to do their jobs well. This is an integral component to stability.

Managing relationships and push-back

Further, those in higher level management and clinical roles described the need to man-age relationships with the funding bodies to ensure that the funded obligations are met, without jeopardizing the day-to-day running of the organization itself. Some partici-pants indicated that the ability to 'push back' against the funding bodies provided a greater ability to ensure more appropriate matching of residents in the houses.

"…we always have a say in terms of some kind of push-back but when it comes to the crunch, they have the final say in what you have to take. This child needs to be in your agency." **SJ, area manager**

"…one of the things that gets in the way of matching, just like transition time, is the pressure that's put on agencies by the placement coordination units that sit within departments. That pressure gets in the way of matching. For example, they've got

one bed target that they're funded for, the placement coordination unit says 'well we only have one child that's been referred right now so you have to take them because we are paying for that bed and we have a child here'. So therefore, really, what's being left unsaid is, you may not do any matching process with this case."
SM, clinician

"If it's not going to work, then [it is important] *actually not being afraid to push back on FACS* [funding body] *and say 'look this is not going to work, this is our only vacancy and this is not going to work because of A, B and C and this is the background information we have obtained and this is what we have found (without naming young people)'. They generally know but this is behaviours that have been moved into, this is why it's not going to work and you know they will agree to it. They can't push back if you have done your homework and you can't just say no without having evidence to back that up."* **NL, area manager**

"But in terms of how much of influence you have, it is relative. When you think about it, you are contractually obliged to have certain places and if there's a vacancy then you are contractually obliged to take whatever is remotely applicable. So even if that matching is not entirely workable, you still have to do it and then consider what the risk is and then ameliorate against the risks. We were always addressing it from a position of risk, of best interest, because you don't have it. If you only have 10 houses and you only have a vacancy in one of those houses, then the referral can only go there. Otherwise what you're doing is moving other young people to create spaces." **SJ, area manager**

The difficulty of managing these relationships with funding bodies was highlighted by these individuals who noted that, while there is some possibility of push-back, this is limited by the contracts and by the need to be able to pay staff when agencies are funded for beds to be filled. This forces a difficult balancing act of managing these relationships, managing less-than-perfect placement options or the possibility of destabilizing otherwise stable placements to make a better match for the referred young person. In order to consider the stability of placements as a priority, this element requires further contemplation. Much like externally stable placements provide the *possibility* of

healing for young people, funding models provide the *possibility* of stability by funding the running of the organization. It is the responsibility of the management staff to negotiate this so as to promote stability for the young people.

Matching

The matching of young people was considered by the vast majority of staff interviewed to be of primary importance. Ideally, placing young people into residential homes involves matching them to ensure the young people are safe with each other as well as being able to get along and enjoy 'sibling type relationships' with each other. It was noted by some staff that when matching was done poorly (or not at all, as discussed in the previous section), negative consequences followed for the young people in the house because of a lack of safety.

"They put kind of the wrong clients in the house. They put different needs, so promiscuous girls, you know aged 15 to 16 who also have drug and alcohol issues as well as behaviour of verbal abuse and violence, and then they moved in a little 12 year old in the house. It didn't work. There were police every day, staff were threatened, there was property damage, everyone refused to work there." **SK, coordinator**

"Yes it's like playing chess, chess not chequers. Absolutely, because you can have several programs that are actually really stable because you have consistent staff and things are going particularly well. You can have four, five, six programs that are going really well and then you have one young person where you have to consider which program you're going to put them in. And you know wherever you're going to put them, it is going to really upset the progress that's been happening in those spaces. So they're always very difficult decisions to make because, for the sake of one, person you have the potential of upsetting three or four, depending on how many kids you have in the house, two or three. So that can be a tricky thing. How you make the right decision, again it's about safety and it's about what's going to have the least amount of impact on others in that space, how detrimental will it be to others if I put them in house A and there's a little bit of chaos there? Can it be managed? Can the complement of staff manage that? Or if I put them in house B, will the whole thing fall apart? And we'll see a lot

*of aggression from the young person in the program, so you kind of have to make an overarching decision to place the young person. Sometimes it's literally the lesser of several evils." **WC, manager***

*"They do a really good job of placing kids in homes where they think they'll get along with other kids. You know a young boy's age, it's really quite easy to have a look at a child, look this kid likes football, he likes animals and he likes doing crazy stuff or whatever, what's happening in the house with these other boys who love going camping and stuff like that? You can usually get that sense pretty well, it's more of the breakdown of actually what occurs inside the home that causes lack of stability in my personal opinion." **EF, youth worker***

Matching was also described by a smaller subset of staff to include the matching of young people to appropriate staff members and staff teams, with skillsets and personalities suited to the young people.

*"Yes, it really weighs up... and there are a number of things there. So you're looking at the staffing, but you are also looking at the cohort of young people. So if you have got a young person coming with self-harming behaviours for example, into a house with a team that know self-harming behaviours, you might have one other in there. You're going to want them to go into a stable team versus casuals where you know there's staff on leave. I have often said that in the meetings. What about the stability? There are casuals in and out, how is that going to impact?" **NL, area manager***

"Look, in terms of Aboriginal placement principles, you have to consider if you have Aboriginal staff, they should be with Aboriginal children. But if you have a child who's exhibiting sexualized behaviours towards women, you might want to consider having less females on the team than males, that kind of thing." **SJ, area manager**

"The other thing was the complement of staff, what staff is this young person going to relate to well? Given that we have an understanding of what each particular skill set and interest set are for each staff member as well, that was something we took into consideration. We know this kid likes to play basketball so he's probably going to get

on well with a house that has a basketball court with a youth worker who likes to play basketball. So yes, those were some of things that we took into consideration" **WC, manager**

The matching process was considered to be significant for increasing stability; when young people were matched well, there was greater safety for them and fewer issues with their being influenced to engage in inappropriate behaviours. The importance of ensuring that staff teams are equipped to cope with the presentations of young people was also noted, as well as catering to their cultural needs. For matching to be done well, this requires an understanding of the teams that the young person is going into, the young people residing in the house, and the new young person to be placed, and then ensuring the risks can be managed as safely as possible.

Therefore, when taken with the evidence presented in the previous section regarding the need to 'push back' against the referring agency, findings emerged confirming a need for agencies to be autonomous to make decisions about referrals, have appropriate transitions to ensure positive relationships and protect the young people already in the placement against inappropriate matches. This finding is significant as it adds to the body of knowledge on residential care and stability. In order for stability to be present, operational decisions need to be made to ensure the stable running of placements. Therefore, due consideration needs to be given to how the organization operates, in order to promote stability for young people.

Trauma informed care

Staff participants identified the need for an understanding and implementation of trauma informed care. Within this context, staff identified that when they are able to understand the impact of trauma on the developing brain and attachment systems, they are better equipped to respond in helpful ways to the young people and maintain a positive and stable placement. With this knowledge about the impact of trauma, staff were able to understand the dynamics within the house better and make informed choices about how to respond, rather than reacting to problematic behaviours and interactions. They could acknowledge that, without trauma informed approaches, staff may enter

into power struggles and have problematic interactions with young people who are experiencing distress, which can lead to instability within the placement.

"Let's just say that we have staff who are known, who are familiar, who are stable, right? If they are not themselves well versed in especially the relational impact of developmental trauma, yes, then they're not going to understand the ruptures that are likely to emerge once a child is stabilized. Once your child is stabilized, they're going to enter into the very unfamiliar realms of a stable placement. Now that's very unfamiliar for the child, so they need assistance in being able to tolerate safety and care. Nut the problem is that, when you have staff who don't understand this concept, who don't understand that care and stability could be intolerable, then they will have no understanding whatsoever as to why the rupture will be there, why the child will be pushing their buttons personally, why are they reacting to it, why the child seems so ungrateful for all the good things that they are doing right. And then you will end up with placement instability. Either there will be pressure to move that child from that placement, in which case it's 100% unstable because they're not there anymore. Or it will be unstable because the staff themselves will remove themselves and they will either quit or they will want to move to another area and then that creates instability. Or it will cause the staff to remain, for the child to remain, but the staff to play into the internal working model of that child and to begin to behave with more punitive means and actually then begin to damage the relationships that they have developed." SM, clinician

"...a lot of the time we see staff entering into power struggles and conflict cycles with young people. They allow ego and power to dominate the conversation, as opposed to the development of the child. There was a lot of that that we saw. But once staff get a really good understanding of trauma informed practice, then things tend to change" **WC, manager**

Trauma informed principles of care allow staff to experience what is going on in the house from a position of knowledge and make informed choices about how to respond, rather than reacting from fear or anger, which likely plays into the working models the young people have of themselves, as was discussed in Chapter 1 where the theoretical underpinnings of the study were set out. Reacting unhelpfully, rather than from a

trauma informed perspective, can lead to unstable placements as either the staff leave the placement, or the young people may leave the placement, or the relationships dynamics between some staff and some young people placement continues to play into those young people's negative working models about themselves. Therefore, in seeking to understand stability, a trauma informed workforce is more likely to focus on the development of the young person. They understand the dynamics at play and work with that young person, rather than against them, in times of crisis. They are able to repair any ruptures that occur. Thus, promoting a stable placement requires staff to be able to manage difficult interactions in helpful ways. According to staff, this is facilitated by an understanding of trauma informed care.

Relationships as key

The centrality of relationships, including staff motivations and their impact on the capacity of the placement to be stable, was noted by many staff. Particularly floor staff and those in management who work closely in the houses noted that it is important for staff to be working for the 'right reasons,' and that this is transmitted to the young people. Staff mentioned that the desires to help young people and do their best by the young people were imperative in achieving positive outcomes and stability for the young people. They identified that the house needs to feel like a home, with staff providing genuine care and support for the young people they work with. The staff reported that being able to do this allowed the young people to feel cared for, and begin to develop trusting bonds with the staff members.

> "*It made them feel safe and secure and it made them, in a way, although corny as it sounds, it made them feel valued and loved.*" ***JA, manager***

> "*Yes there are new lounges, you can't really tell that it's a residential house, apart from the white cars at the front. We try to make it homely, gardens at the back, just everyday things. We chat with them, sit with them, chat with them at night, at night I give the boys and girls a hug and say 'see you later.' People might think that you can't do that but that's just how I work and that's how I trust the kids and they trust me. That's how I deal with my kids at home and they like a hug here and*

there. Treat it like a home rather than a workplace, I don't call it 'here at work' I use another word instead of work." **IE, youth worker**

"...so in saying that the agency allowed that [going above and beyond in the role] *to happen, like I can talk about times when there were kids' birthdays and we would all come in our own time. That's fine. The agency allowed us to do that. That kind of flexibility, the other agencies don't allow. You don't go there or sort of bend the rules per se, but it think it's bending the rules for the right reasons and not bending them for the wrong reasons."* **JG, coordinator**

"...support, that sense of support, that for the first time ever, this is what I've heard directly from young people, for the first time ever I'm not doing it on my own, is one of the things I've heard which was very powerful and it stuck with me. It was a long time ago." **WC, manager**

With staff giving support and care, even love to the young people, this provided them with a sense that they were truly cared about, rather than that the staff were working only to get paid. The staff indicated a willingness to provide both greater care and greater attention to the young people, but this required assistance from the agency and management. This family-like encouragement, in addition to caregiving, as is the requirement of the staff's role, may give the young people a sense of being supported and not alone, likely building a sense of "felt security" (Cashmore and Paxman, 2006). This finding adds another layer of understanding to stability: that there are consistent staff who are known to the young people and each other, who build relationships with the young people and do so in a way that is genuinely caring and provides a sense of stability.

6.4 Staff Explain the Impact of Stability

In explaining stability, staff spelled out the impact of stability and instability on young people. They discussed the reparative power of stability in helping young people heal, as well as the negative impact of instability.

Stability as reparative

Staff noted that when stability was present, they observed reductions in problematic be-
haviours and increases in prosocial behaviour. One staff member observed that, for
some young people, stability may only provide the effect of maintenance, with nothing
worsening but with overt improvement being limited. Notably, only one staff member
spoke about limited improvement with stability.

> *"...young people getting into employment, finding their own accommodation, fam-
> ily restorations, young people starting their own businesses, getting their licenses,
> going on to live independently. You know, we've seen young people that have
> grown up and had their own children, being good mums and dads, basically break-
> ing generational curses."* **JA, manager**

> *"...*[They] *weren't getting in trouble, a huge list, just no crimes committed, like,
> you'd get every now and then they'd wag school, they were going to education. All
> three of the younger kids were going to education and the older boy was pursuing
> TAFE to be able to pursue work. Like, they were doing fantastically, they were do-
> ing what the sector is supposed to do for them."* **EF, youth worker**

> *"Well, I think there are some cases where we're talking about stability, there are
> cases where young people have not been adversely affected by a certain stability.
> For example, in a residential program where there was a young person living there
> for about 5 years from 13-18, came in at that early mark, left at 18, moved into
> ADHC and then now into NDIS. So, with that kind of stability, low to no negative im-
> pact in residential care. But if you have to then consider what's the other outcomes
> involved here, what can we say are positives in terms of any kind of achievement or
> progress that this person is making? Very hard to tell. That's just sustained at a
> particular level, if we want to say that that's representative of stability and then,
> yes that works. I can say there are cases like that and I know of a few cases like that
> and very recently I've seen one. An ex client who I know for being in residential care*

from 13-18 and he's not in NDIS, a supported placement, but is that person any better or worse off? No, I can't say that, is the person presenting to me in any different way? No. The client has the same issues that he had when he was 15? Yes." **SJ, regional manager**

From the perspective of staff members, stability provided the impetus for increases in young people's connection to staff and opportunities for healing their trauma.

"The kids felt more settled and were more open with us and able to talk to us about more things. They weren't shutting us off from things that were happening outside of the house, with their friends and peers and stuff, so that was positive." ***AB, youth worker***

"I've seen kids go on to basically, once they've had stability, they've been able to resolve their trauma. And when they've been able to do that, I've seen an increase in their educational functioning, I've seen an increase in their health functioning, I've seen an increase in their social functioning." ***WF, clinician***

"Oh huge! Kids are happier. They want to hang out with staff here, do activities. We've had young people who had moved in last year and at the last placement they used to run off, they's spend probably two nights there and 3 weeks away from there. But when they come here, they haven't run, they just stayed" **IE, youth worker**

According to staff, the presence of stability, encompassing what has been discussed in this chapter, provides a fertile ground for young people to grow and develop, forming connections with safe adults, reducing problematic behaviours, attending school, working and parenting well. This finding differs significantly from previous findings regarding stability which have suggested that stability may, at best, provide a buffer against deterioration, although one staff member did identify that for some young people this was his perception. A preliminary understanding that, on a case by case basis, stability can be reparative provides an additional layer to the understanding of stability. The evi-

dence from these staff is overwhelmingly clear: that stability as described here, encompassing consistent and genuinely caring relationships, organizational support and careful decision making, can be reparative and provide healing for young people. This chapter has provided heretofore undiscovered information about how powerful this can be.

Instability can be damaging

In elaborating about the alternative, staff identified that a lack of stability was damaging for young people. It was considered to be retraumatizing, given their earlier experiences of instability.

> "[when staff members move, you get] *a lot of withdrawal, so basically you just reinforce what every other adult has done to them in their life and you really reinforce the trauma that has occurred for them and concrete it down. Again, that affects their willingness to build connections with people. What's the point in having a relationship with someone if they're just going to get up and go and not even tell you when they go?"* **WC, manager**

> "[With] *instability, they will start to build barriers. If they already have barriers, trust will become an issue. Relationships are lost and broken because a lot of the residents actually form relationships with their caregivers and when they have lots of changes obviously 'oh great, that's another person out of my life again', which gives disappointment. It's like that cycle just continuing."* **SK, coordinator**

Staff also noted that instability impacted on the young peoples' sense of self, reinforcing negative self-views that developed as a result of their exposure to trauma.

> "*Especially, I suppose, for young people that do have behavioural issues and do tend to, or have been moved placements because of that, whether that's sexualized or violent behaviour, you're essentially reinforcing what they've been testing. If I push these boundaries, you're not going to stick around like mum or dad, whoever it might have been. That's sort of 'I'm not good enough' and so when they test those boundaries and do end up getting moved placements, it's kind of feeding into that*

*core belief stuff that you're wanting to try and essentially work through." **SH, coordinator***

According to staff, instability can impair a young person's ability to form relationships with others, particularly staff. Being traumatized by ongoing loss and having a sense of self further impaired by ongoing rejection may affect a young person's willingness to form additional relationships, which, by extension, impairs their ability to feel stable in later placements. Forming genuinely caring relationships with consistent staff consti- tutes one of the core tenets of stability identified in the current research. Given this, when a young person is unable to form those relationships, this significantly impairs that young person's ability to feel stable, even if the placement does not end prema- turely.

Increases in risk-taking

Some staff participants observed that, with an absence of internal and external stability, there is an increase in risk-taking behaviour, which may lead to problematic mental health or a worsening of mental health, involvement with the juvenile justice system or problems with schooling.

*"...And then obviously you've got the legal aspect, so if they're in an unstable placement they're at risk. So either they're displaying those behaviours or they're at risk of dis- playing behaviours. That can get them into contact with the justice system. If you've got a kid with an intellectual disability and sexualized behaviours and they don't have a safe placement and they're able to act on those impulses or desires, they're then go- ing into contact with the justice system. Um, educational, I've known kids to miss school because in the morning the routine isn't consistent or reliable. Then they kick off, they miss school. Or they get to school and they're still 'kicking off' so they get ex- pelled or they get suspended or those kinds of punitive outcomes." **WF, clinician***

"Again, what I've seen is lack of engagement in education programs. That's probably the number one thing. The first thing to go is that they will not engage in their pro- grams. That will then result in an increase in mental health [issues], *drug and alcohol*

abuse which then impacts on mental health. Then an impact either in the health or juvenile system because if they're really unwell, it then goes on into the health system and if not, the juvenile justice system where they're involved in offending. Some of the offences can be assaults on staff or property damage, but a lot of times the young people enter the community and engage in behaviours as well. There are the armed robberies, thefts, car thefts, whatever, all kinds of stuff, but your higher end of offences."
WC, manager

Difficulties in engagement with school and increases in risk-taking behaviour link to internal instability. This, in turn, can cause problems within the placement itself, particularly with criminal charges and drug use within the house, which can then lead to external instability. Notably, though, this can be a bi-directional relationship. As noted by participant WF, with instability within the placement, there is a greater likelihood of internal instability, leading to risk-taking behaviours. Therefore, ensuring stability within the placement of routine and of relationships can work to lessen the internal instability.

The staff members suggested that instability within the placement leads to more negative outcomes for the young people, such as involvement with juvenile justice or difficulties engaging in school, among others. These comments speak to the consequences of instability within the placement, i.e. that it can lead to ongoing instability within the young person. This finding regarding the negative consequences of instability highlights the importance of ensuring placement stability where possible.

Loss of stability after turning 18

A number of staff identified the impact of leaving care at 18 years of age. They noted that the experience of being rejected by their carers at 18 can undo much of the stability that has previously existed. The knowledge that they will leave care can be destabilizing well before the eventuality, according to the staff. This can be remediated, however, by preparing ahead of time and staff maintaining contact with the young people once they have turned 18.

"I think at 18, it's too early, obviously, and destabilizing. I think that the kids already fear that, well, not fear, although it's warranted, that fear. They know it's going to happen, they are going to be rejected by the carer which is the state. They're going to be rejected by their parent once they turn 18. So, the other kids see that this happens. It's confirmed to them that once you turn 18, no one cares about you anymore. It can destabilize those who are 16 in that same placement. But if it's well planned and celebrated and it goes well and the other kids can see there's a follow up, an ongoing relationship after they turn 18, a I have seen a couple of programs that do this successfully. Most don't do it and can't do it and feel that there's too much liability and risk but some do and do it very well and actually it has a really good impact on the other kids" **SM, clinician**

"Yes, that's right, it can be that simple but in terms of the person's life, what does that mean? At 18 then you're out. OK, yes, you've had two placements since you've come to this organization or agency. At that age, you've only been in two places, wonderful, stability. After that? Don't know." **SJ, regional manager**

"Sometimes we can keep in contact with some of them as long as it goes through the agency, which is good. For a long time, there was a stigma saying we can't once they're 18 have any contact with them. The stigma was around for a long time which doesn't now exist. We actually can keep in contact with them as long as we let the agency know, whatever agency that we work for. For myself, I just have to let the agency know, so they can put that down in my file saying that this person has contact with that person. So there was a stigma for a long time that we're not allowed to have contact and it's sad. Because you've spent a lot of time with that young person, that person then goes back home and sometimes they don't have that network support from even their family. I do agree that until 21 they should get support and I agree that should keep happening. 18 is too young, way too young." **AB, youth worker**

"A lot of them went on to have good outcomes, a lot went on to having a huge amount of aftercare done because the workers that were working with these young people for a long time, were still working within the house. So it was always a place

that you could come back to. They could call up, we would talk to them. We would also always give them therapeutic interventions even after they had left. A lot of the workers went above and beyond anything they had to do." **JA, manager**

The staff here noted that the stability young people experienced during their time in care is, at best, for a few years out of a life span, and this may not be sufficient to repair the harm that was done prior to their time in residential care. It may also not be sufficient to buffer them against the upcoming instability that is often the parting gift for care leavers. Care leavers are known to experience worse outcomes than their non-care receiving peers (Mendes, Snow & Baidawi, 2016).

A trauma informed response to this reality, according to clinician, SM, is to prepare the young people to anticipate follow up relationships with the staff, which provides ongoing contact after the end of their time in residential care. This would likely reduce the feelings of abandonment and terror at being legally deemed an adult without the support of those who previously provided care.

This finding is significant in its relationship to understanding stability in residential care. The end of care at 18 years of age provides an element of instability, regardless of the amount of stability experienced while in care. This must be taken into account when operationalizing stability. To provide further stability, it is likely that there needs to be an extension of the caring relationship, such that ongoing contact is possible for the young people as they leave.

6.5 Conclusion

It is notable that staff were generally able to identify positive outcomes as a result of stability within the houses. They noted that, where young people lived in houses with stable staff with whom they were able to build relationships, they were better engaged in the houses and with their education programs, and displayed improved emotional

regulation and a greater ability to build the lives they want. Without stability, staff observed damaged or lost relationships and a retraumatization through reinforcing the loss and abandonment that may have been part of their early life experiences.

In the following chapter, the findings from the young people's interviews will be discussed. These findings will first consist of an overview of the demographics of the young people, after which results are synthesized concerning how the young people define, understand and explain stability within residential care.

Chapter Seven: The youth speak

"[stability taught me] people can be nice and care and aren't going to hurt you and will respect you." **B, 18 years, female**

This chapter presents the findings from the young people's interviews whereby the young people provide their views on how they define, understand and explain stability in residential care. It incorporates the information discussed previously regarding the demographics of the young people who participated in this research and provides an analysis of the major themes they identified. These major themes include external stability, internal stability and the strategies that need to be implemented by the organizations in order to provide stability, such as appropriate matching within the houses as well as the need for peer relationships to be supported by staff. The chapter concludes with a discussion of the impact of stability and instability on young people to begin determining whether stability, as operationalized as a multi-faceted theme, can provide a reparative effect.

7.1 Young people's interviews

Table 4.4 provides a summary of the demographic information regarding the young people who participated. Detail has been provided around these demographics in chapter five. The information was true at the time of the interview, i.e. age, education etc. Information was gathered regarding the young people's mental health, disability, contact with juvenile justice (JJ), education and current housing because this particular population is known to be particularly disadvantaged and more likely to have less educational attainment, greater contact with the justice system and difficulties with mental health (Mendes & McCurdy, 2020).

Table 4: Young people's demographics

Participant	Age	Gender	Indigenous	Highest education level attained	Mental health and/or disability	Contact with JJ system	Current housing
B	18	Female	No	Year 12	Yes (Mental health)	No	Semi-independent
J	20	Male	Yes	Year 12	Yes (mental health and disability)	No	Family
D	21	Female	No	Year 8	Yes (mental health)	Yes	Semi-independent with children
E	18	Male	Yes	Year 12	Yes (mental health)	No	University campus
K	22	Male	No	Year 12	Yes (disability)	No	NDIS funded placement
T	24	Female	No	Year 10	Yes (mental health)	Yes	With partner and children
A	24	Male	No	Year 9	Yes (mental health)	Yes	Alone (child removed)

M	22	Male	Yes	Year 10	Yes (mental health)	No	With partner and children

The above table sums up the information covered in detail in the previous section. Notably, half of the sample (n=4) had achieved Year 12 qualifications, and half (n=4) being young parents. These groups did not overlap. Those who had completed Year 12 did not have young children; those who did not complete Year 12 did. Further, everyone in the sample reported having a disability or mental health condition and everyone had safe housing at the time of the interview.

The following table provides a summary regarding the young participants' experiences of entry into the care system, their entry into residential care and their placement experiences. This information was gathered to identify levels of stability and instability, both during their time in residential care and prior to entering it.

Table 5: OOHC experiences

Participant	Age at which entered OOHC	Reasons for entering OOHC	Age at which entered residential care	Reasons for entering residential care	Overall time in residential care	OOHC placements (not incl. residential care)	Residential care placements
B	15	Neglect	15	Neglect	2.5	0	2
J	Unsure	Unsure	Unsure	Unsure	unsure	2+	2

D	5	Drug use and home-less-ness	13	No foster care place-ments avail-able	2	7	2
E	4	"Unfit mother"	14	No foster care place-ments avail-able	3	32	1
K	13	"Prob-lems"	13	"Problems"	5	0	2
T	12	Domes-tic vio-lence	13	No foster care place-ments avail-able	3	2	6
A	12	Domes-tic vio-lence	14	No foster care place-ments avail-able	4	8	28
M	8	Unsure	10	No foster care place-ments avail-able	8	20+	3

Some participants struggled with recalling details about their time in care and prior to it, so were unable to provide precise numerical information. This makes accurate estimates of the average numbers of placements, of schools and even of the age of entry into the care system difficult to assess. It is notable that almost all the participants who entered residential care via foster care reported that they did so because of a lack of further foster placements. The smallest number of total placements experienced by one participant was two, the highest number was 36. The smallest number of residential care placements was one, with the highest being 28. Of those who had been in foster care, the smallest number of foster care placements was two and the highest, 32.

In the following section, the findings from the young people's interviews are discussed.

7.2 Young people define stability

In a similar way to the staff participants, the young people interviewed defined stability as having two main elements, external stability and internal stability. In defining external stability, they discussed the need for external elements in their world to be predictable and consistent. In defining internal stability, they discussed the impact of external stability and instability on their internal world.

7.2.1 External Stability

Consistency

Young people described the need for consistency and structure as forming a significant part of stability. When a consistent structure was in place, it allowed for bonding and relationships to build and for this to be passed on to new residents:

> "*Yes, I mean there was never bad times. It was always good times you know, whether it was dinner in the afternoon, we would all sit down and cook food, sit down at the table and eat together, it was just a very family orientated house. And we obviously tried to incorporate that with the new kids that came in, so it was not*

to re-shake the entire structure. We took time and took a lot of bonding between us and the workers to build that. I don't know how that house worked. That structure, any worker that would go to that house would tell you that was the best shift they had ever had." **M, 22 years, male**

This young man explained that the structure of the house, a consistent way of living within the house, encouraged feelings of being part of a family. The consistent family-like structure that was developed was passed on to new residents when they came to live in the placement. This allowed everyone to know what was happening, what was coming next and that the young people would be included in the activities with the staff.

Staff consistency

Consistency, according to the young people, was multifactorial. Consistency was needed in the staff, other young people and placements – specifically, reducing the numbers of placements. Consistency of staff was noted by young people as of primary importance because it allows for the staff to build relationships with the young people:

> *"with stability there's kind of got to be that permanency, like we went through probably three clinicians in the two and a half, three years that I was there, two educational consultants, two house managers. So there was never permanence and even with permanent staff, they rotated a few times as well but… and the staff have to be able to build a connection with the kids: one, it would make working easier and two, it's much more effective."* ***E, 18 years, male***

> *"Obviously the carers that are coming in and out – if they keep them regular as such so then, you know, you have your handful of carers that are coming in and out, so then that child has familiar faces all the time. Not obviously different faces every single day, I believe that would go a long way."* ***T, 24 years, female***

Co-resident stability

Consistency of the residents in the house was also discussed as being significant for the running of the house. It affected the mood within the house and may also have impacted the young people feeling that their own placement was safe. The young people, like the staff, did note positives and negatives associated with other residents changing placements. Indeed, the same participant identified multiple different experiences of co-resident changes. As also identified by the staff, this appears to be an area in which consistency is less important. However, positive relationships with co-residents can be beneficial:

> "*Oh definitely, you feel the difference in the atmosphere when someone [young person] moves out, you know. You don't feel as cheery as when they were around, kind of thing*" **A, 24 years, male**

> "*I never really got along with most of my housemates, so when they left it was fantastic. Got peace and quiet. I've had housemates to the point where I had a room downstairs, they had a room upstairs and they've been jumping on the floor all night. So, I'm just like 'yep, bye, I can sleep now'*" **A, 24 years, male**

> "*[YP moves] It doesn't [matter], you get more time if you're in a house where there is two staff members and two kids. Once they leave, you get two staff members so it's better. Until, that's for as many hours [as] there is not another kid shoved in straight away after, which usually happens*" **M, 22 years, male**

Consistency within the placement

Stability and consistency of the placement itself was also seen as integral. Reducing the number of moves for a young person allows that young person to form bonds with the staff and residents, and also the community in which s/he is living, such as the school and local friends:

> "*A placement [being] stable is, obviously mine wasn't stable because I was always moving around and getting told at the last second that I'm moving. If you want a child to be familiar as such and not act out, don't move them hours away from the*

*placement where they were. You know, don't move them... because they're moving away from schools. Not just schools that they have made friends, they have made friends in that area. And when you're pulling them away, they have got to start again and that mentally disturbs a young person because their life is just jumbled. They're thinking to themselves 'well what's happening? Why can't I just stay put? Why can't I be in that same area to be able to still go to the same school as what I was at?' What they're familiar with, they just don't care, they just take it out from underneath them and move them a whole hour or two hours away. It disturbs that young person. So I believe that keeping them in placement rather than continuously moving them around would go a long way." **T, 24 years, female**

Consistency, according to young people, provides the structured predictability that allows them to know who is taking care of them, who is living with them and the environment in which they are living. This finding is significant as it suggests that being in a single placement is insufficient as a measure of stability, in the absence of the other types of consistency. Living in a single placement features in stability. However, if the staff and young people around them are inconsistent, then it would not only affect the structure and running of the house but also the mood within the house and the relationships that can be built between household members.

Ongoing staff contact

Young participants further described the impact of being able to have ongoing staff contact once they had left care, or through the process of changing placements. The continuity of support provided by ongoing contact provided significant benefit for them. They noted that the relationships they formed with staff sometimes felt like family relationships that at times continued on into adulthood. These strong relationships have provided the benefit of support once the care experience was over. Whilst still in residential care, continuing relationship contact can make the transition to a new placement easier as the young people were able to transition with one relationship that was intact:

"We felt like a lot of these blokes, you know, they still speak to you to this day and have met my kids, you know. All these blokes, they still keep in contact, you know. They've offered hands when I need it, they're part of my family that I see." **M, 22 years, male**

"Well I still talk to them to this day. So I must have had a good connection with them because I still see them and talk to them. Like, they know my kids and stuff…" **D, 21 years, female**

"Yes [staff member moved to new placement with him] because they said I was closest to him of any of them, and that I will feel more comfortable if he came along and stayed…" **J, 20 years, male**

The experience of continuing attachments highlights the importance of relationships within residential care. The staff are not simply individuals who provide shelter and meet basic needs. Rather, they form strong relationships that allow young people to feel safer when transitioning to a new placement, and with whom young people form relationships that may continue into adulthood. The young people here noted that the staff members continued to provide emotional support, at times physical support, such as helping to move house, and have relationships with their children.

The depth of connection expressed here goes far beyond the experience of simply being put in a placement that continues for a period of time and thus contributes to a sense of stability. The possibility of ongoing relationships provides an additional element of stability; not just in the continuity of relationship, but the depth of relationship experienced. This continues past the care experience and allow the staff members to have relationships with the participants' children.

Casual staff

The young people also described the importance of limiting the number of casual staff. They described the impact that an organization's employment of many casual staff can have on their sense of stability, which concurred with staff's comments:

"[impact of casual staff was] very bad coz they don't know you. They come in and they read your file and that's what they judge you off. And then they don't like, there's no point in you having any contact or getting to know them because you're never going to see them again. Or if you do, it will be like one more time. You'll never see them, you kind of turn, well I isolated myself and just didn't get to know them. They were just going to be there for 10 hours and then going to go and I was never going to see them again so..." **B, 18 years, female**

"The same way they were, like a kid wouldn't be OK for you to go look after some other baby and just leave your kid. That's how we feel, these people were like our parents, so we want consistency. We don't want you here one day of the week and then back the next, then you know, off for two weeks and then drop back in again." **M, 22 years, male**

The young people noted that the presence of casual staff was destabilizing. This is because not only are they unfamiliar with the young person, sometimes they may make judgements about the young person based on file records rather than being able to get to know them. Further, the lack of consistency provided by the casual staff can contribute to a sense of abandonment, as expressed by Participant M above, in likening it to one's parents going away to look after someone else's child and a casual staff member dropping in periodically.

The experience of the presence of casual staff highlights the need for a deeper understanding of stability. Previous operationalizations of stability have focused on the ongoing nature of a single placement as constituting stability. However, if this were an accurate depiction of stability, the presence of casual staff would have little impact as the placement has not changed. What has changed, even for a single shift, is the experience of the placement and the loss of consistency and relationships. This is sufficient to be destabilizing, which suggests that stability requires consistent routines and relationships.

7.2.2 Internal Stability

Young people also defined overall stability as involving an internal component, i.e. that their internal world felt stable, in terms of their ability to self-regulate and get to know themselves. They identified the impact of external stability and instability on mental health; on incorporating increases in emotional regulation capacity, and on the development of a sense of self and a sense of belonging:

> *"Well I was always angry before they taught me how to calm down and that. They said the way to calm down is to talk about my problems, which was fine."* **J, 20 years, male**

> *"Before I moved in [to residential care], I was a bit crazy… [staff] teaching me how to be nice to each other, how to be helpful."* **K, 22 years, male**

> **"***I just feel like there is nothing worse than just getting settled in and like calling somewhere your home or something and then you have just got to pack up like do it again. You get comfortable somewhere then you gotta go."* **D, 21 years, female**

The young people interviewed identified that the residential care staff had the ability to explicitly teach skills in emotional regulation, life skills and, alongside that, to assist a young person to develop a sense of belonging within the placement. This was, however, noted in the negative, that the sense of belonging may just be beginning to take hold and then the placement would end and the feeling of belonging would also end. The young people have highlighted an additional element of stability: the development of internal stability in the form of emotional regulation skills. By promoting the development of emotional regulation skills, the staff have assisted the young people to better manage their internal worlds.

Genuine care

The young people interviewed were able to discuss the process by which the external stability impacts on the development of internal stability, which is through the genuine care from staff and a connection to the home environment. The sense of being cared for

and living in a warm home environment provided an external stability that allowed the young people to develop greater internal stability:

> *"For the life I was given, why I had to go through all these foster placements why my parents couldn't look after me, why I had to endure the shit I endured. It was all just a big question of why. It took me a long time. But being loved, it does something to a kid. I couldn't be bad if I wanted to, you know, because I had love and respect for them and I knew that it was mutual, you know."* **M, 22 years, male**

> *"You know, a lot of them understood me and so, you know, if I was to act out as I said, you know, they will still be there. They would still come and talk to me and I did have a lot of them outbursts, not violent outbursts but upset and crying and didn't know how to feel, you know. If the workers through that week or day or whatever were helping me and saying '[name] are you OK? Let's go have a coffee, you know let's go get a milkshake, let's go for a drive somewhere, let's talk about this.' You know, rather than just sitting there and sweeping it under the carpet. Well that young person, you know, is going to feel worthless as such and their mental health as such or whatever the case may be, it's not worth their time. Do you know what I mean? And so I reckon, in my situation, because when I was at that placement, a lot of the workers were Islander. And you know, they're very family orientated. They sat down with me and they made my time there pleasurable. They made it that I felt welcome, I felt needed, you know. I felt cared for as such, you know, and that went a long way."* **T, 24 years, female**

> *"[having consistent staff] the idea that someone is there for them and someone actually cares about how they feel. Someone that wants to listen."* **A, 24 years, male**

> *"But then again, the houses I was living in felt like home. So they didn't feel like a youth house, It felt like a home. The cupboards weren't locked. The kids were allowed in the office. You know, the screen safety door was left open. It wasn't locked. You know, we were offered our medication, not told to have it, you know."* **M, 22 years, male**

The young people identified the value of feeling genuinely cared for, "loved" as identified by Participant M. This has the effect of helping young people feel welcome, as though they matter to someone, which, in turn, can assist them to want to behave in prosocial ways in order to please the attachment figures.

The finding that genuine care is required for a placement to be stable is further significant in that it challenges the placements-over-time paradigm that has been in place in the extant literature. A young person remaining in a single placement does not bring any guarantees of genuine care from the staff. As noted by Participant T, if staff were to "just sit (sic) there and sweep (sic) it under the carpet" when a young person is experiencing distress, the young person may feel "worthless". If remaining in a placement for a period of time was sufficient for stability, then the genuine care should not make a difference to an individual's experience of stability. Therefore, this finding highlights the insufficiency of this operationalization.

7.3 Young people understand stability

Planning for good matching

In understanding stability, the young people identified organizational processes that create stable environments for them. Similarly to the staff participants, young people were aware that the way organizations were run could increase or decrease stability for them. These young people identified the importance of organizations actively planning to achieve stability as the aim for the young people, through better matching and ensuring safety for the young people:

> *"[What makes] a bad placement bad - if you have children in there that are not getting along as such and are always fighting and knocking each other's heads. They can't get along, do anything as such, a young person is always running away and not coming home. I believe that – yes, OK, there is a lot of children in care, I understand that. But putting two young people together who obviously are not going to be able to live with each other or anything like that, as they are going to assault*

each other all the time or whatever the case may be - that in itself needs being looked at a little bit. Because I have been in placements with [staff member] at [location], another girl came in, her name was [name] and she would just always, just act out, always try and boot down my door for no given reason. For the simple fact that she was just having a bad day and she took it out on me as the other young person. I did not want to be at that house because I felt intimidated. I felt that I couldn't live safely in a home in that I should be feeling safe. Because of another young person." **T, 24 years, female**

"Maybe get to know the kid before they move in. Instead of just pushing the kid into a placement like, just sit down, 'so what are your interests? And what do you like to do with your spare time?' and all that type of stuff. So that they can understand the kid." **A, 24 years, male**

These participants have commented on the need to ensure appropriate matching between the young people in the placement. The participants, respectively, commented on the need for planning matches that allow the young people to feel safe within the placement and the need to understand the young people who are being matched in the first place.

Should a young person feel unsafe in the placement, it is unlikely that they will feel stable within the placement. In particular, as Participant T commented, the young person may regularly run away because of not wanting to be at the house. This finding adds another layer to understanding stability within residential care: the need to feel safe within the placement through good matching and the need to feel understood by those in positions of power who make decisions about where a young person lives.

Planning for transitions

Further, planning for transitions is considered to be a key component by the young people. Notably, the young people identified that this planning did not appear to occur very often, and its absence had significant negative impacts on their wellbeing. In contrast to

the staff participants, young people identified that planning for transitions rarely happened in their experience:

> *"Instead of just like moving in with someone, a complete stranger, maybe like introduce them beforehand and get them to know each other. Then when they live together, they will know what each of them is like so they're not clashing heads and stepping on toes."* **D, 21 years, female**

> *"It happened like every other week, it got to the point where I refused to even unpack my belongings because I knew that I would have to pack them up again.*
> *Interviewer: How was it that they told you that you were moving?*
> *Respondent: The day that I was moving.*
> *Interviewer: Every time?*
> *Respondent: Every time."* **A, 24 years, male**

> *"Not really, because I didn't get really told why in many of my placements, as to why I was moving. Even when I was in [organization] transferring to [different organization] I was not told until that day, that I was moving to a whole different organization, that I had to get my own way there. Thank goodness I had my licence and a car. I had to get my own way to [location] and I did not know where the hell [location] was and it was in [location]. And I was told that day, 'you are moving'. 'OK. Why? I am in [organization]. Why am I moving to a whole different organization, rather than a different house?' That was not explained."* **T, 24 years, female**

Planning to achieve stable placements required an understanding of who the young people are and what would be appropriate matches for them. Such planning also involves ensuring that moves are communicated in appropriate time to the young people so they could begin to adjust to the moves. In the absence of stability, young people would begin to disengage from their placements, to the extent of refusing to unpack belongings, likely making it difficult to form relationships with staff.

As discussed previously, these relationships formed the basis of external stability which allowed young people to develop internal stability. Communication to explain moves

and preparation time for the young people to adjust and form relationships with individuals at the new house were both highlighted by staff as key features of a positive transition. Without these, young people may struggle to settle into a placement as each day may bring with it the information that they are moving to a new placement.

Therefore, to understand stability, an individual requires an expectation of ongoing stability, which is likely impossible when placement moves are communicated on a day-by-day basis. Adding another layer to the understanding of stability, the continuity of a placement is insufficient, if the young person has no expectation that the placement will continue. The fact that it does continue may not allow a young person to feel stable.

7.4 Young people explain stability

Maintenance of external relationships

In contrast to the staff interviews, young people spoke about the importance of relationships outside the residential care environment. Further, they identified that sometimes staff facilitated these friendships in a beneficial way; whilst at other times the maintenance of these relationships was impeded by staff:

> *"Yeah, I had a few of them [friends] but they were in [my organization] as well… Because I wouldn't plan it, so they'd [the staff] usually just plan it [the activities with friends].' **J, 20 years, male***

> *"Um [long pause] because I spent that year and a half with just them [staff], when I first went to school and started making friends, they didn't think it would be good if I hung out with them. So, and then when I started to, like, they'd hang around with me. So they wouldn't let me and my friend do what we wanted to do. Like, they'd hang out with me and follow me and make sure I was doing like, yeah. So, in a way they did make it pretty hard." **B, 18 years, female***

*"I think that's a big part of child's life to be able to have friends over and OK maybe not sleepovers or anything like that. I get that. But you know, being able to have your friends there, to interact with your friends, to interact, it makes you feel a bit more comfortable. I would, you know, being able to have my friends there you know, on weekends or whatever. But you're not allowed to and it's a bit upsetting. It really is." **T, 24 years, female***

The young people noted here that friends outside of the residential home are important to their sense of wellbeing. Friendships may extend into adulthood, or foster a sense of normality or provide a sense of oneself being included in a group. This finding provides another significant aspect to the operationalization of stability: encouraging and supporting positive external friendships may provide additional buffering and stability for a young person, particularly if a placement becomes unstable.

School relationships

The young people identified external relationships as being an area of importance, particularly friendships and schooling. Having friends allowed the young people to feel more "normal." The continuity of these relationships, which can extend beyond a placement and give an alternate stability, provided a unique support. Young people identified that it was important for staff to facilitate these relationships:

*"Well, I go to an alternative school so everyone there has a diagnosis. So it was hard, but it was easy because pretty much 50% of the school are in care. So it was, everyone was really nice. It wasn't like your typical high school." **B, 18 years, female***

"I think the biggest thing would be school, because you know, no matter how much a kid changes houses, school can be that one permanent thing. Sure, sometimes it becomes a bit ridiculous getting there. I mean, you know where [location] is? I was living in [location], so I had to make a 2.5 hour trip each day. So that became a pain. But you know, school is an environment where kids can make friends and

build those necessary relationships. Where, these houses, you probably won't get that chance. Plus, education is key!" **E, 18 years, male**

Young people also identified that they were better able to learn at school when feeling stable; whilst, equally, school can provide stability. Stability within the home can make it easier to attend school and achieve within the school environment. However, in the absence of a stable home placement, a stable and consistent school can provide the stability a young person needs to be able to flourish.

> *"Went to school, had two jobs, that's after I left school, completed Year 10, got two jobs. I worked at Taronga Zoo, got that certificate there, worked there for two years, got my boat license afterwards, Cert III Maritime and Marine Distribution. I learned to drive boats at Sydney Harbour. I worked for Tribal Warrior, you know the proof [regarding stability] is definitely in the pudding."* **M, 22 years, male**

> *"Through the 32 homes I moved through, I was always at the same school."* **E, 18 years, male**

Peer relationships, particularly those established through school, can extend beyond the residential placement. The young people quoted here highlighted the need for school to provide these outlets for permanence and inclusiveness. School as a source of stability has not previously been incorporated in the operationalization of stability. This finding suggests that it should be. School and the friendships therein may provide an additional layer of stability for young people.

Relationships with staff

The young people noted that, through stable and significant relationships, they were able to reap the benefits of stability. They noted that relationships with their peers, staff and schools provided important scaffolding to give them support. The young people described the support given through these relationships, including that it increased engagement in positive activities and provided motivation:

"So when I was with like, workers that I liked and didn't mind hanging around, I wouldn't go off and get in trouble and stuff because I didn't mind staying at home with them or doing stuff with them. But if I was off doing my own thing because they weren't there, then I would get into trouble. I would do different things than when I was with a worker that I liked." **D, 21 years, female**

"Well we rarely did anything at the residential house. I knew I liked physics, that was my thing, it always sparked an interest in me but I never went anywhere with it. It was kind of a hobby. She, just in the first fortnight of knowing each other, she [staff member] took me to the observatory at Western Sydney University at the Werrington Campus. And yeah, it was like the best night ever! It was really cool! It just shook my interest through the roof for it! Then I really started pushing for university because of that, so…" **E, 18 years, male**

"[With good staff] yes, I wanted to do more stuff. I wanted to go out and I wanted to interact with people. I felt a connection with another human being and it made me feel wanted." **B, 18 years, female**

Conversely an absence of stable attachment relationships may result in an increase in risky behaviours:

"The one thing I don't regret is my son. But maybe if I'd gone into the one placement, maybe I wouldn't have got on drugs. I wouldn't have got into trouble with the law so much." **A, 24 years, male**

The primacy of relationships with staff indicates the significance of attachment relationships in providing support and prosocial influence. The presence of these relationships resulted in greater engagement and lesser risk taking; the absence of these relationships resulted in problematic and risky behaviours.

This finding holds significance in its understanding of the reparative nature of stability. Stability that involves positive relationships with staff appears to provide a desire to en-

gage in prosocial ways, forge connections and increase motivation. Appreciating the capacity of stability to provide these benefits further changes the understanding of measuring stability. In the extant literature, it has been hypothesized that stability may provide only a buffer against a worsening of outcomes (Tarren-Sweeney, 2017). However, this finding suggests otherwise, provided the operationalization includes more than an adherence to a paradigm of placements over time.

Support within Relationships

The young people noted that supportive relationships buffer against their internal experience and their historical experiences via their ability to work together through problems, their feeling of a positive connection to the staff and the staff having a positive influence:

> *"Yes, I think it is they're caring too, they're not selfish or anything, they help out"* ***J, 20 years, male***

> *"Loved. I put care and loved as two different words, you felt loved"* ***M, 22 years, male***

> *"I believe that it's made me the person who I am today. You know, because when I was first in care it was a very bad, traumatic… experience and at the end of… residential care with the end and everything, as I said you know they were there for me. You know, they were there to support me… and I think that in itself went a long way, you know. I felt that I had got a little bit of support… around me and I think … it's helped me in some regard being a good parent if that makes sense. It makes me a better parent to not parent my children how I was brought up. Or with some carers, they just turn their back. Well I don't turn my back when my son comes to me and is very emotional [with] autism or anything like that, you know. I don't do that, I don't turn my back. I sit down, you know, and speak to my son and comfort him and… I think I learned a lot from some of the carers in residential care… how to be as a parent… as a support more so, support and understanding for different situations."* ***T, 24 years, female***

Further, they described that an absence of stability can be retraumatizing and cause further damage. Instability can give young people a sense that they do not matter, that adults cannot be trusted and there is no point in forming relationships with people who will simply leave again:

> *"Well I just felt there was no point in being on this earth, there was nothing, no reason. Like, I didn't have like, not having a routine and not having stability and not having people there all the time and not having people I could connect with, like, to make me feel like, no one on earth cared and no one wanted to get to know me. Or the people that tried to and I did, would then leave. I was in a state where I was, like, there's no point in even getting to know anyone or connecting with anyone because they're going to leave."* **B, 18 years, female**

> *"Try and understand, you know, every child's circumstance because they're all not the same. You know, a lot of children can have a lot of bad things happen to them as children. I have sat down with other young people and I have heard stories, you know. God, some of them have it worse than what I did. If a youth worker isn't understanding of that, of, say for instance, a child being raped. Do you know what I mean? On numerous occasions, being a child what impact does that put on a child's mental health? You know, in these situations, or their parents are big drug addicts, or things like that, take every case differently. And yeah, as I said, try and, you know, work with that young person rather than working against or using every child's case the same. Because in some situations you have got to tread lightly, you know, because they could be more emotional. More, you know, about their traumatic past, you know. Children aren't in care because of something small. Children are in care because they have had a lot of things wrong, you know. So having a carer that is understanding, you know, I think goes a long way."* **T, 24 years, female**

The young people who were interviewed spoke about the support provided to them by the residential care staff. The experience of stable relationships that were meaningful and genuine provided modelling for how to be adults and parents. The relationships

provided guidance and practical support to solve problems. This assisted the young people to experience safe, healthy relationships even for a short period of time.

Conversely, in the absence of stable, genuine and meaningful relationships, the experience for the young people in the current study was feeling that there was no point in developing close bonds with anyone. They felt their mental health being impacted in negative ways.

This finding is significant because it expands our understanding of the reparative nature of stability. When stability is more completely operationalized as involving meaningful, genuine relationships with consistent staff, with life lessons provided by stable caregivers, not only can healing occur, but also positive trajectories are promoted.

Stability provides support

As discussed, participants described how consistency was required on multiple levels for optimal outcomes. The consistency of staff, residents and placement provided benefits for the young people, allowing them to feel 'normal' but also allowing the young people to grow into their best selves.

> *"It helps rebuild life in a way, because you've been through so many changes already coming into care. Then, like, your life isn't like a normal child's life. Having stability makes you, in a way, feel a bit like a normal person."* **B, 18 years, female**

> *"It allows me to be myself obviously and grow in a very structured environment. It allows me to grow and be the best I can. Obviously having good workers, it sort of gives you a bit of motivation to want to make them proud, as you would your mother or your father."* **M, 22 years, male**

The young people identified that, with the elements of stability discussed through this chapter, they can reap the benefits. They indicated that some of the positive emotional outcomes of stability were feeling 'normal' and that their prosocial behaviour to connect

with and bring pride to their residential care workers was promoted. This finding is significance for the theory that those in residential care in adolescence are not necessarily in a "last resort" (McPherson et al., 2021 p. 2) type of accommodation. Rather, residential care accommodation can provide love, teaching and acceptance when it incorporates the necessary elements of stability.

7.5 Conclusion

Staff and young people identified common elements that contributed to stability, and also common observations about the effects of stability and instability on young people's trajectories. They discussed the importance of stable and consistent staff, good matching processes, planning for any changes and the need to communicate these changes. The young people also noted, alongside staff, that relationships with others - be it the staff or peer networks - provided the impetus for prosocial change. In other words, with positive relationships, the young people acknowledged they were better able to engage in positive behaviours, reduce risk taking behaviours and engage in education programs that allowed them to flourish.

It was also noted that this stability can come from an external arena, such as a school, if there is an absence of stability within the residential house. Stability, according to the young people, requires not only a consistent placement, but consistent and genuine relationships with those around them. The absence of such consistent and genuine relationships leads to, or amplifies, problems within the houses and within the individual.

In the next chapter, the findings regarding the staff's and young people's interviews will be compared, contrasted and subsequently discussed in light of the extant literature base.

Chapter Eight: Where the Twain Shall Meet

In the current study, I sought to answer the research question, "*How do young people, who have lived in residential care, and residential care workers define, understand and explain placement stability?*" and aimed to:

1.   Understand the experiences of placement stability or instability for the young people, drawing on data from young people and residential care staff.
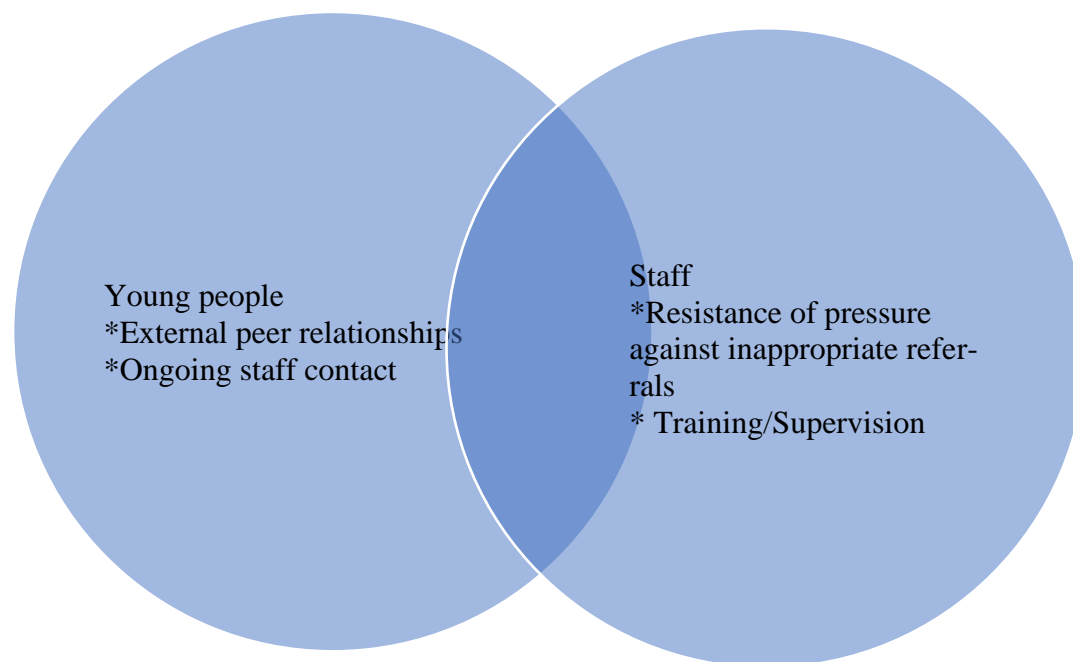
Once (1) was understood, I proposed to:

2.   Develop a multi-dimensional operationalisation of stability for young people in residential care.

In this chapter these aims are addressed explicitly; I discuss the research findings from the current study in the context of the extant literature. In doing so, I compare and contrast the findings from the staff's and young people's interviews, in light of the above aims. Central to the current research is incorporating the voices of young residential care leavers and ensuring that their perspectives are highlighted on what works and what does not. Following on from that, this chapter concludes with a discussion of future directions for research in this field.

The following diagram represents the overlap between the staff's and young people's perspectives. It demonstrates that the vast majority of issues raised by the participants were overlapping, with only four issues being raised which were not common to both groups.

Figure 3: Diagram of points of difference between groups

Young people
*External peer relationships
*Ongoing staff contact

Staff
*Resistance of pressure
against inappropriate refer-
rals
* Training/Supervision

8.1 Aim one

Understand the experiences of placement stability or instability for the young people and staff involved.

In the current research, are multiple elements of stability were found to fit together to make a placement stable. Each of these elements is discussed in turn. Firstly, there is a need for external stability. This encompasses a need for consistent staffing, for limited and/or consistent casual staff, for co-resident consistency, for ongoing staff contact after leaving care, for changes to be planned and communicated as well as for peer relationships external to the placement. Secondly, internal stability is required. For this to develop, it largely depends on external stability. Internal stability encompasses felt and actual safety and increased connectedness, leading to improvements in a sense of self, belonging and the resultant decreased risk-taking. Thirdly, organizational scaffolding is essential to ensuring the first two forms of stability can occur. This comprises providing

training and supervision as well as pushing back against the funding bodies to avoid inappropriate referrals. Further, organizational scaffolding encompasses appropriate matching of clients to ensure they could live together safely and the recognition of understanding and enacting trauma informed care. Finally, both staff and young people identified the impact of stability on the young people's wellbeing.

Notably, there are only four significant points of difference between the staff's and young people's interviews. Two are discussed by the staff and not the young people, while the other two are discussed in detail by the young people and not the staff. The first is the staff's need for the organization to resist pressures from the funding body for inappropriate referrals and the second is their need for training and supervision. The third and fourth, discussed by young people, are the benefit of ongoing contact with staff once they leave care and the need for external peer relationships. Each point raised by the participants is now discussed in more detail.

8.2 External stability

Staff consistency

Staff and young people both identified the need for externally stable elements for a placement to be considered stable. In particular, both sets of participants emphasized the need for consistent staffing as being vital. The extant literature on attachment suggests that those in OOHC have disproportionate rates of insecure attachment, particularly disorganized attachment (Bifulco et al, 2017; Oskis et al., 2011). The development of a secure attachment requires input from consistent and attuned caregivers who are responsive to the needs of the individual (Ainsworth, 1989; Mikulincer & Shaver, 2007), which is replicated in a placement with consistent staff members. Both sets of participants were aware of the need for consistency for a placement to be felt as stable.

Consistency applied to both the staff members and constancy within the house, including staff interpretation and enactment of the rules and routines and how the staff man-

aged various situations, such as maintaining routines or addressing behavioural difficulties like property damage or self-harm. It is notable that for both sets of participants, this is considered to be one of the most vital elements that brought stability to a placement, and it may encompass both the house staff as well as the ancillary staff such as caseworkers, managers and clinicians. The young care leavers typically reported, on average, 8.9 placements prior to entering residential care (min = 0, max = 32), with an average of 5.7 placements while in residential care (min = 1, max = 28). Within residential care there are, generally, five core care staff on a rotating roster plus casual staff associated with the placement, as noted by staff participant SJ, "so obviously if the team is made up of 5 or 6 people, now you have 15 people" when staff are not appropriately supported. With 5.7 as an average number of residential care placements, with up to 15 staff associated with each placement, a young person may experience 85 caregivers across their time in residential care, if staff stability is not prioritised.

Some of the young people reported they had had a great deal of instability of staff, even while remaining in a single placement, or two placements, which led to feelings of disconnection and a fundamental sense that the placement was not positive. Other young people who reported a greater number of placements, but still had placements within which there was stability of staff with whom they felt connected, reported more positive experiences within residential care. The UN guidelines on alternative care for children (2010) highlight that within residential care, there should be sufficient caregivers who can provide individualised attention to the young people with an opportunity for the young people to form a strong bond with a particular caregiver. The current findings regarding the need for staff consistency highlight the importance of that specific guideline.

This finding has not previously been made in the existing literature on stability. However, this can be explained by the previous literature being based on foster care. The key difference between foster care and residential care is that foster care is a family-based model, in which the young person resides with the family, as part of the family. Therefore, for a placement to be consistent, the caregivers also, by definition, are consistent and known to each other and those in the placement. This difference between the placement types highlights the need for researchers to specifically examine stability

in residential care. Within residential care there is no guarantee of consistent caregivers, nor that these caregivers are known to each other, as in the case of new employees or casual staff. Thus, this particular finding needs specific consideration.

Furthermore, with a closer examination of the stability literature in foster care, the connection between the child and the caregiver and the reciprocal ability for the child and caregivers to form relationships with each other (Withington et al., 2016) are identified as important elements in behaviour management. Alongside these elements, a consistent approach to caregiving showed improvements in internalising and externalising behaviour in the young people (Proctor et al., 2010). These previous research findings accord with the current findings, that consistent caregiving and caregivers are crucial elements to stability.

The significance of this finding cannot be underestimated as it is likely that without this element, stability is not possible to achieve. The use of casual staff (to be discussed next) can often cause difficulties within a house. As the primary researcher has had experience of working in residential care, both as a floor staff member and as a clinician, it is possible for her to speak to the difficulties experienced when there is a lack of consistent staffing. One of the most common situations for the over-use of casual staff is within a house with young people who are either poorly matched or present a combination of behaviours that are extremely challenging for staff to manage, such as if they 'gang up' on staff, or become threatening towards them. Alternatively, poorly matched young people often present highly challenging risks to each other. The presence of such risk factors can put constant and high pressure on the permanent staff working in the house, leaving them to take the leave allowed to them. Thus, casual staff are required to cover those shifts.

Moreover, given that the experience within the house is highly challenging, once there is a presence of casual staff, the young people tend to become more internally unstable, as discussed in Section 8.3. This makes working within the house even more challenging. This challenge can present as too great for the casual staff, such that they do not wish to

return to the house, so the staffing becomes even more unpredictable, further exacerbating the problem. On another occasion, an entire staff team was required to be dismissed, meaning that an entire suite of staff had to be casual while new staff were hired.

Casual staff

Both sets of participants identified the presence of casual staff as destabilizing for the placement. The participants, as a group, noted that casual staff are unfamiliar both with the residents themselves and the routine. This leaves the young people feeling unsettled. The consistency provided by regular staff is, according to Cashmore and Paxman (2006), the conduit by which "meaningful and trusting relationships" (p. 238) are formed. The presence of casual staff inhibits the development of meaningful and trusting relationships because they are not consistently there. The young people likened the presence of some casual staff with feeling akin to being abandoned by their parents.

As noted, however, if consistent casual staff can be arranged as part of the team, these issues are reduced, particularly if they are familiar with the routines and the young people. This finding is notable, in that it wholly expands the understanding of stability as extending beyond a paradigm of placements over time. The experience for both groups of casual staff as destabilizing, as reducing the stability of the placement, highlights that simply being in a placement over a period of time is insufficient as an operationalization of stability. For a young person, if simply remaining in one residential house for an extended period of time were a sufficient experience of stability, the presence of casual staff, while all else remains the same, should not detract from the stability of the placement. The fact that, according to the young people and staff participants in the current study, it has a significant effect, enhances the understanding of what it means to be in a stable placement.

As a corollary, the presence of stable casual staff, who are also known to the young people and the other staff, has a less dramatic impact on the stability of the placement. This was true for both groups. This finding suggests that it is not casual staff per se that cause difficulties within the placement, but rather the presence of unknown staff, or staff who are, as noted by the young people, present for a day and then return two

weeks later for another day. When considered in the context of trauma informed care, exposing young people who have experienced trauma and abuse to the experience of caregivers who are fundamentally strangers would necessarily be destabilizing. Forming a pool of casual staff would alleviate this experience of distress by ensuring there are additional people known to the young people who are available as ancillary carers.

Significantly, in previous research, casual staffing has not been discussed as being related to stability. However, attachment theory would contend that the presence of consistent and attuned caregivers is a key component for developing a secure attachment (Mikulincer & Shaver, 2007). This, as noted by Graham (2006), is one of the key tasks of residential care. As discussed in Section 2.5, the presence of casual staff would not have formed part of the discussion within a foster care setting. Because this is a family-based environment, there are no leave allowances, thus eliminating the presence of casual staff.

There is, of course, the opportunity for respite care for children in foster care. Respite care, as discussed in the literature review, is the provision of alternate care for children for a period of time. It can be either formal (typically provided by licensed caregivers and possibly funded) or informal (such as provided by family networks; Owens-Kane, 2007). Researchers suggest that the ability to receive formal and informal respite care increases stability within the family, augments family cohesiveness and reduces stress (Madden et al., 2016). While researchers and practitioners have not previously formally discussed the consistency of carers, however, it can be surmised that informal respite, if not formal respite, would be provided by people known to the children. This is because they form part of the extended network of carers' family and friends. The ability to provide respite care with safe adults known to the children would function as an opportunity for a break for the carers while maintaining consistency. Residential care is a unique environment, with the rotation of staff and presence of casual staff. This highlights that it is imperative that researchers look specifically at residential care, to understand the nature of stability within this environment, rather than extrapolating from research into foster care.

Co-resident stability

External stability was, to a lesser extent, influenced by the stability of the co-residents in the house, according to both the staff and young people. No research to date has been found regarding the specific relationships between co-residents and the impact of stability and instability on them. This is, however, unsurprising, given the analysis of stability and instability as being based solely on the numbers of placements. The finding concerning co-resident stability in the current research was significant. Both groups of participants agreed that the stability of co-residents was not necessarily required for a placement to feel stable. Both staff and young people identified that, at times, co-resident moves could be positive for those remaining in the house, particularly if those who had moved on were displaying problematic or frightening behaviours.

Additionally, the experience of co-resident moves may be neutral for young people, especially if they had not formed strong relationships with each other. Some did contend, however, that the experience of co-resident moves can be deleterious to the placement and may cause grief at the loss of that co-resident. Some stated that such moves may alternatively highlight the instability of one's own placement, particularly if someone ages out of the care system and has to leave.

Young people in residential care are both the 'resident' and the 'co-resident'. They live in the placement with other young people and other young people live in the placement with them. Therefore, anything that befalls a 'co-resident' can also befall a 'resident' and is possibly experienced as such. A young person who is the 'resident' staying put, has likely also been experienced by someone else as a 'co-resident' who has been left behind, and vice versa. The experience of being both the 'resident' and 'co-resident' may tangle many themes as a young person is not simply the focus, but rather one of the foci. In other words, while they consider their experiences in light of themselves as 'resident' and others as 'co-resident', the other residents see them as 'co-resident'.

Findings from Bifulco and colleagues (2017) regarding the high level of insecure attachment, particularly disorganized attachment, may inform this particular finding. Disorganized attachment, as discussed in Section 2.1, is an attachment style that initially develops in response to a caregiver who is both the source of comfort and the source of

fear (Schimmenti & Caretti, 2016; Van der Kolk, 2014). In this situation, a child has to attempt to resolve the unresolvable paradox of whether to seek care from someone who may be as likely to offer comfort as harm. This particular attachment style can leave young people with difficulties managing their emotions and interpersonal relationships (Schimmenti & Caretti, 2016). This may explain the lack of connection, as well as some of the frightening behaviours displayed by young people. Some young people and staff noted this behaviour existed in many co-resident relationships.

As discussed previously, however, meaningful and trusting relationships are central to the development of a secure attachment style. Therefore, a rotation of other residents within the house would inhibit the development of a secure attachment style. The fact that the residents may express concern about co-resident rotation may reflect both difficulties in the placement and an insecure/disorganized attachment style. Forming attachments to peers may not always be positive. For instance peer contagion (Mendes et al., 2014) occurs when young people are influenced to behave in antisocial ways through social modelling. However, the ability to form positive peer relationships is integral for mental health benefits.

Ensuring positive matching would reduce the likelihood of pairing antisocial peers and mitigate the risks of peer contagion, to some degree. This theme plays into the importance of planned and communicated placement changes; forming relationships ahead of the placement move would likely facilitate the development of positive relationships. Ensuring changes are planned and considered in the best interests of all the young people in the placement would likely guarantee the possibility of prosocial relationships. This would thus facilitate the development of secure attachment styles.

Ongoing staff contact

One important element of stability that only the young people focused on was the staff contact that continued beyond their time in residential care. They commented that the relationships formed with staff were similar to positive relationships with family. They stated these provided ongoing practical and emotional support after their time in care

had ended. As Schofield and colleagues (2017) argued, those who had positive residential care experiences felt a connection to the staff, "like a mum" or "like a dad" (pp. 787-788) and this ongoing connection sometimes persisted post-care. Graham (2006, p. 1) further noted that residential care can provide a "second chance" at a secure base, reshaping the attachment styles from insecure to secure. This appears to be the case for some of the young people in this study. Some young people asserted that residential care staff taught them about parenting and made them feel loved. This echoes the findings from previous literature (e.g. Gallagher & Green, 2012; Verso, 2011). Residential care agencies may need to focus more on the importance of ongoing contact after leaving care. They could do this by not only supporting but encouraging this contact and making provisions for the staff to be able to maintain it.

The notion of social capital, particularly through developmental relationships (Scales, Boat & Pekel, 2020), provide key elements that were highlighted by the young people in the form of staff being able to express care, provide support, providing respect and collaboration, and expanding possibilities. The young people identified that staff would provide practical support as well as emotional support and this form of social capital provided a feeling of being loved and cared for. Scales and colleagues (2020) highlighted that the social capital described here linked to reductions in risk taking behaviour, increased thriving in school environments. The staff appear to have provided a key form of social capital to the young people, particularly when those relationships were able to be ongoing beyond the statutory care period.

While the young people commented on the need for ongoing contact with staff, this was a lesser issue for the interviewed staff. The reasons for this are unclear. However, it may relate to the smaller proportion of floor staff interviewed. Only three of the staff participants worked primarily or solely as youth workers. Many others had been youth workers, however, management or clinical roles formed the majority of their experience. Floor staff would likely be the ones having the ongoing contact. Managers and clinicians may be less likely to form ongoing relationships as they are less involved in the day-to-day care of the young people.

Alternatively, given the focus of the interviews was on what makes a placement stable, the staff may not have been considering what occurred once the placements ended. Under different circumstances, they may have placed a great deal of importance on ongoing contact.

A third explanation may be that, for the young people, the ongoing contact has more significance and meaning than it does for the staff members, given that these young people may have connected to a small number of their carers. In contrast, over a long career, the staff are likely to have worked with a large number of young people. This issue may benefit from exploration in greater depth, to determine whether ongoing contact is sufficient, or if it needs to be a specific kind of contact with particular staff members.

Given recent policy changes to extend care until the age of 21 years in five jurisdictions, the notion of ongoing contact will require additional consideration. The implementation of extended care for those in residential care appears to have been a challenge for policy makers. As discussed by Narey (2016), the resulting situation of adults (over 18) living with minors (under 18) and the prohibitive cost of the additional years of full-time care led the UK to develop a pilot program called Staying Close (Mendes & Rogers, 2020). This program made provision for young people to stay near to their residential house and visit regularly to spend time with the staff and young people.

As discussed in Section 3.9, there are multiple practical difficulties with this program. These include a lack of clarity around what supports are provided, who locates the accommodation, who funds it, what kind of emotional and practical supports are provided and how the program is different to existing semi-independent living programs. Indeed, young people living in extended foster care arguably present the same logistical difficulties as young adults living with children. Yet, in contrast, they are able to retain the ongoing care and day-to-day practical support of their caregiver. While the financial contribution from the government is markedly different for foster care and residential care, the practical difficulties are not particularly different. Ongoing evaluations of these programs will yield interesting results to determine their efficacy.

Planned and communicated changes

The final element of external stability relates to the need for planned and communicated changes. Staff and young people alike spoke of the need to plan changes of placements and communicate with the young people about these. Further, preparing for transitions was of primary importance to both groups; however, they differed in their expectations of this preparation. Notably, the staff spoke about the need for long transitions, with the ability to form relationships with those in the new placement, prior to moving in. This was a more idealistic assessment of how transitions *should* be conducted, rather than an analysis of what *was* conducted.

The young people interviewed primarily spoke about the lack of planning and communication with regards to their own placement moves. In general, the young people identified that changes occurred with little notice and little to no ability to form relationships ahead of time. Despite the different points of view, both sets of participants were in agreement that short transitions were problematic and longer transitions were beneficial.

The finding in both groups was clear: that greater emphasis should be placed on planning and communicating changes. This identifies a need for a more complete understanding of stability. There is an awareness and acceptance that some instability is inevitable, under certain circumstances. However, equally shared was the view that this instability can be planned and managed in ways that may promote stability in the next placement and reduce anxiety while in a current placement.

Given that planning likely requires an expectation of ongoing stability, changes that are communicated without notice and preparation may instead provide an ongoing expectation of instability. For example, Participant A had 28 residential care placements, each of which was communicated on the day of the move. There would likely be an expectation for this participant of ongoing instability, knowing that each day could bring the news of another placement change. Therefore, holding an expectation that any moves would be communicated well in advance and that a period of time would be available to adjust and form relationships with those in the new placement would likely provide a greater sense of stability.

External stability encompasses the world around the young people being consistent, stable and focused on their best interests. For the young people, this also includes ongoing consistency once they have left state care. Ensuring consistency within the placement and timely and useful communication about changes provides an important pillar of stability for young people in residential care. This understanding of external stability offers a great deal more information regarding what constitutes stability. This is because the day-to-day care being consistent and provided by consistent people is qualitatively different to simply remaining in a placement for an extended period of time. The absence of a consistency of approach and a consistency of individuals creates instability, even if a young person remains in a placement for the entirety of their time in residential care.

8.3 Internal stability

Staff and young people noted that internal stability is distinct from external stability but intrinsically linked with it. The development of internal stability is often predicated on the experience of external stability. Internal stability is the experience of being internally stable. This involves the capacity to feel safe, have a sense of self, regulate emotions and feel a sense of belonging. These elements will be discussed in turn, with reference to the literature and the findings from the current research.

Safety

According to the staff and young people, the development of an internal sense of stability relied upon the experience of both felt and actual safety within the placements. This means that the young people were physically safe from harm within the placement, but also felt safe while they were there. This finding accords with the attachment literature; young people who have experienced trauma have an impaired ability to build a sense of trust and safety (Davies and Frawley, 1994) and those in OOHC experience the world as unsafe and themselves as being unsafe (Balluerka et al., 2014). Further, Graham (2006)

argued that one of the core tasks of those in residential care is to become more success-ful in seeking comfort and safety from responsible others, particularly residential care staff and, indeed, those young people who felt a safe connection with the staff members had more positive outcomes in adulthood (Schofield et al., 2017).

As discussed in Chapter 2, research into the impact of early trauma on brain develop-ment indicates changes to brain regions that make feeling safe more challenging. Early stress, such as trauma and abuse, sensitizes the amygdala, the fear centre of the brain, to stay in the fear state longer and to become activated more easily (Pechtel et al., 2014; Schalinski et al., 2016; Teicher et al., 2016). This makes attaining a feeling of safety more challenging, even in an environment that is safe. What this means is that a young person in OOHC may become afraid or activated more easily, by a greater number of events of occurrences, and find it harder to calm down or be calmed than someone who has not experienced trauma.

Often, as discussed in Chapter 2, when an individual experiences the setting off of the 'smoke detector' amygdala, by seeing something out of the corner of their eye that re-sembles something feared, such as a hairball that looks like a spider, the fear can be down-regulated by the prefrontal cortex, as the individual realises it is just a hairball and therefore, calms down. This is far more challenging for someone who has been trau-matized, therefore, the experience of feeling safe is often more challenging, even when there is objective safety. Cashmore and Paxman (2006) also identified the importance of felt security for a young person in a placement, which extends beyond remaining in an apparently stable placement to a sense of security within the placement and a connec-tion to safe others. This supports the current findings.

The discussion by both staff and young people in the current research highlights that the feeling of safety is as important as the experience of being physically safe. Both the staff and young people cited the need for physical safety within the placement. How-ever, notably, the young people referenced safety almost exclusively in the context of safe peers rather than safe staff, or feeling safe with staff. Staff typically, however, dis-cussed safety in the context of healing. They expressed the view that young people who felt safe had greater opportunities to heal the harm to which they had been subjected

and to participate in therapeutic interventions. As noted by one staff member, SM, those who are internally unstable and in unstable placements will not have the opportunity for healing, whereas those who may be internally unstable and in a stable placement have greater opportunities to heal.

Organizations, therefore, have a responsibility to provide an environment within which a young person can experience safety and stability and staff can provide a safe and stable environment. This environment will begin to allow young people to heal, through developing emotional regulation skills, a positive view of themselves and a sense of belonging in a positive and safe environment. The development of these skills and attributes can only occur within a stable environment, through stable and positive relationships with others who genuinely care for them and think well of them.

There may be multiple reasons for the discrepancy in viewpoints regarding safety. Firstly, many of the young people interviewed had positive relationships with staff, given their ongoing contact was one of the means of participating in the study. Therefore, their experiences of being with staff may have been more positive. They may also have had more varied experiences of being in placements with other young people.

Secondly, as has been noted in the literature, young people in residential care experience a wide range of externalising behaviours, many of which could be quite frightening, including aggressive and threatening behaviour (Carmody, 2013; Pottick et al., 2005). This may make the felt lack of safety more pronounced for young people, should they have been a victim of or witness to such externalising behaviour. Theoretically, they should have been less likely to be exposed to externalising and abusive behaviour from staff members.

Thirdly, staff have an ability to discuss the theory of residential care and how it can best work, rather than the experience of having been a child within it. The young people, on the other hand, have a deep and personal acquaintance with the lived experience of residential care, but then are limited by their own one-off experience of residential care. This necessarily means they think about their own experiences of what felt safe and what did not, whereas the staff can discuss how safety can theoretically be beneficial.

Connectedness to staff leading to changes in day-to-day functioning

According to the interviewees, an increase in internal stability produces greater connectedness to the staff. This, in turn, can lead to improvements in the young person's sense of self and belonging, and decreased risk-taking. These are the core ingredients of internal stability. Staff and young people both discussed the capacity to self-regulate as developing through the connections to staff. The relationships between internal and external stability are iterative and interactive. The development of internal stability is dependent on external stability. However, an absence of internal stability can lead to a breakdown of external stability.

As discussed by SM, "*Let's just say that we have staff who are known, who are familiar, who are stable right? If they are not themselves well versed in especially the relational impact of developmental trauma yes, then they're not going to understand the ruptures that are likely to emerge once a child is stabilized. Once your child is stabilized, they're going to enter into very unfamiliar realms of a stable placement. Now that's very unfamiliar for a child, so they need assistance in being able to tolerate safety and care. But the problem is that when you have staff who don't understand this concept, who don't understand that care and stability could be intolerable, then they will have no understanding whatsoever as to why the rupture will be there, why the child will be pushing their buttons personally, why are they reacting to it, why the child seems so ungrateful for all the good things that they are doing, right? Then you will end up with placement instability. Either there will be pressure to move that child from that placement, in which case its 100% unstable because they're not there anymore, or it will be unstable because the staff will remove themselves. They will either quit or they will want to move to another area and then that creates instability. Or it will cause the staff to remain, for the child to remain, but the staff to play into the internal working model of that child and to begin to behave in more punitive means and actually then begin to damage the relationships that they have developed.*"

SM has highlighted the iterative and interacting nature of stability. An externally stable environment can impact on a young person to the extent that the placement may become unstable. Young people described the staff teaching them how to regulate, often

quite explicitly, and reaching out to them when in distress. The ability to regulate their emotions assists young people to manage their internal worlds, which may have a relationship to supporting placement stability. For example, Fawley-King and Snowden (2013) found that those young people who used mental health services more frequently had greater rates of instability. Therefore, the development of emotional regulation skills arising from a stable placement may reduce reliance on mental health services. This may, in turn, promote further stability. Fawley-King and Snowden's (2013) findings further support SM's supposition that internal and external stability interact and impact on each other. This leads to a further point, the need for trauma informed care, which is discussed in Section 8.4.

The staff spoke about the young people being able to engage more within the house, participating in activities and attending school. Both groups identified that these achievements were advanced through relationships between the young people and staff. Notably, one particular young person, who had had only one residential care placement but felt entirely disconnected from the house staff members, experienced those relational bonds with staff employed by the agency but outside the residential home. Despite the apparent consistency experienced by this young person, he actually experienced a lack of consistency and a lack of connection concerning support staff members, such as clinicians. Therefore, he did not experience the placement as stable and positive.

The staff and young people discussed the need for the young people to feel a connection to the house they lived in, a connection to the staff and a sense that the staff genuinely cared for the young people. Both staff and young people identified that the staff had to genuinely care for the young people in order for change to occur. These findings concur with the literature on therapeutic care (Gallagher & Green, 2012; Verso, 2011) that, through therapeutic interactions and appropriate interventions, there can be increases in community connection and school attendance, and decreases in risk-taking behaviour. Further, the attachment literature is predicated on Bowlby's (1973) theory that the quality of the child's relationship to the caregiver, in terms of how responsive the caregiver is to the child's needs, determines the attachment style.

Recent research into neuroplasticity, such as Doidge's (2015) work, suggests that with the appropriate input, change to neural pathways is possible, leading to changes in day-to-day functioning. This appears to support what staff and young people discussed: with appropriate, predictable, genuine and engaged caregiving, changes to day-to-day functioning occurred in their ability to regulate their emotions and engage in positive and prosocial activities.

Internal stability refers to a young person's ability to feel stable within themselves, control their emotions, feel connected to others and have a sense of self. It is worth reiterating that the development of internal stability, to a large degree, first requires external stability to be present. With consistent caregiving from staff who genuinely care about the young people, alongside explicit coaching about how to regulate emotions, the young people developed skills and formed an improved sense of belonging and sense of self.

The development of internal stability is a second significant pillar of stability for young people in residential care. This internal stability adds to an understanding of stability for young people in residential care. While the external world needs to be stable and consistent, that is a necessary but not sufficient explanation of stability. For stability, a young person also needs to feel stable internally, with an ability to navigate his or her internal world while feeling safe and connected to safe others.

Peer relationships

The theme of peer relationships was unique to the young people. The staff did not discuss the need for relationships outside the residential home at any length, nor how they could facilitate these to increase a young person's sense of stability. The young people did, however, highlight the need for external relationships, such as friendships and consistent schooling, as a feature of stability. The discrepancy may relate to rules within residential care that make having friends over difficult because of the need for approvals from case managers. There is also an awareness that the friends young people in residential care choose may vary from those who are prosocial, to others who are antisocial and provide a negative peer influence. It would likely be difficult for staff to monitor

the types of friendships they form, and it may be additionally difficult to support friendships they know are providing a negative peer influence. As a result, often young people may spend time with friends outside of the residential home, without staff support or supervision. Therefore, this may be something the staff do not consider, because it happens without their presence, or alternatively, it may cause stress for the staff because of the lack of permission to engage with peers.

Nonetheless, the lack of consideration for peer relationships outside of the placement may reflect a lack of a holistic understanding of adolescent needs and development. Residential care staff need to focus more on peer relationships. Notably, in none of the reviews conducted within Australia into the broader OOHC systems was the need to facilitate friendships or peer relationships reported. This further highlights that this may not be a current focus of residential care staff.

The broader literature concerning adolescents' relationships with peers and their associated brain development suggests that the formation of close friendships contributes to reductions in poor mental health such as depression and anxiety (Landstedt et al., 2015; Narr et al., 2019), while Siegel (2014) emphasized that adolescence is a time during which "intense social engagement" is of utmost importance for the individual (p. 71). Furthermore, the presence of engaged adults with whom there is open communication can help to buffer any risk-taking that may occur as a result of peer relationships (Siegel, 2014). Scales et al (2020) noted that peer social capital relates to multiple factors, particularly the diversity of peer networks, the popularity of young people and the ability to spend time with friends, at each others' houses reciprocally. It is notable that the young people in the current study highlighted the need for such peer social capital, however, typically were less able to access it. Rogers (2015) in his doctoral thesis noted that reciprocally-supportive peer relationships provided a form of social capital that allowed young people to form an 'in-group', which positively contributed to a sense of identity, somewhat limiting the associated risks of peer contagion or peer pressure. The forms of informal social support that is provided by peers (i.e. not provided by paid staff) has a benefit of being able to be ongoing throughout life and can provide greater availability in a more ongoing way than formal, paid support can provide (Waugh, Mendes and Flynn, in press).

This suggests that the young participants in the current study were correct in highlighting the importance of their peer relationships and the need for staff to facilitate, rather than hinder these. The absence of any relevant comment on this by the staff participants suggests, perhaps worryingly, that they are unable to provide the buffering against adolescent risk-taking that is commonly a feature of more intense peer relationships (Siegel, 2014) due to a lack of engagement with these relationships.

It may be necessary for residential care organizations to identify means to address this disparity to normalise and encourage appropriate peer relationships. Facilitating these relationships would function as a means of achieving stability as well as improved mental health, which, as suggested by Fawley-King and Snowden (2013) may be a predictor of placement stability. The previous and current research indicates that the importance of peer relationships buffered by adults with close relationships to the adolescent can lead to improved mental health and wellbeing, which implies a greater a likelihood of maintaining placement stability (Fawley-King & Snowden, 2013; Siegel, 2014; Narr et al., 2019).

Staff did discuss schooling, but typically this was limited to how stability within the placement assisted with engaging in school, or how the lack of stability made engaging with schooling difficult. The young people, however, discussed school as a way to maintain stability in the absence of stability within the home and as a way to meet others who are like them to form friendships. The stability of attachment figures, including peer friendships and teachers, can provide "meaningful and trusting relationships" (Cashmore & Paxman, 2006 p 238), which may be of greater significance in the context of placement instability.

As discussed in Section 7.4, a participant explained in detail how he experienced his main form of stability through schooling, despite substantial instability within his placements. Despite having only one residential care placement, he experienced staffing instability and, prior to this, had experienced 32 foster care placements. For him, the experience of a stable school was crucial and provided a base of support which allowed him to achieve success in the form of attending university.

8.4 Organizational scaffolding

Organizational scaffolding refers to operations within the organisation that support stability within the houses. These practices do not provide stability in and of themselves, but without them, stability is hard to achieve. In this section, the elements are discussed that the organisation needs to provide to promote stability within the houses.

Matching

Both staff and young people identified elements associated with the organisational structure and how they scaffold the staff. The key area of accord was in regard to matching young people and planning for placements to be stable. Both staff and young people identified that residents should be matched, not just for risk, but also for them to experience a positive relationship. Staff identified that the residents could enjoy a sibling type relationship when matching was done well. The young people, however, tended to highlight the fear associated with living with someone who was poorly matched and potentially volatile in behaviour.

This finding would suggest that co-resident matching and relationships constitute an important element for young people to feel stable. Positive matching explicitly relates to the need for planned and communicated changes as it is integral that decisions about where to place young people are made in their best interests. Being able to build relationships prior to the move, as discussed above in Section 6.2.1 allows the parties involved to determine whether the match is positive or safe, ahead of time. As poor matching may result in a fearful environment, leaving young people feeling unsettled within the placement, appropriate matching is a vital element to a stable placement.

This relates to the notion of actual and perceived safety discussed previously. Should a young person feel unsafe within a placement, or indeed actually be unsafe within a placement, they are unable to feel internally stable, and this may lead to the need to

change placements for one or the other of the young people, causing even further instability.

The extant literature, as mentioned in Section 8.3, pays limited attention to the matching process and the impact of good and poor matching. The current research has highlighted the need for this to be a focus of future research, as it is clearly an area of importance for both staff and young people. The attachment literature has highlighted the need for consistent caregivers (Ainsworth, 1989; Mikulincer & Shaver, 2007). However, a consistent peer group is likely an important element of stability that contributes to a sense of wellbeing for young people. The principle of matching co-residents links in significant ways to the discussion on co-resident stability. While the staff and young people identified positive, negative and neutral elements relating to co-resident changes, matching appropriately at the outset would tend to lead to greater stability. Further research will be needed to better understand the process of matching, as well as its impact on the young people in the house, the young person coming into it and the staff.

A small subset of the staff participants noted the need to match young people to the staff teams where possible, either to ensure a cultural or skillset connection or a connection via personality. This was considered by staff to enhance the stability of the placement because staff would tend to be more equipped to cope with the presenting behaviours within the house. Staff also thought it provided an easy means for them to connect with the young people to build strong relationships. Given the need for genuine and consistent relationships between staff and young people, providing a means for this to be enhanced at the outset would likely be beneficial.

This finding is supported in the neurodevelopmental literature, with Perry and Szalavitz's (2007) argument that patterned and repetitive input of rhythmic activities such as dance or music, particularly undertaken with a caregiver, helps to regulate the brain and produce improvements in functioning. Being able to undertake these activities with a staff member who also enjoys them would tend to be beneficial and facilitate relationship building.

Push back

Push back was a topic limited to the staff participants' discussions. The young people did not raise this as an issue for stability. This personality probably because the larger machinations of running of a residential care facility are not within their purview. Some staff, specifically those in upper management and one clinician, were able to identify the need to push back against the funding body where possible to ensure appropriate matching. The issue of push back fundamentally relates to advocacy and managers' expertise about the individual young people, houses and staff's capabilities. The management staff are in a position to know whichever referrals are manageable at a house level. They may often need to advocate for young people who are unsupportable not entering houses. The staff noted that, while the funding body ultimately has the final say about whether a child enters an agency or not, there can be some push back to refuse inappropriate referrals, given the placements available. For example, if there is only one free bed, and the referral is for a young girl and the others in the placement are boys with sexualized behaviours, the agency may be able to push against this referral as being potentially very damaging with a difficult to manage risk.

Researchers have not previously raised the issue of pushing back against the funding body to allow for more appropriate referrals. However, the Community Affairs References Committee (2015) inquiry into residential care recommended that the needs of the child(ren) supersede the "bums in beds" approach to funding (p. 81). The committee accepted a submission from Anglicare Victoria which noted that the latter approach ignores the child's needs, development, preferences and vulnerabilities which should supersede the need for simply filling a placement. The staff's discussion on push back supports the inquiry's recommendation. Being able to argue against inappropriate referrals would facilitate the matching process as discussed previously. Such push back makes positive matching more likely for staff teams and the other young people in the placement. This would increase the likelihood of stable placements. The inability to do this, however, creates a fundamental flaw in the capacity to plan for stable placements.

Training and supervision

Staff identified training and supervision as important. The young people tended not to raise this as a salient issue for them probably as this is not part of their day-to-day experience. Nonetheless, the staff identified that ongoing training and supervision was valuable in assisting them to continue their work with young people. This is particularly so during difficult times, such as when a poor match between co-residents increases stressors in the house, or if a young person displays particularly challenging behaviours.

Staff noted that training allowed them to understand what was occurring with the young people and develop strategies to more effectively assist them. Further, ongoing supervision provided support to the staff. They noted that, without support, staff tend towards burnout and may take advantage of their leave entitlements. This, in turn, creates greater instability for the young people. The staff, at all levels, spoke of the need for training and support so they could cope better with their demanding work role. The support provided by management appeared to assist the staff to manage the ongoing difficulties within the residential houses, such as challenging behaviour or difficult dynamics between residents. This support helped staff commit to remaining consistent with the young people. Without such support, the consistency of staff would be compromised.

Within the broader literature base, of the 15 governmental reviews conducted within Australia, seven made specific recommendations for training and upskilling residential care staff. The frequent references to the need for training highlight that this is recognized as an important element of good residential care. However, this does not appear in the empirical literature. The outcome studies regarding young people in residential care do not typically refer to staff training and this has not been a feature of any analysis to date.

Given the apparent importance to the staff, and within the governmental reviews, this should be an area of future research. Researchers may be able to identify whether particular training approaches provide better outcomes for staff stability and/or young people's outcomes, which are likely linked. Some specific research has been conducted examining trauma informed practices and therapeutic care, as discussed below. The provision of training and supervision, while not a direct component of stability, does

provide a buffering for staff against the challenges of their work. Thus it brings a greater likelihood of stable and consistent staff and approaches to their work.

Trauma informed care

Trauma informed care was explicitly raised by staff as a useful and necessary model for working with traumatised youth in residential care. The staff described how awareness of the influence of trauma on the developing brain and attachment systems altered the way they interacted with the young people, particularly during difficult periods, such as when the young people were acting out towards the staff. Notably, the youth workers talked explicitly about trauma informed care less frequently than the managers. This may be because the staff spoke about how they work with young people, rather than the overarching principles. Alternatively, this may indicate a lack of training in therapeutic care principles, with the staff interviewed being naturally inclined to work therapeutically, without the language of trauma informed care.

It is notable that at least two of the youth workers referred young people to be interviewed. This means that, between two and six years after leaving care, the young people have ongoing meaningful relationships with those staff members. Therefore, while they did not use the language of trauma informed care, they have naturally engaged in it. Furthermore, the young people interviewed also did not use this language, but also referenced the impact of what can be described as trauma informed care. In essence, the staff participants noted that when trauma informed practices are implemented, staff are better equipped to cope with the occurrences in the house and maintain stability. The young people reported that they had enhanced outcomes from the staff being genuinely caring and involved with them.

The Australian Federal Community and Disability Services Ministerial Advisory Committee endorsed the 2010 definition of therapeutic care, "therapeutic residential care is intensive and time limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and developmental

needs" (National Therapeutic Residential Care Working Group; NTRCWG, 2010). This definition provides a framework to understand what therapeutic care is and to understand the young people's experiences.

The young people identified the importance of relationships to provide a buffering against their internal instability. They stated such relationships promoted their ability to regulate their emotions and feel better about themselves. One young person spoke about feeling loved by staff. Another spoke of developing skills in parenting from being cared for by the staff, while simultaneously discussing the positive experiences with the staff. This young person noted that with genuine relationships, the young people were more inclined to engage in activities and less inclined to engage in risk-taking behaviours.

Without using the language of trauma informed care, the floor staff managed to create positive, safe and healing relationships within the residential care environment. Both staff and young people identified the principles of trauma informed care as imperative for positive outcomes, particularly through the relationships formed between staff and young people. The staff described this as being about working for "the right reasons"- to form genuine relationships with the intent to help others, rather than solely as a means to make money. Furthermore, as Participant T described, staff can interpret challenging behaviours displayed by the young people as requiring an empathic response rather than rejection or punishment, "…*a lot of them understood me and so you know if I was to act out as I said you know they will still be there, they would still come and talk to me and I did have a lot of them outbursts, not violent outbursts but upset and crying and didn't know how to feel you know, if the workers through that week or day or whatever were helping me and saying [name] are you ok? Let's go have a coffee, you know let's go get a milkshake, let's go for a drive somewhere, let's talk about this…"* This highlights a trauma informed approach to addressing challenging behaviour through safe relationships and experiences based on the need for healing (NTRCWG, 2010). Indeed, Participant T described both healing relationships and healing experiences that were facilitated by staff.

Further, Australian and international findings on therapeutic care have suggested that young people in OOHC, when engaged in therapeutic care, have more positive outcomes. These include improved quality of relationships, increased community connections, a sense of self, enhanced mental and emotional health, greater control over behaviour and increased trust and confidence (e.g. Carter, 2011; Gallagher & Green, 2012; Gallagher & Green, 2013; Verso, 2011). These findings that therapeutic care environments lead to enhanced confidence, relationships and sense of self were supported by the current findings from both the staff and young people.

Within Australia, of the 15 governmental reviews conducted over the past 13 years, seven recommended the implementation of therapeutic or trauma informed care and one found that this was already occurring. These recommendations suggest that trauma informed care principles are understood as important to guide residential care and day-to-day interactions in it. However, as this has been so frequently recommended, this suggests therapeutic or trauma informed care are not happening regularly enough to be identified by those conducting the reviews.

8.5 Impact of stability

In the current study, the impact of instability and stability were explored. Within the literature, researchers into foster care have found that the instability of placements has led to a host of negative outcomes for the individual in multiple domains, including mental health, behavioural problems and offending (Fawley-King &Snowdon, 2013; Newton, Litrownik & Landsverk, 2000; Ryan & Testa, 2005). On the other hand, stability has not been found to advance more positive outcomes. Indeed, Tarren-Sweeney (2017) and Tomlinson (2008) both hypothesized that positive outcomes may simply be related to a lack of deterioration, or that youth experienced lesser adversity than they may have done had they remained in the family home.

In order to understand stability within residential care, it is not merely necessary to understand the interconnecting dynamics that contribute to a sense of stability for a young person. It is also imperative to explore whether the lack of apparent improvement for

young people detected in previous studies was connected to Tarren-Sweeney's (2017) and Tomlinson's (2008) hypotheses, or whether it was related to the general operationalisation of stability.

In this research I has sought to identify a more complex operationalisation of stability that takes into account greater depth of experience than a placements-over-time paradigm. This paradigm works on the basis that a young person remaining in a placement for a period of time is a sufficient operationalisation of stability and would provide sufficient information about how stable a young person would feel. The research in this thesis suggests that this is, in fact, an insufficient operationalisation.

There are multiple layers to stability. These include the continuity of a placement, the continuity and quality of the relationships within the placement, as well as the internal sense of stability and feelings of belonging and safety. Therefore, in this section, the impact of instability and stability is discussed with reference to the perspectives of the participants in the current research and the extant literature.

In considering instability, the staff participants concurred with the extant literature that placement instability leads to negative outcomes. In the current research, staff across all levels identified that with instability, there is often an increase in risk-taking behaviour, negative impacts on an individual's sense of self and disengagement from the house and school. The staff noted that when there is instability, the young people may become involved in the juvenile justice system and use alcohol and/or other drugs (AOD). This behaviour occurs either as a result of feeling internally unstable, or because, as Participant WF identified, there is not a stable team around them to prevent inappropriate or problematic behaviours. Furthermore, the staff identified that instability within placements can lead to damage to a young person's sense of self, through a reinforcement of early experiences of abandonment. The staff participants expressed an understanding that the young people had often experienced instability in their childhoods, including the loss of their family, and would likely experience the loss of staff and/or placements as a replaying of those early abandonments. Hence, placement instability reinforces to them that everyone leaves, possibly with the sense that they are not good enough and that is why adults keep leaving.

The young people equally identified that when they were disengaged from the staff they may get in trouble with the law, engage in AOD use, and that their sense of self may be hurt. One participant noted she experienced the instability as leaving her feeling that there was "*no point in being on this earth…not having stability…ma[de] me feel like no one on earth cared…or the people that tried to and I did would then leave*" (B, 18 years, female). The young people reinforced the findings of the staff that when there is instability, a young person is likely to suffer its ill-effects and may experience long-term consequences, particularly if there has been juvenile justice or AOD involvement. Importantly, the young people noted that instability can have holistic effects on their functioning and lead to behaviours or activities that they may regret in adulthood, which may have been mitigated with stability. It is noteworthy that both groups of participants identified the same consequences of instability despite their different vantage points. The young people spoke from their own experiences of instability in their own lives, while the staff described the consequences they had seen. This suggests that these consequences of instability are common and typify the experience of instability on a young person.

Contrary to Tarren-Sweeney's (2017) and Tomlinson's (2008) hypotheses, both staff and young people identified common positive outcomes as a result of stability. The staff participants were able to identify positive elements of healing associated with stable placements, including improvements in connections to the house and the staff, increased school engagement, improved communication and an ability to heal from their past trauma. The young people identified that having stable relationships was the impetus for positive change. The young people specifically stated that stability provided support through the relationships they had with staff. Typically, when discussing stability, the young people spoke about it as stable relationships with staff, *feeling loved*, *having support, having people to connect with, working with the young person, being helped*, rather than the experience of one consistent placement.

As discussed in Chapter 5, the two with the fewest residential care placements had some of the least positive experiences compared to others who had objectively more instability in terms of the predominant placements-over-time paradigm. These young

people enjoyed significant and secure relationships with at least one staff member. There was agreement between and within the groups, that stability, particularly relational stability, provided positive outcomes for young people. The young people specifically discussed school success, parenting success, engagement with staff, engaging in positive activities and feeling better about themselves. Notably, these outcomes are diametrically opposed to the consequences of instability, suggesting that stability can provide reparative support.

This finding is particularly significant given that it is contradictory to all previous research findings. Tarren-Sweeney (2017) and Tomlinson (2008) both hypothesised that, at best, stability could provide a buffering against negative outcomes. Indeed, one staff member accorded with this view and proposed the example of a young person he had been involved with for five years who showed no decline. This young person, on leaving care, experienced the same difficulties as he had experienced at the beginning of residential care, despite apparent stability.

The other staff members were unanimously able to identify positive outcomes as a result of stability for their young people. Indeed, the staff member who noted the young person who had experienced no improvement also spoke of some positive changes for other young people as a result of stability.

In order to make sense of this finding, we must consider the initial proposal that operationalising stability as the number of placements a young person experiences over a timeframe, excludes certain important elements of stability: the consistency and quality of relationships. As discussed in Section 8.2, the previous research has all been conducted in foster care settings in which a young person lives with a family, thus nullifying the need to examine the consistency of caregivers. Nonetheless, this still does not take into account the quality of the relationships, the ability of the caregivers to provide adequate and trauma informed care, and the quality of the relationships between co-residents which may also occur in foster care with foster siblings or the biological children of the foster parents.

In sum, concurring with the extant literature, the participants in the current study experienced instability as leading to a variety of negative outcomes for young people in multiple domains. Contrary to the literature, however, the participants in the current study argued that, on the whole, stability led to positive engagement, a reduction in problematic behaviours, improvement in mental health, emotional regulation and the ability to heal. The following section comprises a discussion of this research's multi-dimensional operationalisation of stability. Such a nuanced operationalisation may be better equipped to answer the question of what stability is and how it provides positive outcomes.

8.6 Aim two

Develop a multi-dimensional operationalisation of stability for young people in residential care, taking into account that stability may comprise more nuancing than placements over time.

This research has queried whether the placements-over-time paradigm has accurately and effectively operationalised stability. If it has not, then the finding that stability can, at best, offer a buffer against negative outcomes would likely be inaccurate as stability has not sufficiently been measured. Indeed, the current findings suggest a great deal more to placement stability than the experience of a single placement over time. This includes the experience of a consistent set of caregivers, well-matched co-residents, and staff members who are well-trained and supported to provide care and cope with the difficulties that arise when working with traumatised young people who display "complex" needs (Carmody, 2013). Furthermore, when these elements are in place, alongside other forms of stability such as consistent schooling, external peer friendships and the possibility of ongoing contact with staff after the statutory care is completed, almost universally, the staff and young people identified that stability can be healing and has reparative power.

In the following section a model is built and described of the elements that, according to the current research, contribute to stability in residential care placements. Within this, the factors that contribute to stability are identified as proximal or distal contributors

and their interactions are outlined. This model is based on the findings from this research. It is a formulation of how the elements may best work together to provide the greatest opportunity for stability.

Figure 4: The Stable House

In the above diagram, the multi-dimensional operationalisation of stability in residential care is demonstrated. The house itself represents the residential home, in which the young people live and the staff work. This home is central to all that provides stability, through a continuous placement. The elements within the house form the proximal elements for stability. The elements outside the house and forming the roof constitute the distal elements. The interior walls of the house are made by consistent staffing, genuine care, safety and connectedness to staff.

Consistent staffing was discussed by all the participants as a fundamental part of stability in residential care. The need for the staff to be consistent, both in their presence and their running and management of the house with consistent rules and approaches, is represented here. Without this consistency, one of the fundamental tenets of stability is absent. The walls represent the safety of the young people, both felt and actual safety, and their connectedness to staff. Safety encompasses feeling safe within oneself, feeling safe in the continuity of the placement, safe with the co-residents, safe with the staff and safe from the outside world. The connectedness to staff forms the load-bearing wall that contributes to an ability to self-regulate emotions, understand one's emotions, avoid risk-taking behaviours and feel a connection to the staff and the placement, allowing for a prosocial engagement with both staff and placement. The ceiling represents genuine care experienced from staff, which forms the overarching ability of a staff member to connect with a young person. The connectedness between staff and young people forms the conduit for prosocial engagement, and the connectedness is achieved through the genuine care that is shown by staff. Both staff and young people discussed the need for staff to work for the "right reasons", with an intention to help and support the young people, not just a need to earn money. Therefore, the floor, ceiling and the walls are the primary supporting structures that form stability for a young person in residential care. Without these, stability is impossible.

Within the house are two windows. These represent the importance of good matching which allows for safety and for positive relationships to be experienced within the placement and in external peer relationships. Without these windows, a young person may experience a level of stability, but without the joy of safe and sibling-like relationships and without the typical and important adolescent milestones of significant peer relationships. The windows represent important elements of stability that provide for a sense of normalcy and joy. The young people and staff both spoke about the impact of co-resident changes. They noted that often, when a young person left the placement, this was either a neutral or even positive experience. It might be neutral because of a lack of a relationship with the person who has moved, or positive because they were a stressful or even dangerous presence within the house. Therefore, good and thoughtful matching in the first instance is more likely to result in stable placements because there would fewer movements would be needed and there would be a greater likelihood of

positive relationships between the young people. The peer relationships formed an important element of discussion for the young people but was not a significant issue for the staff. This signals a dissonance between what is important for different groups and the need to recognize and include key milestones in adolescent development. Therefore, the windows are key elements that contribute to stability for a young person in residential care.

The front door is both an entry and an exit point. For young people, the door represents the entry and exit into a placement and, in this model, it represents planned and communicated changes. Without planned and communicated changes, the young people cannot rely on a key element of safety. They may live with the constant idea that their placement will prematurely end. One particular young person interviewed reported that every time he experienced a placement change, he was notified on the day, each of 28 times. For a young person, there cannot be safety in a placement when he has lived experience that on any given day, he could be informed his placement is changing, so tomorrow may bring such a change. Therefore, it is vital to plan changes and communicate them to youth in a timely manner. This enables them to adjust to transitions and, ideally, become familiar with the new staff and residents. Similarly important is a resident in an existing house receiving an introduction to a new resident. Current residents need to become familiar with new ones prior to them moving in. Under these circumstances, young people may become more settled in a placement, knowing that they will not be moved without due care, notice and planning via a transition that facilitates safe relationships and provides an element of stability. This element also acknowledges that change is inevitable. Staff members may be sick, take leave or want a change in their working environment. Young people will move on, or surpass the age limit for residential care. At times, there will be forces that require placement changes. A door that can open and close stands for planned and communicated inevitable change.

The first distal element of stability is depicted by the tree next to the front door. This represents ongoing staff contact. A number of young people discussed the value of ongoing relationships with staff members. The young people noted that staff formed part of their extended family who provided practical and emotional support. The side of the tree nearest the house thus implies ongoing growth and development for the young

people. A tree is also a relatively permanent fixture and represents stability and growth in an ongoing way. Other young people discussed the value of transitioning to a new placement with a staff member with whom they had a significant relationship. Therefore, the front door and the tree allow for change, with respect for the need for ongoing relationships, preparation, planning and communication. These elements form essential components of stability that give a young person faith that their placement and their significant relationships are not transient. On the far side of the tree is 'casual staff'. This element was placed away from the house because it typically represents instability. Staff and young people identified that casual staff often destabilised the placement, either for a single shift or when casual staff are regularly used. This creates an environment in which the day-to-day structure is altered and unpredictable. The casual staff element, much like the inevitability of change, can be managed in a way that supports stability. However, as the staff discussed, provided there is a pool of casual staff who are known to the young people and the regular staff and are familiar with the house routines, destabilising is avoided. Stability, in this way, can be reinforced by this approach to casual staffing as there is a greater pool of familiar caregivers who can be called upon when needed, rather than relying on unfamiliar individuals.

The roof represents the other significant, yet distal elements of stability. One arch of the roof symbolises training and supervision which the staff identified as important to understand what is occurring within the house, to feel supported and to avoid burnout. The other arch represents trauma informed care. Trauma informed care is, as discussed in Chapter 3, an approach to providing care based on principles of trauma, attachment and brain development. As the young people emphasized, experiences and care rooted in genuine care and understanding of these principles provided the young people with a greater ability to regulate their emotions, feel connected and reduce risk-taking behaviour. The staff also reported that with an understanding of trauma informed care, they were better equipped to handle interactions more positively and read what was occurring. Finally, on the roof is the chimney, which represents the practice of management within residential care organisations to push back against the funding bodies to avoid inappropriate referrals. While the staff acknowledged this as important, it is only possible under certain circumstances because of the nature of the contracts funding the organisations. Therefore, while training, supervision, trauma informed care and push back

do not themselves bring stability to a placement, they scaffold the staff and the organisation to be able better to maintain stability within the house.

The above model encapsulates the multi-dimensional operationalisation of stability that has been developed with this research. The model encapsulates many different elements that contribute to a placement not only being stable, but also feeling stable for a young person. This model takes into account the experiences of young people who have been in residential care and the staff members who support young people in residential care. The model further takes into account the extant literature, principles of attachment and important developmental milestones. This model adds to the literature base in two major ways. Firstly, it explores the theme of placement stability within residential care. This has not been previously done.

Secondly, this model explores the elements that contribute to stability to identify a more complete operationalization. Again, this is new ground. As discussed, previous research has explored stability within foster care and employed an operationalization of placement over time. This identified the number of placements a young person has experienced and the outcomes associated with that, or the predictors for greater instability. Within the current research, we have begun exploring stability within residential care. With rotating staffing and high complexity among the residents, as discussed in Chapter 3, this can add significant complexity to the issue of stability. Therefore, this model comprises the first step in exploring stability with greater depth and nuance than has been done previously.

8.7 Study strengths and limitations

Limitations of the current research

There are a number of limitations associated with this study and its methods. These include a sample of staff and young residential care leavers that is heavily reliant on professional networks, the impact of being a practitioner-researcher, a small sample size

that is limited to NSW, and the absence of perspectives from either DCJ (the governing body of OOHC in NSW) or family members.

Sample reliant on professional networks

The sample was heavily drawn from the researcher's professional network. While this did not encompass the entirety of the sample, a number of staff members who consented to participate were known to the researcher. This likely increased their desire to participate, and enabled the development of rapport as they were aware of the researcher's experiences working in residential care. Samples were also drawn from further afield through seeking participants not previously known, and from organisations with which the researcher had no relationships, in order to ensure a variety of experiences and opinions.

Nonetheless, the use of professional networks to seek participants may increase the homogeneity of responses. Further research could explore this issue in more diverse settings of residential care. Given the exploratory nature of the research, however, as discussed in Chapter 4, experts were sought in their field to develop an understanding of a hidden topic, rather than representative views.

Impact of being a practitioner-researcher

As a practitioner-researcher, there are strengths associated with the research, including, as mentioned above, having connections to professional networks to access participants, an inherent understanding of the internal workings of residential care settings and an understanding of the young people living in residential care. There are, however, limitations of being a practitioner-researcher that may be somewhat difficult to identify. For example, there is the risk of the researcher making assumptions based on practice wisdom or, as occurred in an early interview, a participant spoke about a training course that was known to the researcher but not generally understood. Details about the training were not drawn out in the interview, limiting the utility of discussing the training program. The supervision process allowed this to be identified very early in the

interviewing process to ensure that detail was elicited from participants, despite the researcher's understanding of what is discussed. This also raised some confusion with participants in later interviews who may have been confused by the researcher asking questions that would have felt redundant or obvious, because of the shared practice wisdom. As a result, some participants were debriefed afterwards and had it explained that questions were asked to have the participants' own words to use, rather than the researcher's understanding of what the participant likely meant.

Small sample size drawn from NSW

As mentioned in Chapter 7, recruiting young residential care leavers was challenging. This was in part due to this cohort comprising a very small proportion of young people in OOHC, who, in turn, make up a small proportion of young people in NSW. Further, young people who have been in residential care are considered a vulnerable population who are often difficult to find, let alone recruit for research. Therefore, a smaller number of participants was recruited than was initially hoped for. This impacts on the generalisability of the findings, particularly given the participants' limited breadth of placement experiences. This sample was also drawn only from NSW which again impacts on the generalisability of the findings.

As discussed above, representativeness was not an aim of the current research. Moreover, as discussed in Chapter 3, residential care is remarkably similar across jurisdictions despite not having a cohesive national strategy and different laws governing OOHC generally. Therefore, it is not expected that experiences would be markedly different in different jurisdictions. However, this is an important area for consideration in further research. Future research could extend these findings with larger sample sizes from multiple jurisdictions, which would enhance their generalisability.

Absence of additional relevant views

The data explored the experiences of staff who currently or previously worked in residential care and young people who have left residential care. This was to provide an intimate account of how stability and instability are enacted and experienced from those

who are closest to it. The researcher did not, however, take into account the experiences and opinions of those who are peripherally related to residential care. For example, the governing body for OOHC, DCJ, does not directly operate residential care facilities, but funds them. Therefore, DCJ is acquainted with residential care at a tertiary level. Participants from this body may have provided additional information about the nature of funding, how young people are placed, and the challenges around identifying suitable placements for young people. DCJ participants were not excluded from the study, however, none of the DCJ staff approached consented to participate in the study.

Secondly, it would have been a valid to obtain the perspectives of family members of young people in residential care. They may have been able to provide second-hand opinions on the impact on their children of stability and instability and perspectives on their own involvement in the children's lives and the subsequent stability of placements. Future research would benefit from these additional perspectives.

Strengths of the current research

Despite these limitations, there are a number of strengths associated with this study. These include building upon and extending the current literature base, identifying key points of stability and including the voices of both staff and young residential care leavers.

Building and extending on the literature base

As discussed in Chapter 3, the status quo regarding stability has been to count placements. Some researchers, notably Cashmore and Paxman (2006), examined 'felt' security within a placement. No researchers to date, however, have exclusively examined this issue in residential care, nor have they taken into account the environment of the placement as contributing to that stability, such as the stability of the staff or other residents. Therefore, this research adds layers of complexity to the discourse about stability while also examining the issue in a new population; i.e. residential care.

Identifying key points of stability

Mostly to date the issue of stability has been examined by counting placements. In the current study, the points of change were specifically discussed, both the point of coming into residential care and placement changes within it, as far as the participants were able to recall. Other specific points of change were also discussed, such as staffing changes, the presence of casual staff and co-resident changes. These moments in time of stability and instability were analyzed to reveal a fuller story of stability, what it is to experience stability within an unstable system, and how this is possible.

Inclusion of staff and young residential care leavers

The study's strength also lies in the triangulation of interviewing both staff and young residential care leavers. Both of these groups are intimately involved with residential care. They have insights into how it works and how it may benefit or harm those within it. The benefits of interviewing staff, particularly at different levels, meant that overarching ideas could be explored, with many staff having over 10 years' experience. These staff could reflect on the development of many of the young people they worked with. This allowed for examining what happens when stability is present and what happens when it is absent. The young residential care leavers were able to reflect on their internal experiences of stability and instability, and the perceived impacts on themselves and those with whom they shared the placement experience. This is the first investigation to date of what stability means in residential care. This study was possible by discussing the issue with those who are most affected by it.

8.8 Implications for policy and practice

The study findings, despite being exploratory, have the capacity to indicate some areas of policy and practice that may need to change to benefit young people in residential care. They suggest that, contrary to previous findings, stability can be reparative and provide support and healing for young people who have experienced trauma and instability. Therefore, a focus on approaches that would provide the greatest stability is necessary.

At a house level, staff need to ensure that they are providing a consistent approach to the young people, including being familiar to each other, not just the young people. Given the rostered nature of residential care, this may result in some staff working together frequently and other staff having little to no contact with each other. Therefore, increasing meetings between the staff, or staff bonding days may benefit the consistency within the house. Increasing time for staff to be together for meetings and bonding time would likely allow for building greater interpersonal familiarity. This could enable a stronger sense of being part of a team which would arguably advance greater consistency and trust among the staff. This would translate to the experiences of the young people.

One of the key findings was that genuine care and a bond forming between the staff and young people were important in progressing healing opportunities for the young people. One way this may be achieved would be to have activities planned that include the entire house staff and all the young people in the house to spend time together, such as attending the Easter Show or going to the beach. An activity such as this would allow for further bonding among the staff themselves, and with the young people. This also gives staff opportunities to observe each other work when they may not get this chance if they are rarely working together.

Focus on staffing

At an organisational level, house managers and higher level managers need to ensure they are providing support, supervision and training for their staff, both formal and informal. In their day-to-day work, this would give staff a sense of being assisted and encouraged. It also allows them the space to discuss any concerns, either about how they are managing or about how the house is running. When staff are able to provide and receive feedback, they may be better equipped to cope with the difficulties in undertaking challenging work, while also perceiving that their managers are regularly and genuinely available to support them.

Furthermore, organisations need to ensure that, where possible, they make considered and careful decisions about moving staff and young people. While at times this may be unavoidable, in principle, the stability of the house must be a primary consideration, given the benefits this provides. If a placement needs to be changed, as much notice as possible must be given to the young people so they can begin to adjust to this. Ideally, young people requiring emergency placements would not enter existing residential houses. Rather, they would be accommodated in an independent house for emergency placements. This house would have staff equipped to get to know these young people and make informed decisions about which houses would be suitable for them. The existence of such a house would then provide the organisation the ability to enact a long transition for the young person moving into a house, ensuring that relationships are established before the move. Furthermore, this approach would allow for more effective matching between the young people and staff at the available houses so as to reduce the likelihood of needing to change placements.

Also at an organisational level, it would be beneficial to develop a house-linked pool of casual staff who can regularly fill in at one or two houses. This is another way to ensure continuity of care for the young people. With such a pool of two to three staff members, the young people need not fully recognise that they are casual staff. Indeed, they are additional staff members who come in periodically, known to the staff and known to the young people. Such a casual staff pool would also offer consistency within the house as these casual staff would be familiar with the house rules.

Furthermore, purposeful planning of ongoing contact between staff and young people within the house is essential. Organisations should consider how this could best be enacted. This could be a single staff member who maintains contact with the young person. Alternatively, the 'house' might maintain contact. This facilitates the young person remaining connected to the house and the staff where they felt a sense of belonging. Being able to maintain a continuity of relationship in such a way normalises the need for ongoing contact. It provides an assurance for young people that once they 'age out' of statutory care, they are not abandoned. Rather, they can continue to access practical

support from staff. As young people can observe this happening with older young people, they can then prepare for this ongoing relationship themselves as well, once they leave care.

Finally, a trauma informed care approach is essential for all residential houses. While the research is relatively new and a great deal more is required, the research demonstrates an ability to provide better outcomes for the young people (e.g. Verso, 2011). In order to do this, however, greater funding is needed for organisations to implement a trauma informed approach. Also, a commitment is needed from organisations to ensure that this approach is followed and maintained at all organisational levels.

Focus on peer relationships

Discussions on residential care typically do not place any focus on peer relationships. The current research suggests this may be an error in the enactment of residential care as it does not take into account typical adolescent development. Adolescence is a period during which the development of close peer relationships, buffered by close adult relationships, provides an important tool for maximising mental health, both in adolescence and through the lifespan. The residential care staff provide essential tools for buffering the impact of peer relationships, particularly the likelihood of engaging in risk-taking behaviour, which is often a concern held about young people in residential care (Ainsworth, 2005; Baldry et al., 2015). Therefore, the relationships the young people have with staff may assist with the development of healthy relationships with peers, through supporting the peer relationships and coaching to instigate and manage relationships and buffer against risk-taking behaviour, as parents of adolescents do.

The current research suggests that a greater focus on forming appropriate peer relationships may give an additional level of stability for young people, particularly as these relationships can continue across the lifespan and across any placement changes. They are not necessarily affected by statutory care arrangements. This focus involves streamlining the process of approvals for young people in residential care to spend time with friends, with the support of staff. Given that young people may need to leave their placements to spend time with friends, without such approval from their case workers or the

residential care staff, the young people's safety can be less well protected than if the staff could facilitate this.

While the argument may be made that the friends they choose may not be prosocial influences, it is accepted that young people need ongoing relationships with family members and siblings, some of whom may also be antisocial influences. The process of facilitating these relationships is simply done with safety in mind, including increased supervision. Providing greater supervision and support may be the best solution to facilitating peer relationships, rather than less supervision.

Focus on placements as relationships, rather than buildings

This research has highlighted the critical importance of relationships as being the central tenet of stability. Both staff and young people identified, throughout the interviews, that the young people's relationships with the staff and their peers - either in the house, in school or in the community - were the main drivers of their feeling stable. Without close and meaningful relationships, particularly with the staff members, the continuity of a placement was insufficient to bring about a sense of stability, either internally within the young person or externally in the placement.

Despite having multiple placements, many young people identified that they felt deeply connected to some or multiple staff members. Some of these relationships extend into adulthood once the young people had left care. The young people who spoke of having those deep connections with staff highlighted the benefits of stability in their own lives and how those relationships had facilitated positive changes.

Therefore, a policy shift is encouraged: stability can only exist within continuous, meaningful and deeply connected relationships in which the young person feels a sense of belonging and acceptance. Prioritising relationship development will likely be more successful to facilitating stability than making arbitrary decisions about maintaining someone in a placement or changing that placement. It would also provide an opportunity for maintaining stability despite a placement needing to change, should that be the case.

8.9 Future research directions

The current research was an exploratory examination of the meaning of stability in residential care. I sought to identify the elements that contribute to a young person in residential care experiencing stability and feeling stable. Many elements were identified that contributed to a sense of stability, with remarkable accord between interviewed participants, both staff and young people. Nonetheless, given this is exploratory research, there are many options for moving this research focus forward.

Initially, conducting interviews with larger groups of participants, from more jurisdictions around Australia would provide greater reliability and generalisability than the current findings. These additional findings could then be shared with senior managers at the NSW funding body, DCJ (formerly FaCS). Focus groups conducted jointly with senior managers and young people with lived experience could then discuss the findings and exchange views on how these could be used to implement changes within residential care. Such findings could then be disseminated at international conferences to develop an international advisory committee to progress the project forward.

Furthermore, future research would benefit from examining in greater detail some of the specific findings from the current research. One such area would be the matching process of young people and the impact of co-resident relationships. Currently, matching is conducted by comparing the behavioural risks and protective factors related to the existing young people in the house and the person to be introduced. Often there is limited information regarding the new young person so making decisions can be difficult. The current research findings that there are frequently positives associated with a young person moving from the placement, typically due to young people feeling frightened of that person. This would suggest that the matching process is insufficient at times. Indeed, it would be beneficial for future research to examine the co-resident relationship in greater detail to determine the benefits of good matching and whether positive or neutral relationships have an impact on stability and relationships with staff. It makes sense that positive co-resident relationships would add to a sense of stability. Equally, young people who would rather spend time with their peers may be less willing to form strong relationships with staff.

Future research may also benefit from examining the issue of ongoing staff contact. The research base has suggested this is beneficial. This is supported by the young people in the current study who also reported that their ongoing relationships with staff were a source of practical and emotional support. However, it is unclear whether these additional supports are beneficial because they are freely given or if it would have the same, or even a greater effect, if it formed part of the staff's job description.

This approach would have the benefit of allowing young people to expect ongoing support once they had left care. It also removes the element of 'above and beyond' care that this currently represents. The current system may leave some young people feeling further rejected once they left care because they have not managed to maintain an ongoing relationship with staff. Further research in this area would provide additional information to inform policy and practice around this issue.

Training and supervision also provided a fertile avenue for further research. Staff identified that training and supervision provided education to understand what was occurring with the young people and additional strategies to assist with coping with the difficult behaviours displayed by the young people. Professional supervision also provided support to the staff members to continue to cope when things were challenging within the house. As discussed previously, of the governmental reviews, almost half recommended implementing therapeutic care approaches while one indicated that this approach had already been implemented. James (2015) highlighted a lack of consistency across implemented approaches, which makes comparing across programs difficult. Given the recognised benefits of therapeutic care, training and supervision, further research could benefit from examining these issues in greater detail. This would open up an understanding of which benefits particular types of training and/or supervision yield, and which offer the greatest benefits. This would begin to streamline and bring about greater consistency in training and supervision approaches.

Despite a number of the participants, particularly the young people, identifying as Indigenous, there was little focus on the need for cultural sensitivity in providing a stable environment. Further research would benefit from examining the necessary elements of

cultural consideration that contribute to a young person feeling stable, particularly if they are placed outside of their community.

Finally, further research could test the model developed within the current research to determine if each of the elements that were found to relate to stability are actually necessary and sufficient to develop a sense of stability. It may be the case that some of these elements do not add additional benefits over and above the others. This may suggest they are less integral as areas of focus.

Additionally, it would be beneficial to identify whether there are improved outcomes as a result of implementing the elements, to determine whether stability can provide a healing environment and lead to improved outcomes. Indeed, being able to identify elements of stability is only useful insofar as it can be used to determine whether it leads to better outcomes. One guiding principle of the current research is that, in previous research, 'stability' as experienced by young people, has not been accurately measured through a placements-over-time paradigm. This is why the finding that stability has not had reparative power is called into question. Therefore, it would be an important piece of research to determine if stability, as developed in the current thesis, does have reparative power.

8.10 Conclusion

In this chapter, the research findings from the current study have been examined in light of the extant literature base. The findings were compared and contrasted across study groups researched within the literature, and hypotheses about discrepancies between the groups were theorised. The specific findings were discussed regarding external and internal stability, organisational scaffolding, the impact of stability and instability on the young people within residential care and what these findings mean in practice for the young people, staff and organisations.

The model developed based on the current findings was presented and justified. This model illustrated how stability can be understood as a multi-dimensional operationalisation. The 'stable house' comprises the significant information found in the current study. It places the pieces together, to understand the proximal and distal impacts on stability and how these can function together to form stability.

Following this was a discussion of the limitations and strengths of the study as well as the policy and practice implications and suggestions for future research. Based on the findings from the current study, it was identified that stability, as a construct, has many layers. Each of these needs to work together with the others to provide an environment that engenders stability for the young people within residential care. Any of the elements on their own are insufficient to provide stability, however, when put together, they make possible an environment that feels stable to a young person. The findings also suggest that, not only is stability a possibility, it may have the power to provide a healing environment for the young people.

8.11 Thesis conclusion

In the current research, I set out to answer this research question:

"*How do young people, who have lived in residential care, and residential care workers define, understand and explain placement stability?*"

This question was developed to form a preliminary understanding into how stability works in residential care, an environment with many moving parts, including a rotating roster of staff, multiple co-residents and organisational structures that impact the stability of a given placement.

To date, no empirical research has explicitly examined this issue in residential care and in very few studies have researchers begun to identify the elements of stability beyond the number of placements a young person experiences over their time in OOHC. As has

been discussed in Chapter 3, stability is related to many more factors besides the continuity of a single placement, particularly in residential care, where a single placement may be marked by changes of staff and changes of residents. While the extant research has been unanimous in the finding that instability leads to negative outcomes, including sexual behaviour problems, offending behaviours and poorer mental health, the positive correlates of stability have not been found in previous research.

In the current study, I argue that this is because of extant research following a misconstrued paradigm and operationalization of stability: placements over time. While this paradigm is easy to implement as it offers readily measurable data, it does not take into account the multifaceted nature of what stability actually is and what it engenders. The current exploratory research has offered empirical data on the multiple dimensions of stability.

As discussed in Chapter 2, theories of attachment and the neurobiology of trauma underpinned the research, both as theories to interpret the extant research, to guide the data analysis process and to provide explanations for the data findings. These theories provide an explanation for early maltreatment's effect on young people in regard to two aspects: firstly, their developing attachment systems and subsequent abilities to form relationships; and secondly, their brain development and the subsequent impact on emotional and behavioural control. These underpinning theories also provided an explanation for the findings in the current research, as discussed in this chapter.

The significant findings of the current research, as discussed in Chapters 6 and 7, include the important need for ongoing stable and consistent relationships with safe adults who genuinely care about the young people. The staff that provide those supportive relationships, equally need to be supported by the organisations that they work for, through management, training and supervision. These findings challenge the assumption that remaining in a single placement was sufficient for an experience of stability. They emphasize the need for consistent caregivers and the difficulties associated with casual staffing. This research provides unique insights into the benefits associated with stability, which has not previously been shown in the empirical literature. Significantly,

it has been theorised that stability would provide beneficial outcomes. This exploratory study is one of the first to have empirically examined this issue.

To conclude this thesis, attention is drawn to the case studies that were introduced in Chapter 3. These cases support the findings that stability, as understood and constructed in this research, is beneficial for young people in residential care.

Johnny, a 14-year-old boy, has been in his placement for 18 months. This is his first placement since entering residential care. He is fortunate enough to have a fairly stable team and a 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. Three other young people live in the house, none of whom he has a good relationship with. It is unclear who will replace the team member who is moving to another house. He has met the new team leader once.

Tallulah, a 16 year old girl, has ongoing difficulties with drug use and aggression. Her staff team have been fairly stable for the past six months, and she enjoys good relationships with them. Prior to this, there was some instability as the organization had restructured and had a shortage of permanent staff. All of the young people living in the house when she moved in, however, have moved out. One left because he turned 18, another because she was incarcerated for theft offences and another because of assaulting one of the staff members. Currently, Tallulah is waiting to find out who will be moving into the bedroom next to hers.

Ben is 13 and lives in a house with three other boys, all of whom can be quite aggressive and have long criminal histories. The staff are not happy at work because of frequent threats of abuse from the young people. They regularly call in sick. Because the house is known to be really difficult, familiar casual staff are hard to get so agency staff are often called in. Typically, they are not known to the young people. 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 during the day or she visits once a week.

Based on the findings in the current study, Ben's placement would be considered to be particularly unstable. He is placed with young people who may make him feel unsafe and he has an entirely unstable staff team. Tallulah may feel stable in her placement, as, based on the current findings, co-resident stability is not a particularly significant feature of a stable placement and in fact, changing co-residents may be a benefit for her. Johnny is likely to feel the most stable of the young people as many of his staff team maintain consistency and he appears to have a positive relationship with them.

The experience of stability has little to do with an ongoing placement, however, this is a necessary condition of stability. A felt sense of stability within a placement appears to be related more strongly to a safe, consistent placement with whom the young people can forge and maintain (beyond their time in care) genuinely caring relationships that are supported by the management of the organisation.

Overall, this study provides policy makers and those in positions to influence practice with an emerging guideline on the necessary elements that contribute to a stable placement. The benefits of stability have been identified by the current research. Ongoing research would gain from continuing to explore whether there are quantifiable benefits to stability or not. Ongoing research would also be enhanced by investigating which elements are necessary, which are sufficient and how these may best be achieved. The findings herein highlight the need for a sustained and considered focus on the development of stability for young people in order for their healing to occur.

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Appendix 1 Ethics approval

MONASH University

Monash University Human Research Ethics Committee

Approval Certificate

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project ID:	10980
Project Title:	Placement Stability in Residential Out of Home Care in NSW: An Exploratory Study
Chief Investigator:	Assoc Professor Philip Mendes
Approval Date:	15/10/2018
Expiry Date:	15/10/2023

Terms of approval - failure to comply with the terms below is in breach of your approval and the *Australian Code for the Responsible Conduct of Research*.

1. The Chief Investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved projects including changes to personnel must not commence without written approval from MUHREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of five years.

Kind Regards,

Professor Nip Thomson

Chair, MUHREC

CC: Dr Catherine Flynn, Ms Jenna Bollinger

List of approved documents:

Document Type	File Name	Date	Version
Consent Form	Consent form staff mk2	03/03/2018	1
Consent Form	consent form YP mk2	03/03/2018	1
Explanatory Statement	Explanatory statement staff	10/03/2018	1
Explanatory Statement	Explanatory statement YP	10/03/2018	1
Questionnaires / Surveys	Demographic questions- staff 16042018	09/05/2018	1
Questionnaires / Surveys	Demographic questions- yp 16042018	09/05/2018	1
Explanatory Statement	Explanatory statement staff ethics review	11/08/2018	2
Explanatory Statement	Explanatory statement YP ethics review	11/08/2018	2
Consent Form	Consent form staff mk2 ethics review	11/08/2018	2
Consent Form	consent form YP mk2 ethics review	11/08/2018	2
Questionnaires / Surveys	Interview questions- management staff 09052018	11/08/2018	1
Questionnaires / Surveys	Interview questions- yp 16042018	11/08/2018	1
Questionnaires / Surveys	Interview questions- staff 16042018	11/08/2018	1

Appendix 2 Explanatory Statements

MONASH University

EXPLANATORY STATEMENT- Young people
Placement Stability in Residential Out of Home Care in NSW: An Exploratory Study
Project ID: 10980

The goal of this research is to better understand stability in residential out of home care services. We are aiming to:

- Investigate the experiences of residential out of home care for both staff and young people

- To understand what constitutes stability

- To understand the impacts of placement stability or instability

- To understand how placement stability can be achieved in residential care

The study will be carried out by the Department of Social Work, Monash University, Caulfield. The Chief Investigator of this project will be Dr Philip Mendes, Associate Professor, Department of Social Work, Monash University, Caulfield (Ph: 99031132 or email Philip.Mendes@monash.edu).

Interviews:
We want to interview people to understand their experiences. Interviews will take between 45 minutes to one hour and can happen at a place convenient to you, such as at a café or library. You will be asked to complete a brief questionnaire prior to the interview and all interviews will be audio taped and transcribed. You will be asked to sign a consent form before the interview starts.

You will be assigned a pseudonym by which you will be known for the duration of the interview and subsequently in any written-up versions of the data. Quotations from the interview will be used in the write-up of the data and you will be identified by that pseudonym.

Possible benefits and risks:
It is hoped that this research will help services develop policies and practices to understand what stability means in residential care and to increase the stability of placements for young people in residential care. In order to do that, we need to understand what constitutes stability in residential care, given the complex care arrangements including the presence of other young people in the house and multiple staff. Your participation in this research will help us to do that.

It can be difficult to talk about experiences in out of home care, particularly if they were negative. In order to help manage this, you are welcome to bring a support person to the interviews.

Managing Distress:
If you feel distressed by anything in the interview, we can stop and talk to you about how you are feeling. We can then either take a break or finish the interview then. Further counselling will be made available to you if necessary. This will be made available by one of the following 24 hour telephone counseling services or a referral back to the service that told you about the research;
Lifeline- 131114
SANE Australia- 1800 18 7263

Voluntariness and Confidentiality:
Participation in this research is entirely voluntary, and you are free to withdraw from the study up to four weeks after the initial interview by notifying Monash University either verbally or in writing. After this time, your responses may be used as part of the study. Your answers will be fully deidentified and you would not be able to be identified. You will not be penalised or disadvantaged in any way if you choose not to participate in this project. Participants have the option of either stopping the interview altogether or not answering questions with which they are uncomfortable.

No information that could identify a participant will be published and each participant's right to privacy and anonymity will be maintained. Only the researchers listed will have access to the research data.

The interview notes will be stored by the Department of Social Work for five years as prescribed by the university regulations. You will have the opportunity to review the interview transcript if you wish, by contacting the researchers directly. The overall results will be made available to the participants if they ask for them. The information collected from these interviews will be used in this project and may also be published and presented to various forums.

While the contents of the interview are confidential, certain disclosures must be managed according to university policy. The following are never confidential:

- If we think you might hurt yourself

- If we think you might hurt someone else, or that someone else might be hurt

- If you tell us about a child that is being hurt, or that children may be at risk of being hurt such as if you disclose sexual abuse by someone who has access to children

- If you tell us about any serious offences you have committed but have not been charged for.

If you do make any disclosures about these issues, you will have a say in deciding what happens next, however, they cannot be kept confidential.
Managing Complaints:

The ethical aspects of this study have been approved by the Monash University Human Research Ethics Committee. Complaints may be directed to the Executive Officer (phone 03 9905 2052, fax 03 9905 3831, email muhrec@monash.edu). Any complaint you make will be investigated promptly and you will be informed out the outcome.
If you have any questions about this research project, please to not hesitate to contact us.

Yours faithfully,

Dr Philip Mendes   Jenna Bollinger
Associate Professor   Researcher
Department of Social Work   Department of Social Work
Monash University   Monash University

MONASH University

EXPLANATORY STATEMENT- Staff

Placement Stability in Residential Out of Home Care in NSW: An Exploratory Study
Project ID: 10980

The goal of this research is to better understand stability in residential out of home care services. We are aiming to:

- Investigate the experiences of residential out of home care for both staff and young people

- To understand what constitutes stability

- To understand the impacts of placement stability or instability

- To understand how placement stability can be achieved in residential care

The study will be carried out by the Department of Social Work, Monash University, Caulfield. The Chief Investigator of this project will be Dr Philip Mendes, Associate Professor, Department of Social Work, Monash University, Caulfield (Ph: 99031132 or email Philip.Mendes@monash.edu).

Interviews:
We want to interview people to understand their experiences of what makes placements stable, what gets in the way of stability and your thoughts on how this could be improved. Interviews will take between 45 minutes to one hour and can happen at a place convenient to you, such as at a café, library or at your work place.
You will be asked to complete a brief questionnaire prior to the interview and all interviews will be audio taped and transcribed. You will be asked to sign a consent form before the interview starts.

You will be assigned a pseudonym by which you will be known for the duration of the interview and subsequently in any written-up versions of the data. Quotations from the interview will be used in the write-up of the data and you will be identified by that pseudonym.

Possible benefits and risks:
It is hoped that this research will help services develop policies and practices to understand what stability means in residential care and to increase the stability of placements for young people in residential care. In order to do that, we need to understand what constitutes stability in residential care, given the complex care arrangements including the presence of other young people in the house and multiple staff. Your participation in this research will help us to do that.

Managing Distress:

If you feel distressed by anything in the interview, we can stop and talk to you about how you are feeling. We can then either take a break or finish the interview then. Further counselling will be made available to you if necessary. This will be made available by one of the following 24 hour telephone counseling services;
Lifeline- 131114
SANE Australia- 1800 18 7263

Voluntariness and Confidentiality:
Participation in this research is entirely voluntary, and you are free to withdraw from the study up to four weeks after the initial interview by notifying Monash University or the researcher either verbally or in writing. After this time, your responses may be used as part of the study. Your answers will be fully deidentified and you would not be able to be identified. You will not be penalised or disadvantaged in any way if you choose not to participate in this project. Participants have the option of either stopping the interview altogether or not answering questions with which they are uncomfortable.

No information that could identify a participant will be published and each participant's right to privacy and anonymity will be maintained. Only the researchers listed will have access to the research data.

The interview notes will be stored by the Department of Social Work for five years as prescribed by the university regulations. You will have the opportunity to review the interview transcript if you wish, by contacting the researchers directly. The overall results will be made available to the participants if they ask for them. The information collected from these interviews will be used in this project and may also be published and presented to various forums.

While the contents of the interview are confidential, certain disclosures must be managed according to university policy. The following are never confidential:
- If we think you might hurt yourself

- If we think you might hurt someone else, or that someone else might be hurt

- If you tell us about a child that is being hurt, or that children may be at risk of being hurt

- If you tell us about any serious offences you have committed but have not been charged for.

If you do make any disclosures about these issues, you will have a say in deciding what happens next, however, they cannot be kept confidential.

Managing Complaints:
The ethical aspects of this study have been approved by the Monash University Human Research Ethics Committee. Complaints may be directed to the Executive Officer (phone 03 9905 2052, fax 03 9905 3831, email muhrec@monash.edu). Any complaint you make will be investigated promptly and you will be informed out the outcome.
If you have any questions about this research project, please to not hesitate to contact us.

Yours faithfully,

Dr Philip Mendes
Associate Professor
Department of Social Work
Monash University

Jenna Bollinger
Researcher
Department of Social Work
Monash University

Appendix 3 Consent forms

MONASH University

CONSENT FORM

Young Person

Project ID and title Placement Stability in Residential Out of Home Care in NSW: An Exploratory Study

Project ID: 10980

Chief Investigator: Jenna Bollinger

I have been asked to take part in the Monash University research project specified above. I have had the project explained to me and read and understood the Explanatory Statement and I hereby consent to participate in this project. By agreeing to participate in this research, I accept that I am willing to consent to the following:

- be interviewed by the researcher

- allow the interview to be audio taped

- provide my contact details as appropriate for the purpose of being sent a more detailed research questionnaire.

I understand the following	Yes/No
That the aims, methods, and anticipated benefits, and possible risks of the research study have been explained to me.	
That I voluntarily and freely give my consent to my participation in the study.	
That grouped results only will be used for research purposes and may be reported in scientific and academic journals. No details that could identify me will be included in any reports or publications coming out of the research study.	
Details of individual results will not be released to any person outside the research team.	

Participation will take between 45 minutes and 1 hour.	
I am free to withdraw my consent for four weeks after the interview, and can ask that any information obtained from me is not used.	
Audiotapes will be electronically stored and will not have my name on them.	
Any paper documents completed by the researchers will not have my name on them and will be stored in a locked filing cabinet at Monash University.	
I have a copy of the Explanatory Statement and Consent Form to keep.	
I am able to ask to view the transcript of the interview if I wish.	

Name of Participant _____

_____

Participant Signature _____ Date _____

_____

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CONSENT FORM

Staff

Project ID: 10980

Project title Placement Stability in Residential Out of Home Care in NSW: An Exploratory Study

Chief Investigator: Jenna Bollinger

I have been asked to take part in the Monash University research project specified above. I have had the project explained to me and read and understood the Explanatory Statement and I hereby consent to participate in this project. By agreeing to participate in this research, I accept that I am willing to consent to the following:

- be interviewed by the researcher

- allow the interview to be audio taped

-provide my contact details as appropriate for the purpose of being sent a more detailed research questionnaire.

I understand the following	Yes/No
That the aims, methods, and anticipated benefits, and possible risks of the research study have been explained to me.	
That I voluntarily and freely give my consent to my participation in the study.	
That grouped results only will be used for research purposes and may be reported in scientific and academic journals. No details that could identify me will be included in any reports or publications coming out of the research study.	
Details of individual results will not be released to any person outside the research team.	
Participation will take between 45 minutes and 1 hour.	
I am free to withdraw my consent for four weeks after the interview, and can ask that any information obtained from me is not used.	

Audiotapes will be electronically stored and will not have my name on them.	
Any paper documents completed by the researchers will not have my name on them and will be stored in a locked filing cabinet at Monash University.	323
I have a copy of the Explanatory Statement and Consent Form to keep.	
I am able to ask to view the transcript of the interview if I wish.	

Name of Participant

Participant Signature   Date

Appendix 4 Interview Questions

Interview questions- management staff

Do you have any questions for me before we begin?

I'm going to be asking you about your experiences of working in residential care. If I ask you anything that you don't want to answer, you can just say 'pass' or hold your hand up and we will move on. If you need a break at any time, just let me know. I am hoping you will share your experiences with me. You are the expert in this and I am interested to know about your thoughts and knowledge in this area.

1. There are a lot of people involved in a young person's life in residential care- the staff, the other young people, the management. What is stability for a young person? What does a stable placement look like to you?
2. In your experience, what impact does a lack of stability have on young people? Why do you think it has that impact?
3. What is the impact of multiple placements? When have you seen too many and what happened?
4. Thinking of your experiences in residential care, which houses worked well? What made them work well? What was the staffing model, and the backgrounds/experiences of the staff? What impact did the houses working well have on the young people?
5. How much control do you have over the placements of young people in residential care?
6. How do you make decisions about who to place where?
7. How do you make decisions about when to move someone and where to move them?
8. How do you make decisions about when to move staff?
9. How do you make decisions about which casual staff to use?
10. How much of an impact does the stability of the staff team have on your decisions to place young people in the house?
11. How much involvement do you have with the young people directly?
12. In your role, have you seen the impact of placement stability or instability on young people? Can you think of any in particular?
13. How do you think placements can be more stable? What does management need to make good or better decisions about who to place where?
14. What do staff teams need to be able to maintain more stable placements and stable teams for the young people?

Interview questions- floor staff

Do you have any questions for me before we begin?

I'm going to be asking you about your experiences of working in residential care. If I ask you anything that you don't want to answer, you can just say 'pass' or hold your hand up and we will move on. If you need a break at any time, just let me know.

1. There are a lot of people involved in a young person's life in residential care- the staff, the other young people, the management. What do you think are the key factors that enable a 'stable' placement for a young person in residential care?
2. In your experience, what impact does a lack of stability have on young people? Why do you think it has that impact?
3. How many placements in residential care do you think is too many?
4. Thinking of your experiences in residential care, which houses worked well? What made them work well? What was the staffing model, and the backgrounds/experiences of the staff? What impact did the houses working well have on the young people?
5. Thinking of your experiences in residential care, which houses worked less well? What made them work less well? What was the staffing model, and the backgrounds/experiences of the staff? What impact did the houses working less well have on the young people?
6. How much control do you have over whether a young person is placed in your house? When you have been able to have a say, what impact has that had?
7. How much control do you have over whether a young person is moved out of your house?
8. How have you managed when young people have moved into the house that you believed would not be a positive addition or who might be vulnerable?
9. In the house you spent most time working in, how much staff turnover was there [was there much stability of the staff]? What impact did that have on the young people?
10. In the house you spent most time working in, was there much stability of the young people? What impact did that have on the young people?
11. When young people need to be moved, how does this impact on the others in the house? Are there times when it has less impact and times when it has more impact? What type of impact?
12. How do you think placements can be more stable? What do staff need to be able to maintain placement stability for young people?
15. For management
13. How much control do you have over the placements of young people in residential care?
14. How do you make decisions about who to place where?
15. How do you make decisions about when to move someone and where to move them?
16. How do you make decisions about when to move staff?
17. How do you make decisions about which casual staff to use?
18. How much of an impact does the stability of the staff team have on your decisions to place young people in the house?
19. How much involvement do you have with the young people directly?

20. In your role, have you seen the impact of placement stability or instability on young people? Can you think of any in particular?
21. How do you think placements can be more stable? What does management need to make good or better decisions about who to place where? What do staff teams need to be able to maintain more stable placements and stable teams for the young people?

Interview questions- Young People

Do you have any questions for me before we begin?

I'm going to be asking you about your experiences in residential care. If I ask you anything that you don't want to answer, you can just say 'pass' or hold your hand up and we will move on. Remember, if you feel upset at any time, let me know and we will pause the interview and decide what to do together. There are no right or wrong answers, I want to understand your experiences. If you need a break at any time, just let me know.

1. You answered on your questionnaire that you had ____ placements in residential care. How many of them were good and how many were not so good?
1.a What made the good placements good?
1.b What made the not so good placements not so good?

2. Of all the residential care workers you had, how many were good and how many were not so good?
2.a What made the good ones good?
2.b What made the not so good ones not so good?
2.c What impact did casual staff have on the placements? Did placements feel different when casual staff were on shift, instead of the usual rostered staff? Were there particular casual staff that did not have that effect?

3. Is there a placement that you can think of that worked really well? What made it work so well? What would a good day or week look like in that placement? What would a bad day or week look like in that placement?

4. Is there a placement that you can think of that worked really poorly? What made it work so poorly? What would a good day or week look like in that placement? What would a bad day or week look like in that placement?

5. (For each placement move, ask separately) How were you told about this move?
   a. Did you feel this was a positive or negative move?
   b. Was the way you were told about it helpful or unhelpful?
   c. (If it was unhelpful) how could you have been told about it that would have made it easier?
   d. What did you think/feel about the way you were told?

6. If you think about all the placements you had in residential care, were there particular placements that you remember as working well because of the other young people? What was good about the mix?

7. If you think about all the placements you had in residential care, were there particular placements that you remember as working badly because of the other young people? How could that have been managed better?

8. Were you directly impacted by the movements of other young people in placement? Were these positive or negative impacts? If you were impacted negatively, what made it negative and how could it have been done better?

9. In the house you spent most time in, how much staff turnover was there [was there much stability of the staff]? What impact did that have on you and the other young people?

10. Did you have friends at school or outside of your residential care placement?
    9.a Did you maintain any of these friendships once you left residential care?

9.b How did having friends outside of your placement help or make things harder in your placement?

10. When you changed placements in residential care, did you have to change schools as well? How did that impact you?

11. Did placement changes also impact on your contact with family members?

12. How many placements do you think is 'too many' in residential care?

13. What impact does 'too many' placements have on young people in residential care?

14. There are a lot of people involved in a young person's life in residential care- the staff, the other young people, the management. What do you think makes for a 'stable' placement for a young person in residential care?