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CARE CONTINUUM – OVERSEAS JURISDICTIONS:

Evidence Brief

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Disclaimer:

This report provides a high-level overview of care services in select overseas jurisdictions. This report does not provide a comprehensive overview of the different care systems. Rather it was designed to provide a preliminary overview of available information in a short timeframe.

Oranga Tamariki has made every effort to ensure the information in this report is reliable, but does not guarantee its accuracy and does not accept liability for any errors.

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EXECUTIVE SUMMARY

Child protection systems throughout the world have to navigate the challenge of looking after children (both the prevention and response to maltreatment), whilst considering parents' rights, and also striving to contain costs (Katz et al, 2016).

Two most common orientations in child protection systems

In western countries the two common orientations in child protection systems have been:

- **child protection** – this approach tends to see parents as responsible, and focuses on abuse detection, investigation, surveillance of families and child removal

- **family support** – this approach focuses on providing supportive or therapeutic services to prevent child maltreatment.

The orientations are useful for broadly understanding different jurisdictions' child protection systems, however, there is variation and most have legislative and policy approaches that are a combination of orientations (Price-Robertson et al, 2014, Katz et al, 2016).

Placement options on the care continuum

The primary aim of out-of-home care is to keep children and young people safe. Typically, placement in out-of-home care is a last resort. On the care continuum for out-of-home care the main types of care placements include foster care (kinship and non-kinship care), residential care and adoption. Internationally foster care is seen as preferential to residential care by practitioners and foster children alike (del Valle, 2015; Keshavarzian, 2016).

Similarities between jurisdictions

Within and between countries there is variation between how out-of-home care placement options are structured and implemented. There are also a number of similarities such as acknowledgment of the importance of contact with biological parents and siblings, increasing professionalism of care workers, a preference for home-based care over residential care and a favouring of kinship care over non-kinship care (del Valle, 2015; Connolly, 2003).

Internationally, there is understanding different options for care placement are needed

There is recognition the care continuum needs different options for care placement, and that all of the main types of out-of-home care have value and a place on the continuum (even if they have not always been implemented in the best way in the past). Care should be tailored to the needs of the child not the availability of services.

Shared challenges in the provision of out-of-home placements

Child protection systems face a number of challenges including recruitment of sufficient foster parents, resourcing constraints, increasingly complex needs of children and their families, increasing referrals, investigations, and a growing number of placements (overall and for indigenous children and youth in particular). Further, these challenges are set against a backdrop of many countries having non-existent or poor data collection, inconsistent measurement, and limited visibility of outcomes (ie, the information that is needed to design quality systems).

A model of care that promotes safety and wellbeing of children

As challenges and costs increase there is a move towards a model that promotes the safety and wellbeing of children. Practitioners and researchers alike have suggested that applying a public health model to child care and protection will improve outcomes for both children and their families. A public health model prioritises having universal supports available for all families (eg, education and medical care); secondary prevention activities targeted at those in need and tertiary child protection services being a last resort[1].

Outcomes sought for children and young people and their families

A number of different outcomes are sought for children and young people. There are 'in-care process' outcomes such as stability of placement, inclusion in school, and development of life skills. There are also 'after care later in life' outcomes such as having a productive life, educational attainment, being confident, having safe and sustained accommodation, and meaningful relationships. Outcomes for families include: a resolution of the issues that led to the out-of-home care placement, parenting competence, and reunification with their children.

Outcomes sought for child protection systems

Outcomes sought for child protection systems include: reduction in referrals to care, (including reduction in referrals to care based on youth offending), reduction in the number of children in statutory care (including reduction in the number of indigenous children who enter care), and greater permanence and improved outcomes for those in out-of-home care (Wise, 2017).

Considerations (or principles) important in relation to the care continuum

There are a number of lessons that can be taken from overseas jurisdictions in regard to out-of-home care including how to address the challenges care protection systems face and key considerations for design of services. Considerations include having a child *and* family focus, providing options for out-of-home care, promoting professionalism and continuous improvement (including data capture and accountability), having a multi-agency, integrated approach, and both a prevention and response lens.

Range of services

A range of services are required to meet the needs of children and young people in out-of-home care, their carers and their biological families. All those placed in care should have a care plan (following a needs assessment) with the services accessed being based on need, and on the outcomes sought. Potential services for children and young people include support for educational attainment, health services, psychological services, developing skills for independent living and transitioning out of care.

Families and caregivers will also need support. Families may need support such as developing parenting skills, drug and alcohol rehabilitation, communication and relationship skills (including conflict resolution) and mentoring. Carers may require support to deal with challenging behaviours and to prevent burn-out, training and financial support.

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[1] https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/an-outline-of-national-standards-for-out-of-home-care-2011

INTRODUCTION

Scope of this report

Oranga Tamariki—Ministry for Children commissioned Russell Research Aotearoa to provide a high-level overview of the care continuum for children in out-of-home care in a number of overseas jurisdictions including (Australia, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Netherlands, Norway, Sweden, Switzerland, the United Kingdom [UK, including England, Wales, and Scotland], and the United States).

The report covers the need for out-of-home care, orientation of care systems, principles in the provision of care, types of care options, outcomes sought, key challenges faced, and considerations for designing out-of-home care services.

REASONS FOR CHILDREN/YOUNG PEOPLE GOING INTO CARE

There are many and varied reasons why out-of-home care is needed

There are a number of reasons why children and young people cannot live with their birth parents for short or long periods of time and need to go into care. Reasons for being looked after in alternative care include[2, 3]:

- facing neglect (including medical neglect) or abuse (physical or sexual) at home
- having been involved in the youth justice system (ie, a juvenile offender[4])
- having parents who are incarcerated in prison
- having parents who are unable to provide adequate care due to mental health or drug and alcohol issues
- abandonment by or death of parents
- being an unaccompanied minor seeking asylum, or having been illegally trafficked into a country
- behavioural issues, regular running away or truancy (on part of child).

Children's pre-care experiences can impact on their development, outcomes and time in care

It is important to understand the range of challenges those entering out-of-home care may have experienced. The experience of these can negatively impact on children's development and outcomes (social, physical and educational)[5] and ability to settle in placements. Additionally, children's experience leading to out-of-home care will typically be taken into consideration for care planning (identifying services and support required).

There are age-related differences for entry into care

Research has shown age-related differences for coming into care; young children tend to come into care because of parental shortcomings and issues at home; older children come into care because of their own behavioural problems (although it has been noted that the majority of young people who come into care because of their own behaviours have also experienced problems at home when they were younger) (Khoo et al, 2012).

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[2] https://beta.gov.scot/policies/looked-after-children/

[3] https://www.thespruce.com/top-reasons-children-enter-foster-care-27123.

[4] Different jurisdictions account for children who engage in criminal acts and substance abuse differently. For example, in Sweden such children would still be looked after within the welfare system. In the UK or the US these cases would be counted in the administrative jurisdiction of the criminal justice system (Gilbert, 2012).

[5] http://www.howkidsdevelop.com/fcChallenges.html

CARE SYSTEM ORIENTATIONS

Child protection systems have competing demands

Katz (et al, 2016) note that child protection systems throughout the world have to navigate the challenge of looking after children (both the prevention and response to maltreatment), whilst considering parents' rights, and also striving to contain costs. Child welfare systems have considerable variation in their legal and historical bases, function, structure, and capacity both within and across countries (Connolly et al, 2014 in Katz et al, 2016).

Different child protection systems have different orientations

Historically, the two most common trends in child protection systems in western countries have been child protection or family support (Gilbert, 2012 in del Valle, 2015, Price-Robertson et al, 2014), outlined below:

– A **child protection orientation**: this approach tends to see parents as responsible (ie, parents as perpetrators), and focuses on abuse detection, investigation, surveillance of families and child removal. The basis of government intervention and services provided is described as "legalistic, investigatory in order to formulate child safety plans" with resources concentrated on families for whom risks of harm to children are perceived to be high (Price-Robertson et al, 2014). The state-parent relationship is sometimes adversarial, with involuntary out-of-home placements (Katz et al, 2016).

  The child protection orientation is found in English speaking jurisdictions such as the United Kingdom, Australia, Canada, and United States (New Zealand would also be classified as having a child protection orientation) (Price-Robertson et al, 2014, Katz et al, 2016).

– A **family support orientation**: this approach has a mode of intervention that focuses on providing supportive or therapeutic services to prevent child maltreatment (Price-Robertson et al, 2014, Katz et al, 2016). Child abuse is framed as a result of family dysfunction resulting from psychological, social or economic difficulties (Price-Robertson et al, 2014). The family support orientation emphasises giving families a chance, training parental skills and other supports, and cooperation with parents (del Valle, 2015). The state-parent relationship is one of partnership to strengthen family relationships, with voluntary out-of-home placements a feature (Katz et al, 2016).

  This orientation is evident in European countries such as The Netherlands, Denmark, Belgium and Sweden (Price-Robertson et al, 2014, Katz et al, 2016, del Valle, 2015). It has been noted that the family approach to service provision (the 'European approach') results in greater numbers of vulnerable families having a wider range of services provided to them (Thoburn, 2010).

In most instances, legislative and policy approaches comprise a combination of these orientations (Price-Robertson et al, 2014).

Other described approaches include:

– **Child development orientation** – this is regarded as a 'synthesis' model converging both child protection and family support (del Valle, 2015; Gilbert, 2012); the mode of intervention is early intervention and needs assessment. This orientation sees the government having a 'paternalistic' role in supporting equal development outcomes with

the state assuming family responsibilities for support and care (Gilbert, 2011 in Katz et al, 2016; Katz et al, 2016).

– **Community care approach** – (relevant to indigenous and minority populations) this approach recognises child protection systems embedded within broader community and family services (for example, harm reduction whilst retaining children and young people in families and Aboriginal communities, with services delivered jointly by Aboriginal service organisations and other non-government services such as seen in Canadian approaches to child protection [Katz et al, 2016]).

Reform is commonplace and often the system's orientations converge

The descriptions of child welfare systems can be useful for understanding different approaches; however it is important to remember that child welfare systems are in a continuous process of change (Katz et al, 2016).

The orientations are regarded as broad types, and it is recognised that there is variation within each orientation, and also that most child protection systems have legislative and policy frameworks that are a combination of orientations (Price-Robertson et al, 2014).

Many countries' child welfare systems have experienced substantial reforms in recent years and moved towards a care system that has both a child protection and a family services orientation. This supports early intervention to prevent children from being placed in care but also acts in the best interest of the children if harm occurs.

For example, Australia's approach is considered a 'child protection' orientation (with out-of-home care mainly being involuntary) but its national framework (*The National Framework for Protecting Australia's Children*[6]) has components of a family service orientation with its emphasis on early intervention and prevention and its inclusive motto of *"protecting children is everyone's business"* (Price-Robertson et al, 2014).

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[6] https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/protecting-children-is-everyones-business

OUT-OF-HOME CARE TYPES

Main broad types of care on the care continuum for out-of-home care

Within the care continuum there are several different living arrangement options for providing out-of-home care for children (aged 12 or younger) and young people (aged 13 to 21[7]) who need statutory care. The main types of alternative out-of-home care include:

- Foster care
- Kinship care
- Residential Care
- Adoption

Within each of the types of out-of-home care listed above there are a number of variations to how the care is structured and implemented. These are discussed in more detail in the next section.

Other options on the care continuum include:

- **Legal Guardianship** – where the child's custody is transferred from the state to legally appointed adult caregivers (may be relative caregivers) (Gilbert, 2012)

- **Informal, voluntary kinship** – where the child is living with relatives as a result of child welfare involvement but not under public custody (Gilbert, 2012)

- **Community-based care settings** – care within family-type settings in their own communities[8] (noted in kinship care in the next section)

- **Independent living** – including private boarding, supported child headed households (one where there are no adult carers are available and children live on their own – typically found in places affected by disease such as HIV, or with genocide or war)[9].

Main alternative out-of-home care types

Foster care

In industrialised countries, foster care typically refers to formal, temporary placements made by the State with approved families who are equipped (eg, via training and support), compensated and monitored[10].

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[7] Young people are generally referred to as those aged 13-21 years. Different jurisdictions have different age groupings for young people (with some ending at 18 years, and others ending in the early twenties).

[8] https://bettercarenetwork.org/library/the-continuum-of-care/community-based-care-mechanisms

[9] https://bettercarenetwork.org/library/the-continuum-of-care/supported-child-headed-households

[10] https://www.bettercarenetwork.org/library/the-continuum-of-care/foster-care

Different definitions for foster care make international comparisons difficult

Understanding foster care arrangements in overseas jurisdictions can be confusing as the term foster care is used in different jurisdictions in different ways, for example, some jurisdictions do not differentiate between kinship (care by a relative or someone known to the child) and non-kinship care when talking about foster care[11]. Given the wide differences in how foster care is defined makes comparisons across countries difficult – this has been noted as one of the key challenges in understanding and designing quality foster care (Keshavarzian, 2016).

Foster care is valued and often preferred over residential care

Foster care is seen as having a valuable place in the care continuum. Internationally foster care is seen as preferential to residential care by practitioners and foster children alike (del Valle, 2015; Keshavarzian, 2016). The family setting is valued for meeting children's psychological and developmental needs for love and belonging (Keshavarzian, 2016).

It is also recognised that foster care is not the best option for every child, and that small group homes or independent living arrangements may be more appropriate (Keshavarzian, 2016). Not all children are comfortable in a family setting because of past abusive family experiences or experience of homelessness (Keshavarzian, 2016). Additionally, those who have specialist needs or who have had multiple placements and need stability in their placement may benefit from an alternative care option (Keshavarzian, 2016).

There are different types of foster care

Foster care can vary in a number of ways including:

- purpose (eg, interim, emergency, respite, pre-adoption, or treatment[12]) and orientation
- duration (short to medium [few weeks to months], long-term or permanent [eg, Home for Life])
- number of children allowed
- design (eg, kinship, known to child but not kin, non-kinship but same ethnicity, same community, parent and baby fostering [eg, to allow a school aged parent to develop their capacity to be a parent without having the care role taken away]).

    There are also small group family homes which offer accommodation in a residential building, which is usually run like a family home with a limited number of children and 24-hour care by foster parents (not professional staff) (Office of the Children's Commissioner, 2016).

Foster care can support family reunification

Foster care is not only about providing a child or young person with an alternative out-of-home care, it is also used as a means of family preservation (eg, when it is used therapeutically to support families develop new ways of interacting) (Keshavarzian, 2016).

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[11] https://www.bettercarenetwork

[12] Treatment foster care (TFC), also called therapeutic foster care, is out-of-home care by foster parents who are given special training and on-going consultation to provide treatment (ie, for children and young people, usually those with significant emotional, behavioural, or social issues or medical needs) (Keshavarzian, 2016) and https://www.childwelfare.gov/topics/outofhome/foster-care/treat-foster/

Demand for foster carers outstrips supply

As the number of children who require out-of-home care has been increasing, many jurisdictions note that there are not enough foster carers to meet demand. Fostering services face challenges attracting, recruiting and retaining foster carers[13].

Kinship Care

Kinship care is the full-time care of a child by a relative or another member of the extended family or with a person who already knows the child (ie, a family friend)[14]. Many countries include kinship care under the umbrella grouping of foster care.

Kinship care favoured within the out-of-home continuum

In the past two decades kinship care has become an internationally favoured system for children who are unable to be looked after by their parents (in United States, Spain, Italy, Romania, Australia and New Zealand) as it allows the child/children to remain within their own family, culture and community (del Valle, 2015; Connolly, 2003). However, the evidence suggests non-kinship foster care is still needed in the care continuum for those children for whom kin care would not be in their best interests or is not an available option for them (Keshavarzian, 2016).

Kinship care is limited in some countries (and efforts are being made to remedy this)

Kinship care is limited in Nordic countries and central Europe, and also in the UK and Ireland (although contact between biological families and foster children is encouraged and promoted). Limited utility of kinship care is being reviewed in the UK with a view to promoting it, and the numbers of foster children in kinship care is increasing in Scotland and Ireland (around 25%) (del Valle, 2015; Department of Children and Youth Affairs, Ireland, 2016[15]).

Kinship care is favoured for indigenous children

In Australia there is an 'Aboriginal Child Placement Principle' which requires indigenous children who need statutory protection be placed within their extended family; if that option is not possible, then a placement within their indigenous community or with other indigenous people is sought. Only as a last resort are Aboriginal children to be placed in non- indigenous care (Katz et al, 2016, Arney et al., 2015[16]). The preference to place indigenous children in kinship care is to promote culturally appropriate care and connection to children's own cultural identity.

There are recognised benefits *and* reservations associated with kinship care

Kinship care is recommended for the benefits it can bring (eg, connection to family and culture, more stable placements than non-kinship foster care, increased likelihood of remaining with siblings and having contact with birth parents – which may ease transitions out of care [Rubin et al, 2008]).

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[13] http://gov.wales/docs/dhss/publications/140530fosteren.pdf

[14] http://www.familymatters.org.au/what-is-out-of-home-care/ and https://www.bettercarenetwork.org/library/the-continuum-of-care/

[15] https://www.dcya.gov.ie/viewdoc.asp?fn=/documents/Children_In_Care/FosterCare.htm

[16] in https://aifs.gov.au/cfca/publications/children-care

Research in the US has found that kinship care has a protective effect on early behavioural outcomes, with those in kinship care being less likely to develop behavioural issues compared to children entering non-kinship foster care (Rubin et al, 2008). However, Rubin (et al, 2008) notes that caution is needed when interpreting this result as kin carers may be less likely to report behavioural issues. Further, the research also found that for those children who did not have a kin care option, placement stability improves all behavioural outcomes.

There are some reservations around kinship care, including:

- **safety concerns** – children in kinship care may have continued and unsupervised access to abusive parents, also the kinship carers may have similar issues to the offending parents (Rubin et al, 2008).

- **vulnerable carers and material hardship** – children in kinship care can have additional hardships because their caregivers tend to be single, older (eg, a grandparent), of poorer health, lower economic status, have more mental health problems, receive less support from child welfare agencies, and have fewer supportive resources than foster parents (Rubin et al, 2008).

Some jurisdictions find it challenging to provide adequate support for relative and kinship carers.[17] There is a danger of using kinship care as a 'low cost' intervention (del Valle, 2015); as costs associated with looking after children exist regardless of whether the child is kin or not, and kinship carers can also benefit from training and support just as non-kinship carers do.

Residential Care

As with foster care there is a great deal of variation of residential care placements internationally. For example, some countries make use of residential care in short or part-time ways to support parents and others use residential care only in a full-time limited capacity.

There are different types of residential care defined either by setting (service offering) or need

There are a number of different residential care settings; residential care can refer to any group living arrangement where children and young people are looked after by paid staff in a specially designated facility[18]. Residential care includes facilities such as emergency shelters, specialist group homes (where children live in a group setting that is professionally staffed), to larger-scale institutions such children's homes and secure facilities.

Residential care exists for a number of needs, including respite care, care for teenage parents and their babies, therapeutic care for children with complex needs, semi-secure care, secure care, residential treatment centres, and supported accommodation in preparation for independence (Hart et al, 2015).

There is an increasingly held view that residential care should be seen as part of a continuum of care which is needs-led rather than service-led, with regular assessment and monitoring to

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[17] Senate Community Affairs Committee, 2015 in Child Community Family Australia Resource Sheet (October, 2017) https://aifs.gov.au/cfca/publications/children-care

[18] http://www.familymatters.org.au/what-is-out-of-home-care/ and https://www.bettercarenetwork.org/library/the-continuum-of-care/

ensure that children's needs are met (Hart et al, 2015). Consideration of needs is especially important given children in residential care are typically the most vulnerable children in the care system (Whittaker et al, 2014 in Hart et al, 2015).

Residential care – a short term solution

Typically, residential care is meant to be provided on a short-term basis whilst family-based care options are secured or efforts are made to assist with family reintegration[19] or certain needs are met. There is an international preference for avoiding long stays in residential care (Lopez and del Valle, 2015).

There is a movement away from residential care but not in all countries

Whilst there is a movement away from residential care facilities towards foster care (Lopez and del Valle, 2015), residential care is still important and well utilised in central Europe (eg, The Netherlands, Germany) and Mediterranean countries (eg, Spain, Italy) (del Valle, 2015).

Different countries with different child protection orientations tend to have differing perspectives and utilisation of residential care

In England residential care is not, in policy terms, defined as a permanent placement, and it has some stigma attached to it, as a 'last resort' or a 'stop gap measure'. The proportion of children placed in residential care for 'care and upbringing' is small in the UK compared to other European countries; Hart (et al, 2015) note the UK residential homes are more often used for 'care taking' not 'parenting' children in care (eg, focussed on health and safety and compliance as opposed to developing a relationship with the child).

This is different to what happens in countries with a tradition of social pedagogy, where staff in residential care are actively engaged in bringing the child up, usually in partnership with parents (Hart et al, 2015). Social pedagogy (concerned with wellbeing, learning and growth), is the approach that underpins residential care in parts of Europe (Hart et al, 2015). In a number of European countries with a family services orientation residential care is used to enable families to access services to support them to overcome the issues they have – in this way residential care is seen as preserving families.

Secure care

The use of secure care has been debated in both the UK and Scotland, however published information is limited and difficult to interpret (with ideology and evidence being blurred) (McLean, 2016). Recommendations have been made to have a welfare-oriented approach (one that makes no distinction between offending and other risk behaviour), as opposed to a punitive (judicial) approach to children's harmful behaviours as the welfare approach is believed to be more effective at addressing social and criminogenic needs (Koehler et al, 2013; Souverin et al, 2013 all cited in McLean, 2016).

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[19] https://www.bettercarenetwork.org/library/the-continuum-of-care/

What works in residential care?

Hart (et al, 2015) summarised the evidence of what works in residential care as follows:

- **Needs based** – residential care seen as part of the continuum of care where a child's needs are regularly assessed and monitored and this information is used to decide which services a child needs

- **Positive relationships in the home** (among the children; and between the children and staff)

- **Family involvement** – working with the families in a continuous way (before, during and after residential placement) and involving them in decisions relating to their child during the residential placement

- **Normal life** -– providing a 'normal life' environment where children feel safe and have access to the same range of support, activities and opportunities as other children (including thing like access to a variety of food, opportunities to participate in sports and other extra curricula activities). In Denmark staff in residential placements actively try to create a 'homely' environment by doing things like their paperwork at the kitchen table instead of in an office.

Adoption

Aging out in care is associated with a number of poor outcomes (Stott and Gustavsson, 2010). Additionally, it has been noted that youth who are not reunited with their families, or placed in adoption or guardianship homes can struggle with feelings of rejection and abandonment (Stott and Gustavsson, 2010). Given this, some jurisdictions have a focus of permanence in placements.

The US and Canada in particular both emphasise permanency planning and have tried to reduce the number of children placed in out-of-home care in recent years – this has seen a corresponding increase in the numbers in informal kinship care and adoption (Courtney et al, 2013).

Adoption to avoid long stays in residential care

Lopez and del Valle (2015) note that the international adoption law (57/2007) which establishes two years for parents to recover from the conditions which led to the removal of their child (with some flexibility) could be a powerful tool to avoid long stays in residential care (eg, five years in Spain).

Tensions exist in systems regarding permanency in care or reunification with families

The tension between a desire to promote reunification with families and also to provide permanency for children is evident in many jurisdictions. Within the Anglo-Saxon child protection model the primary intervention goals in care planning are reunification with family or permanent placement leading to adoption (Holland and Gorey, 2004 in Khoo et al, 2012, Parkinson, 2003 in Khoo et al, 2012).

Countries which have a child protection model (such as the US and UK) embrace the right of children to have a stable family, whereas others with a family orientation such as Sweden or

The Netherlands do not allow adoption against parents' wishes, and in Norway, Germany or Ireland adoption is allowed but not promoted (del Valle, 2015; Bowyer and Wilkinson, 2013 in Hart et al, 2015). In the instance of long term out-of-home care being needed, Finland also favours long term foster care over adoption[20].

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[20] http://childprotectionresource.online/child-protection-in-finland/

CARE CONTINUUM OUTCOMES SOUGHT

Goals of out-of-home care

When a child or young person is initially placed into care, a jurisdiction's first aim is typically to keep the child or young person safe. Additional important aims include keeping them:

- connected to their own families and culture
- connected to others (friends, communities)
- healthy (well nourished, physically and mentally well and free from substance misuse)
- in school with regular attendance and achieving educationally
- free from offending or reoffending
- active – having the opportunity to participate in sports and recreation.

In-care process outcomes *for the child or young person* include:

- the child feeling (and being) safe and secure (Scott, 2009)
- having a sense of belonging
- feeling wanted, loved and cared for (typically mentioned in relation to foster care)
- looked after (physical and emotional needs met)
- knowing what's happening (placement length, their rights, transition planning, etc.)
- stability of placement
- inclusion in school (Safer Scotland, 2015), reduced truancy (Hart et al, 2015)
- development of life skills[21]
- having a 'normal life' (routines, regular bedtimes, get permission from adults to do things)[21]
- opportunities to reach their potential[22]
- positive relationships between staff and young people (residential care) (McLean, 2016).

In-care process outcomes for *the carer* include:

- carer is supported (financial support; training support; emotional support; services support)
- carer is equipped to be a carer (eg, suitably trained, vetted and approved)
- stability of placement.

Out-of-care outcomes sought for *families* include:

- parenting competence (Scott, 2009)
- a resolution of the issues that led to the out-of-home care placement
- sustained family reunification.

Out-of-care later in life outcomes for *those who were in care*, include:

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[21] https://www.correctiveservices.wa.gov.au/youth-justice/youth-detention/default.aspx

[22] https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/an-outline-of-national-standards-for-out-of-home-care-2011

- being literate and numerate
- educational attainment (qualifications)
- having a productive life[23] (eg, being in employment/labour market participation, [Hestbaek, 2014] effective contributors [Safer Scotland, 2015])
- responsible citizens (Safer Scotland, 2015)
- staying out of the justice system (a reduction in youth reoffending)
- an absence of behavioural issues
- confident individuals (Safer Scotland, 2015)
- having somewhere to live (ie, not be homeless or living on the street)
- meaningful relationships (reunification with family, a partner, friends, children)
- physical health outcomes (eg, no alcohol or drug issues)
- mental health outcomes (eg, reduction in self-harm).

Outcomes sought for *child protection systems* include:

- reduction in referrals to care (including reduction in referrals to care based on youth offending [Safer Scotland, 2015])
- reduction in the number of children in statutory care
- reduction in the number of indigenous children who enter care
- greater permanence and improved outcomes for those in out-of-home care (Wise, 2017)
- reduced expenditure in the care system (outcome from prevention efforts)
- safer communities (reduction in offending[23] and reoffending, reduction in substance misuse, safe from crime and disorder [Safer Scotland, 2015]).

There are also wider outcomes that may contribute to a reduction of placements in out-of-home care to consider:

- reduction in alcohol and drug misuse
- reduction in fetal alcohol spectrum disorder (FASD) NB it is estimated in Australia that nearly one in five children living in out-of-home care have FASD (McLean & McDougall, 2014; McLean et al, 2014; Parkinson & McLean, 2013 all cited in McLean, 2016)
- supported families (families have access to support and services and as a result they report less stress and also improved capacity and capability in their role as parents).

Out-of-home care – Challenges to address

Challenges with out-of-home care faced in many jurisdictions include:

Growing demand on the care protection system is experienced internationally

- Increasing numbers of children being referred for care.
- Increasing numbers of children within care (with indigenous children being over-represented in care numbers [Wise, 2017]). In Australia, the national rate of Aboriginal

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[23] https://www.correctiveservices.wa.gov.au/_files/youth-justice/yjs-framework-2015-2018.pdf

and Torres Strait Islander children in out-of-home care is almost 10 times the rate for non-Indigenous children[24].

Children in out-of-home care and their families have complex needs

- The complex needs of the children and their families, internationally systems are increasingly facing what are referred to as 'harder to help' families (families with multiple problems) (Lopez and del Valle, 2015).
- Many kin carers are unprepared for the challenging behaviours of some children and do not receive as much support and training as non-kin carers (Fernandez and Atwool, 2013).

Resourcing issues associated with carers within the continuum of care

- Recruitment and retention issues with foster carers (Fernandez and Atwool, 2013)
- Lack of support for foster carers (can result in burn-out[25] and placement breakdown). Many studies suggest the financial support provided to foster parents is inadequate (Keshavarzian, 2016). In England, foster carers are supported with a fostering allowance, tax breaks, and by a confidential support service helpline called *Fosterline*.
- Demand for foster carers is greater than the available number of foster carers – having a shortage of placements limits the possibilities of matching children to carers (Fernandez and Atwool, 2013).
- Care systems facing resourcing (financial and staffing) issues, including a lack of professionally trained statutory social workers leading to gaps on training and support which puts a burden on foster carers (Keshavarzian, 2016).

Australia (and others) have noted they have insufficient capacity to meet the quantity and complexity of cases of children in statutory out-of-home care (Wise, 2017, ACT Gov[26]).

Placement stability

- Placements of children and young people are notable in their instability (with many children having multiple placements); placement instability (planned or not) is a potential risk to the outcomes placement is meant to achieve (Khoo et al, 2012).
- In recognition of the benefits associated with continuous accommodation, placement stability is one of Australia's 13 National Standards of Out-of-Home Care (FaHCSIA & NFIWG, 2011 in Child Family Community Australia, 2017).
- Despite placement stability being a critical factor for achieving positive outcomes for children in out-of-home care, it remains elusive in many jurisdictions (Fernandez and Atwool, 2013).
- Stability of caseworkers has also been suggested as an issue with young people in out-of-home care; one study found just over a third (35%) of young people had five or more caseworkers during their time in out-of-home care (McDowall, 2013 in Child Family Community Australia, 2017). High turnover of caseworkers has been linked to

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[24] (AIHW, 2017a in https://aifs.gov.au/cfca/publications/children-care)

[25] http://liancefostercare.co.uk/3-common-fostering-challenges-overcome/

[26] http://www.communityservices.act.gov.au/ocyfs/child-and-youth-protection-services/out-of-home-care-strategy-2015-2020/out-of-home-care-strategy-2015-2020

placement instability and a loss of trust for children and young people McDowall, 2013 in Child Family Community Australia, 2017).

There are challenges associated with the care goals of permanence and reunification:

- Reunification is often cited as the key goal of out-of-home care, and there are a number of factors that delay or prevent reunification (Fernandez and Atwool, 2013) including parents' mental or physical health, adverse events, lack of resourcing, non-participation in treatment services, and additional time being needed to resolve the issues that initially led to care.
- The desire to promote reunification with families over permanency of placements sees some children and young people in limbo. For example, Khoo (et al 2012) notes the strong emphasis in Sweden on family preservation has meant 'permanence planning' for children has not taken hold; whilst most in care in Sweden return home within six months some are in care much longer – neither permanently reunited with parents nor having stability within the care system.

Young people leaving care are vulnerable and are not always equipped to live independently

- **Poor outcomes** – research suggests that whilst some young people leaving care experience positive outcomes, many young care-leavers are at increased risk of a range of poor social, educational and health outcomes including mental illness, homelessness, unemployment, substance misuse, contact with the justice system, early parenthood and low education attainment (Campo & Commerford, 2016 in Child Family Community Australia, 2017).
- **Ill prepared for life after care** – additionally, many young people report that on leaving care they were unprepared for the realities of living independently (eg, lacking skills and social networks) and did not receive sufficient support with basic necessities such as housing (Mendes et al, 2011 in Child Family Community Australia, 2017).

  NB Concerns about the challenges faced by young people transitioning from care to independent living have informed campaigns for care to be extended to at least 21 years in some places (and sometimes older – up to 25 years).

Data is key to understanding out-of-home care, however a lack of data, or consistent data remains a challenge

- **Lack of data** in some countries (Switzerland, Canada, Spain) (del Valle, 2015) makes it impossible to understand services, improvements required and outcomes achieved, or to make informed decisions (eg, on resourcing or changes required) (Gabriel et al, 2013).

- **Issues with data collection** – for example, in France, the discrepancies between local departments responsible for implementing child protection services on the actual processes of data collection are so significant that it is impossible to consolidate accurate indicators on children's situations or trajectories (Gabriel et al, 2013).

LEARNING FROM OVERSEAS EXPERIENCE

Better management of referrals

- **Modify approach to referrals** – two overseas examples of ways to reduce referrals are noted below.

Increased threshold for intervention – Australia

In Australia in order to assist with managing number of referrals and investigations the NSW 'Keep them Safe' initiative increased the threshold (for intervention) of reporting to the centralised NSW helpline from 'risk of harm' to 'significant risk of harm'. This has seen a reduction in reported harm and has also seen an increase in the number of families with complex needs getting early intervention services (as opposed to children going into child protection services later) (Cassells, 2014 in Katz et al, 2016).

Changed approach to response – United States

The USA has been able to reduce numbers within the child protection system by developing differential responses at the time of referral and alternative responses post-investigation. The system aims to assess those reported to the system and provide alternative or family support service response for families with children in need but who do not require OOHC (Katz et al, 2016). Those assessed as not requiring an investigatory response include problems assessed as arising from a lack of supervision, educational or medical neglect, poverty or parental drug and alcohol abuse (Katz et al, 2016).

Key considerations for success – care continuum

Overseas care systems have identified a number of considerations (or principles) that are important in relation to the care continuum.

Have a 'family focus' – children and parents

- **The importance of prioritising children's family** – priority must be given to helping children grow up safe in their own family, with efforts to prevent family separation being made (Keshavarzian, 2016). Improvements in alternative care should not take precedence over this priority (Keshavarzian, 2016).

  Many jurisdictions note the importance of maintaining the children's relationship with their birth family (via access and contact)[27], and seek to ensure that regular contact, and the goal of reunification (where possible) is incorporated into children's care plans. Reviews have found that family involvement is linked to children having stability and permanency in their living situations (Child Welfare Information Gateway, 2008).

- **Be more child-centric** (Office of the Children's Commissioner, 2016) – there are many aspects of being child centric including:

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[27] https://www.dcya.gov.ie/viewdoc.asp?fn=%2Fdocuments%2FChildren_In_Care%2FChildreninCareWhat Happens.htm

- give children an opportunity to express their concerns/wishes about who they live with and have contact with (Better Care Network[28])
- have children involved in the design of laws and policies, and ensure that strong legal and policy frameworks exist that have the best interests of children at heart (Keshavarzian, 2016)
- have children involved in the development of their care plan (Office of the Children's Commissioner, 2016)
- ensure that children's perspectives are understood in the monitoring and evaluation of alternative care (Keshavarzian, 2016)
- informing children of their rights, including the right to make a complaint (European Union Agency for Fundamental Rights (FRA), 2015[29])[30]
- alternative care systems should also have child-friendly, accessible and confidential reporting procedures. (FRA, 2015[29])
- child-centred case management (Office of the Children's Commissioner, 2016)
- provision for children to participate in the 'everyday' aspects of childhood such as sports and recreation. Research with youth in out-of-home care who participate in activities indicates that participation has positive effects – enhancing social skills, and decreasing depression, loneliness and drug abuse (Conn et al, 2014).

- **Build the capacity for <u>children's services</u> to be 'parent-child centred'** – have the 'parent-child' as the primary unit of attention (ie, be child *and* parent-centric), this approach would provide a more integrated response to families with complex needs (Scott, 2009). Universal services are seen as useful platforms for reaching vulnerable families and reducing risk factors (Scott, 2009).

  The Sure Start Programme in the UK is a good example of an initiative that is parent-child centred: it involves both parents and children, it is non-judgmental, it has multi-faceted interventions (health, education and parenting), and it is sensitive to the needs of both children and parents (Scott, 2009).

- **Build <u>adult focused services</u> to be more 'child and parent' centric** – this involves broadening the unit of attention from the adult the service is being delivered to, to also include their family/children.

  For example, in Australia work has been undertaken to build the capacity of mental health services for adults to be responsive to the needs of the children of mental health consumers (Cowling, 2004 in Scott, 2009). Ideally the needs of children would be considered in a range of adult focused services (eg, drug and alcohol treatment services, corrections services, mental health services, gambling addiction services, and services for non-participation in the workforce etc.) (Scott, 2009).

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[28] https://www.bettercarenetwork.org

[29] http://fra.europa.eu/en/publication/2015/mapping-child-protection-systems-eu/complaints-child

[30] NB in 11 European Union Member States (Belgium, Bulgaria, the Czech Republic, Denmark, Germany, Hungary, Ireland, the Netherlands, Portugal, Romania and the United Kingdom), there are specific provisions on the rights of children in alternative care to issue complaints (FRA, 2014)

Options for out-of-home care are needed, and support for children must met their needs

- **Different options for alternative care must be available** – there is no one type of care that will meet the needs of all children (Keshavarzian, 2016). Alternative care choices are an important part of the care continuum. There is reportedly a place for both family-based and residential care options; it has been noted that residential care is needed and that it fulfils a gap (ie, for children who cannot live in a family setting) (Hart et al, 2015).

- Denmark, Germany and France all use a diversified range of placements when children need to live away from home, including respite, part-time and shared care arrangements (Boddy et al, 2009)

- **Individualised strengths based care** –developing a plan based on the child and families' unique strengths and challenges as opposed to expecting them to 'fit into' pre-existing services (Child Welfare Information Gateway, 2008; Scott 2009). Germany, for example, has an emphasis on individually tailored interventions and a therapeutic approach to working with children and their families (Boddy et al, 2009).

- **Community-based services** – it is also important to have community-based services which build on the strengths of the child and families community (this approach supports keeping children in their schools and local communities, allowing children to retain their bonds with friends, school personnel and family). (Child Welfare Information Gateway, 2008).

Professionalism and a focus on continuous improvement are needed to obtain good outcomes

What does professionalism look like in out-of-home care?

– **Professionalism of the work force** – invest resources to ensure that alternative care is safe, high quality and that the child welfare workforce is suitably trained and qualified (Keshavarzian, 2016).

– **Regulated foster care providers (including NGOs)** – It has been suggested that these groups be held accountable to a regulatory framework and all be registered and licensed (Keshavarzian, 2016).

– **Cultural competence** – Cultural competence has been noted as a key principle in any successful system of care (Child Welfare Information Gateway, 2008). It is important to have a culturally skilled workforce (Office of the Children's Commissioner, 2016); culture can affect service delivery and the services needed, in addition having a culturally competent workforce can increase families' engagement and participation with services (Child Welfare Information Gateway, 2008).

– **Standards** – Have national standards and guidelines; this will help children in need of out-of-home care be provided with consistent, best practice care, no matter where they live[31].

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[31] https://www.dss.gov.au/sites/default/files/documents/pac_national_standard.pdf

Supporting continuous improvement

- **Monitoring and evaluation** – assessment of the performance of alternative care should be built in at both the individual (ie, case management) level and also the macro (system) level to support continuous improvement and good practice. Research and evaluation, along with public debate and input from key stakeholders is important in order to develop quality foster care (Keshavarzian, 2016).

- **System accountability** – systems need an effective accountability mechanism that includes data collection and analysis, measures, monitoring and evaluation, and support for independent human rights institutions (FRA, 2015). Accountability is important because it supports the safety and wellbeing of children, enables continuous quality improvement and transparency (regarding decision making, funding allocation and outcome achievement) (Child Welfare Information Gateway, 2008).

Promote joined up thinking and integrated systems

- **Whole-of-system approach** – consider the whole system (ie, entry into, experience within and exit from) to ensure that children and young peoples' needs are met throughout their care journey.

- **Multidisciplinary approach and interagency collaboration** – out-of-home care design and implementation requires involvement from a number of different disciplines (including law, social work, medicine, education, health, mental health, substance abuse and others) (Cohen, 2005) and their corresponding agencies, providers and supports (Child Welfare Information Gateway, 2008). NB it has been noted that silo budget processes need to be replaced by multilateral budget bids and budget pooling to support joined up working (as well as changing the measurement or performance focus from outputs to outcomes) (Scott, 2009).

- **Several jurisdictions in Australia** are creating new approaches to build a more robust and coordinated community service system, reconfiguring their out-of-home care and leaving care systems, and investing in Aboriginal services and workforce capacity. (Wise, 2017). For example, a key change in NSW is the transfer of responsibility for providing out-of-home care from the statutory to the non-government sector (Katz et al, 2016).

- **Collective responsibility** – have the principle of collective responsibility for protecting children extend to system stewardship (with diverse stakeholders collaborating to obtain better outcomes for children and families) (Wise, 2017). For example, practitioners in universal services (eg, primary health care) need to be prepared to raise issues in order to support families and protect children) – otherwise families in need may remain unknown to agencies which have a safeguarding role and resources (Thoburn, 2010).

Prevention of the risk factors for out-of-home care

– **Prevention lens** – address issues that cause children to come into care in a multi-disciplinary, integrated way. For example, many children in statutory protection come from households where at least one adult is binge drinking; parental alcohol misuse greatly increases the risk of emotional, physical and sexual abuse and also neglect (inadequate food, clothing and medical care). The problem of alcohol misuse requires multiple services working together and population-based initiatives (social marketing, taxation etc.) (Scott, 2009).

– **Model of response** – different countries including Australia have noted the need to move from a model where child protection is a response to child abuse and neglect and move towards a model that promotes the safety and wellbeing of children[32]. Practitioners and researchers alike have suggested that applying a public health model to child care and protection will improve outcomes for both children and their families. A public health model prioritises having universal supports available for all families (eg, education and medical care), secondary prevention activities targeted at those in need and tertiary child protection services being a last resort[32].

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[32] https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/an-outline-of-national-standards-for-out-of-home-care-2011

CARE SERVICES CRITICAL TO CARE CONTINUUM SUCCESS

Many jurisdictions have issues quantifying the outcomes associated with the care continuum. There are a number of reasons for this including:

- poor or non-existent centralised data collection
- variation in care definitions within and between countries (eg, in Canada out-of-home placements reported in Quebec do not differentiate between children living 'at home' or 'out-of-home', but under the supervision ('care') of child welfare authorities [Gilbert, 2012])
- resource issues
- lack of clearly defined care goals.

Characteristics of effective services for families with complex needs

Based on evidence and literature Thoburn (2010) summarised the characteristics of effective services as follows:

- **Effective assessment and decision making** (essential to this is joint working between professionals). Khoo (et al 2012) notes the importance of understanding the reasons children are taken into care for best planning practices (and to know what outcomes should be sought). A thorough needs assessment will (in theory) ensure that children and young people have their needs met. Studies have demonstrated unmet mental health needs for children in residential care (Hart et al, 2015); unmet needs are likely to lead to placement instability and impair outcome achievement.

- **Deciding whether compulsion is required or not** (ie, whether or not an element of coercion is required – via formal child protection procedures or family justice or criminal courts) (Thoburn, 2010). Systems must be in place to support decision making about entry into care (Keshavarzian, 2016).

  The US and UK have had the lowest out-of-home placement rates, but the majority of these have been involuntary (ie, bought about by the coercive powers of the state) (Gilbert, 2012). In comparison, the majority of out-of-home placements in Finland, Denmark and Sweden are arranged with the voluntary consent of parents (Gilbert, 2012).

- **Effective helping and protection**, which includes (Thoburn, 2010):

  - Availability of at least one authoritative, reliable professional who the family/child can depend upon to provide information and support (the professional may be a different one for the child and the family as a reflection of different support needs, or there may be a co-working model whereby two people jointly meet the needs of the child and family).
  - Integrated team working in a joined up (and supervised) way
  - Awareness of the child and parental history
  - Child having a care plan
  - Small case load for the care worker
  - Parent and child treated with honesty and respect
  - Skilled and knowledgeable care worker
  - Provision of services to meet child's needs (eg, therapeutic services)

- Practical and immediate assistance alongside the assessment process
- Minimising the number of placements a child experiences (Blakey et al, 2012)
- Careful monitoring of placements through frequent visits and community support (Keshavarzian, 2016).

- **Effective approaches to helping families**, which includes (Thoburn, 2010):

- Involvement of universal services (for early identification of support/protection needed and engagement). A 'wide net' is useful as teenagers exposed to neglectful parenting are less likely than children to be referred to services (Stein et al, 2009 in Thoburn, 2010).
- Greater resources need to be put into developing the assessment skills frontline professionals on the environmental characteristics that may lead to neglect (eg, the impact on a child of a parent with mental illness or drug use).
- For families that are 'hard to help' the importance of care continuity is noted, along with better integration of child protection services and targeted services for the family and other local services such as parent training and drop-in family support centres.
- Carers need support with the dual task of building a relationship with their foster children and also with facilitating the connection between the biological family and the foster child (Fernandez, 2009)

Services

The services needed are those that will support achievement of desired outcomes

The types of services children in out-of-home care need depend on their individual needs, ages and stages. Broadly the literature on useful services to offer spans all the areas where outcomes are sought *(NB some places like the US are promoting the use of evidence-based programmes, funding the programmes that have proof they can deliver positive outcomes) (Katz et al, 2016)*.

Services sought include, but are not limited to:

- Support for educational attainment (tutoring, mentoring, literacy/numeracy). For example, promising changes have occurred in the last five years in Ontario, Canada to support access to post-secondary education, with Crown Wards being eligible to receive free tuition support (at all Ontario universities and one-third of Ontario community colleges) (Ontario Ministry of Training, Colleges, and Universities, July 4, 2013 in Courtney, 2013).
- Health services (eg, medical, dental, drug and alcohol, mental health, sexual health).
- Psychological support (eg, therapeutic services, counselling, trauma support, crisis support, behavioural therapy etc.). Research has indicated the potential of therapeutic approaches *(NB Denmark, France and Germany models of care are informed by theories of family therapy and psychology)* (Boddy, 2009).
- Skills for independent living (budgeting, self-care (including personal hygiene), cooking, housework, work skills etc.).
- Relationship skills (eg, communication, anger management, conflict resolution, pro-social skills etc.).

Foster families also need services, for example supportive supervision and mentorship (Keshavarzian, 2016).

Nine identified approaches to minimise placement disruptions

Research in the US identified nine approaches that are being used to minimise foster home placement disruptions, as follows (Blakey et al, 2012) *(NB research is needed to evaluate the effectiveness of these approaches)*:

- **Improving services to foster children** – primarily therapy related services (such as counselling, trauma support etc.).
- **Placement-matching** – matching children's needs with foster parents/placements that can meet those needs, as well as matching the needs of children with the needs of foster parents.
- **Recruitment of foster parents** – this includes targeted recruitment of foster parents from specific ethnic groups, or targeted to care for different types of children (eg, special needs, babies, older children etc.).
- **Services and support to foster parents** – increasing the available supports for foster parents (eg, helplines, care workers, respite care) and improving access to services to meet the needs of foster children in their care (as this helps both the child and their foster parents).
- **Training** – to support foster parents to deal with or meet foster children's behavioural, emotional, and psychological needs.
- **Consultation and collaboration** – in order to understand and support best practice (included consulting/collaborating with researchers/universities, establishing centres of excellence, working with interagency teams, working across states etc.).
- **Collaborative team approaches** – working in a team approach (eg, having meetings, or decision-making teams) for the best interests of the child (teams included family members, community members and other interested parties).
- **Involvement of biological parents** – early involvement of the biological parents, eg, having them met the foster parents within 24-72 hours to discuss the child's likes/dislikes (to support a smooth transition), promoting a 'shared parenting' approach, having the foster parents mentor the biological parents.
- **Prevention** – not a placement stabilisation approach *per se*, rather an approach (ie, like the public health prevention model) to support the child remaining with their biological family through the provision of alternative services or diversion programmes. Prevention activities spanned primary to tertiary prevention activity, including:
  - **Primary prevention –** public education, parenting classes, and family support programmes etc.
  - **Secondary prevention** – targets families with one or more risk factors (eg, teen parents, substance abuse or domestic violence issues) and includes things like respite care, home-visiting programmes, education classes for at-risk families
  - **Tertiary prevention –** targets families where child maltreatment has already occurred, activities include counselling, parent/child therapy, referrals for treatment (eg, substance abuse, mental health treatment, family violence services etc.)

Need for services to support successful family reunification

Pine (et al 2009) note that to support and maintain family reunification post-foster care that families need a range of services targeted towards their needs and the issues that led to placement originally.

Need for services to support successful transition out-of-care

Young people transitioning out-of-care are a vulnerable group, and there is growing recognition that they need support and services beyond care. Supporting successful transition to independent living requires planning and preparation work to begin whilst the young person is in care. After care, the types of support needed include (but is not limited to)[33]:

- Financial support
- Help to stable and retain affordable accommodation
- Living skills development
- Assistance to grow personal and social networks
- Information (ie, options for the future)
- Emotional support and mentoring
- Educational, training and employment opportunities
- Continued access to support, resources and interest from care agencies (including referrals to other agencies)
- Support from the business community (eg, apprenticeships, internships etc.).

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[33] https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/transitioning-to-independence-from-out-of-home-care-discussion-paper?HTML

OVERSEAS JURISDICTIONS – CARE CONTINUUM OVERVIEW

The table provides a snapshot overview of the care continuum in a number of countries. Gaps exist where the information was not readily available or where conflicting information was found. Additional country-specific references for this table are provided at the end of the references section of this report.

Country	Who provides child protection services?	Care orientation	Out-of-home care (OOHC)	Alternative home-based care	Residential care	Leaving care
Australia	State and territory governments (has 8 different protection systems).	Child protection (with aspects of family service)	Seen as last resort. OOHC can be arranged formally (care and protection order) or informally (voluntary agreement). In addition to home and residential care has: – 'Independent living' (private board and lead tenant households), and – 'Other OOHC' (boarding school, motel/hotel, hospital, defence force)	There are four categories of home-based care: relative or kinship care, foster care, third-party parental care arrangements and other home-based, out-of-home care. Majority of all children living in OOHC are in home-based care (with more in relative/kinship care than non-kinship foster care).	Has residential care and family group homes. Less than 10 percent of children were placed in alternative living arrangements such as residential care or group homes.	Discharged on or before 18th birthday. The age that support is available for those leaving care differs by state (eg, up to 18 in Queensland, and up to 25 in Western Australia).
Canada	Local authorities and non-government organisations/mandated agencies. Variations in child welfare mandates across jurisdictions, including: the age of children eligible for services, the length of time a child can receive out-of-home care services, and the definition of 'out-of-home care'.	Child protection (some jurisdictions have adopted aspects of family services, including streamlining lower risk cases to family care)	The first choice for a caregiver would usually be a kin connection or a foster family. Children and youth may be placed in residential settings by parents, children's aid societies, community access mechanisms or in the case of youth justice, ordered through the courts.	Out-of-home care includes placements in residential, foster, and community or kinship care. Definition of foster care includes kinship care. Kinship care is defined differently in Canada compared to other countries. Kinship care *"includes children placed out-of-home in the care of extended family, individuals emotionally connected to the child, or in a family of a similar religious or ethno-cultural background"*.	Residential settings include group homes, provincially operated facilities and youth justice open and secure custody/detention facilities.	Ontario has recently extended the age of leaving care from a person's 19th birthday to their 21st.
Denmark	Local municipality is responsible for child protection services.	Shifting from family services to child protection (eg, number of interventions that do not require family consent increasing) (Hart et al, 2015)	OOHC is a mix of foster care and residential care. Main trends in OOHC include more foster care, less residential care (Hestbaek, 2014). Placements tend to be voluntary. Denmark has the highest placement rate in the Nordic countries (Backe-Hansena, 2013).	Unrelated foster care more common than kinship care but Denmark is looking to expand kinship care.	Residential care is routinely used. Around half of the children in care are in residential care, although Denmark has moved away from large institutes to smaller group settings, with efforts made to recreate a sense of homeliness (Hart et al, 2015). Older children and those with behavioural issues tend to enter residential care instead of foster care (Fallesen, 2014).	Children must leave residential care by age 23.
Finland	The State is responsible for legislation and oversight of the regional government agencies (and private services) that provide out-of-home care. The municipalities are responsible for the implementation of the respite, the recruitment, training and support of out-of-home care services.	Family Services	Taking a child away from their parents and into care is considered the last option (with families being offered help first through the general social and health services, such as the child health clinics). Placements tend to be voluntary. Reunification with the family is the goal.	Foster care is known as 'family care'. Non-kinship care is more common than kinship care. The maximum number of children in one foster family is four, including children who already live in the household (with exceptions made for siblings).	Have 'professional family homes' and institutional care. Residential care is used routinely (moved away from large institutes to smaller group settings) (Hart et al, 2015).	

France	National legislation is the norm for family matters (Gabriel et al, 2013). The implementation of child protection policies is done via local authorities such as regions, municipalities (and especially départements [of which there are 101] when it comes to child protection) (Gabriel et al, 2013). The public education system plays a key role in child protection (as it is the main partner of the services themselves), however as noted above, child protection services are organised at département level. (Gabriel et al, 2013).	Family services	Open-settings (in-home) measures (whether administrative or judicial) are preferred in France over out-of-home placements whenever possible. OOHC is perceived as something to be avoided as much as possible. In France the rights of the parents are taken into account as well as the rights of the child. Parents do not completely lose their parental prerogatives when children are placed (Gabriel et al, 2013). Placements can be voluntary or involuntary.	Home-based care includes unrelated foster care and kinship. France does not use kinship care as much as New Zealand (7% compared to NZ 35%) (Thoburn 2009). Foster care is the preferred method of out-of-home care, accounting for over half of all placements. Three children are allowed by law to be with foster parents (however there is discretion if there are specific needs and if the hosting conditions are appropriate).	Residential care is also commonly used (accounting for around two fifths of placements in 2010 (Gabriel et al, 2013).	Required to support young people leaving care until at least the age of 21.
Germany	Services in each area are locally determined (usually on a case-by-case basis) determined within the national framework (Boddy et al, 2009).	Family services	Germany has an emphasis on individually tailored interventions and a therapeutic approach to working with children and their families (Boddy et al, 2009). A choice of placement options is required in Germany (Boddy et al, 2009). Hardera (et al, 2017) notes that generally in the child protection system there are usually three stakeholders involved in the initial decision-making process: the child, the parents (or the legal guardian) and the professional from the youth welfare office. A fourth stakeholder comes into play once the care facility has been chosen, with a professional from this facility involved in all further decision-making processes.	Foster care in Germany may be emergency, short-term, regular full-time, full-time for children with special needs, authorised kinship, or informal (unauthorised kinship). In some communities a private non-profit contractor provides foster care services. In other communities foster care service has been (re)integrated into the general state children and youth service. Professionalism in residential care is increasing (Hardera et al, 2017). For foster care placements Germany has general provisions about the maximum number of children to aspects such as: the availability of space, the physical and mental ability of the child and his/her needs, the number of adult carers in a foster family and the number of biological children living in the house.	Residential care is routinely used. Around half of the children in care are in residential care. Residential settings operate in different ways, for example, there are residential settings that close on the weekend (so children can return home, parents are also able to visit during the week to facilitate joint work with parents and children (Boddy et al, 2009). There is a great deal of variety in residential care options including therapeutic intensive residential groups, parent model residential groups (usually staff-supported), children's villages, as well as supervised individual residences for older youth and young adults (Bürger, 2001 in Hardera et al, 2017). Parent model residential groups blur the line between foster care and residential care – they are a couple (one of them being a professional) raising a group of children (Hardera et al, 2017).	Required to support young people leaving care until at least the age of 21.

Iceland	The Ministry of Welfare is the ultimate authority in matters of child protection. On behalf of the Ministry, the Government Agency for Child Protection is in charge of day to-day administration of child protection services. The basic unit for child protection in Iceland is the Child Protection Committee (CPA). Local authorities are required to maintain a Child Protection Committee (CPA) – which is responsible for child protection services at the local level. However, the Icelandic Child Protection Act encourages cooperation between local authorities and joint election of CPA, especially in smaller communities. There are 74 local authorities in Iceland and the number of CPAs is 27 (Dec, 2013).	Family services (with aspect of child protection).	In Iceland the role of child protection is to be achieved by strengthening the nurturing role of the family and by applying remedies to protect individual children when appropriate. In an overwhelming majority of cases, cooperation between the CPA and parents is established for the benefit of the child.	Foster care may be short-term or long-term. Foster care may be enforced or voluntary.	There are four institutions and treatment homes for children with behavioural and emotional problems, delinquency (acting out, criminality) and substance abuse.	Children in care are defined as individuals under the age of 18.
Ireland	The Child and Family Agency has a statutory responsibility to provide Alternative Care Services under the provisions the Child Care Act, 1991, the Children Act, 2001 and the Child Care (Amendment) Act, 2007.	Child protection with aspects of family services	In addition to home and residential care Ireland uses special care units – short-term, stabilising and safe care in a secured therapeutic environment. Young people (11-17 years) referred to Special Care Services are described as very vulnerable, sometimes very challenging, with complex psycho-social needs and high numbers of previous placements which have frequently broken down. Children can be placed in foster care in two ways: voluntarily (when a parent or family member asks for assistance) or by a court order (when a judge deems it in the best interest of the child to be placed in care). Most placements voluntary.	Preference to place children in home-based care. Types of home based care include foster care and care with relatives. Training is compulsory for all foster carers.	Around five percent of children placed in Children's Residential Services. Some placed in Children's Residential Services because of issues at home and others because their own behaviour is too challenging to be managed elsewhere. The majority of the residences are community-based.	Services can be provided up to 21 years of age or 23, if in full-time education.
Italy	Social services are organised by regional and local authorities but funded by the state. Children services are managed by partnerships of local welfare agencies, national health service units and the state department of justice (Ministerio della Giustizia). Such partnerships may differ substantially across different regions. What is common, however, is that child protection and child welfare interventions are the responsibility of the same social work unit.	Family services - "Mediterranean model" is a label for Italy, Spain or Greece, where the family network is important to provide welfare solutions.	Placements into care can be made to the court by local social welfare department with parents' permission; if parental consent is withheld the placement decision will be referred to juvenile court. In 2010 only a quarter of placements were consensual (del Valle et al, 2013)	Foster care includes placements with families, single people or family type settings. Slightly higher numbers of children in foster care are in kinship care compared to non-kinship foster care. Kinship carers get little assistance. Italian law states children should not be in foster care for more than two years, but the duration of placements is longer than that typically. It has been noted Italy needs to do more work to improve biological parental competencies (del Valle et al, 2013).	Italy does not allow homes to be run for profit, and religious organisations are still the main providers of non-state care in some places. Residential care is routinely used. Around half of the children in care are in residential care.	

Netherlands	The Netherlands is currently in the middle of a large decentralisation and transformation of the Dutch youth care system. Since the beginning of 2015 all 393 Dutch municipalities are responsible for the whole continuum of care for children, young people and families in need of help. This transition tasks Dutch municipalities with the coordination of most services in the social domain. The Child and Youth Act states local municipalities are responsible for decreasing the number of children in specialised care, increasing preventive and early intervention support, and promoting the use of social networks. The Dutch youth care and welfare system consists of different services: universal services, preventive services and specialised services.	Family services orientation	'One family, one plan, one coordinator' is the underlying principle of change in the social domain. There is a preference for foster family over residential placements, the number of children in residential care (Hardera et al, 2017).	Foster families include kinship and non-kinship care. Around two-fifths of children in foster care are placed in kinship care or with someone known to them such as a teacher. The quantity of kinship foster care is increasing because the policy of foster care providers is to initially search for foster parents in the direct environment of the candidate foster child (Hardera et al, 2017). Foster care may be short-term, crisis intervention, reunification support, holiday foster care, part-time foster care including weekend foster care and day foster care, observation/assessment foster care and long-term foster care (Strijker & Knorth, 2007 in Hardera et al, 2017).	Residential care types include Group care/children's home, Residential treatment centres, 'Semi-secure' placements and secure placements (Hart et al, 2015). Residential care has increased in professionalism over the last few decades (Hardera et al, 2017). As in England, Dutch secure homes take children from both the welfare and justice systems (Hart et al, 2015). There has been a decrease in utilisation of residential care and an increase in foster care. (However, as at 2010 residential care made up 42% of all out-of-home care placements [(Hardera et al, 2017].)	Child and youth care services in the Netherlands look after minors from the ages of 0 to 18 years. Some aged 18 to 23 years are also offered child and youth care services (Hardera et al, 2017).
Norway	The state is responsible for developing regulations and guidelines. Municipalities each have social welfare services responsible for implementing the Norwegian Welfare Act. In addition, decisions about access to care and interventions are made by County Committees for Social Affairs (of which there are 12 in Norway). A County Committee for Social Affairs is a government body – for each case, a board shall consist of a chairperson who is a lawyer, two professional experts, and two 'ordinary members'.	Family services – the fundamental principle that is adopted by the Norwegian Child Welfare Act is that children shall grow up with their biological parents (ie, that children shall primarily be helped in the home. Norway takes a family-sensitive and therapeutic approach to families and children.	Children will be taken into care if it is in their best interests. Most placements are voluntary (with parental consent). It is possible to remove a child from the home without parental consent, but this requires a decision from the County Committee for Social Affairs on the basis of a recommendation submitted by the municipal authority. There is a strong emphasis on using voluntary agreements where possible (Khoo et al, 2012). Norway has the lowest placement rate in the Nordic countries (Backe-Hansena, 2013). A growing number of children and young people receive help in their families while living at home instead of being placed in out-of-home care (Backe-Hansena, 2013).	There has been a shift from residential care to foster care. Of those in foster care, around a quarter (as at 2010) were in kinship care and the majority were in non-kinship care. Foster care is meant to be short-term; however given that Norway spends a long time undertaking preventative measures in home before a child is placed in foster care, such care, once it happens tends to be long-term (Backe-Hansena, 2013). This is further compounded by the fact that there is no legal provision of guardianship or transferal of custody in Norway (Backe-Hansena, 2013).	In Norway, residential care is provided in therapeutic/ high support units (Hart et al, 2015). Policy makers are reducing the utilisation of residential care. There are a number of reasons for this; including children leaving residential care with the same behavioural problems they went in with (ie, it not making a difference – attributed to socialising with other children with issues as opposed to being helped to overcome their own problems), a moral preference for family-based care and the rising costs of residential care (Backe-Hansena, 2013).	18 to 23 years (although not all get support after age 19).

Sweden	Child protection services are governed and provided by local authorities/municipalities, and the workforce which delivers services are varied and locally determined and includes professionals in social work, health, education, or psychology. Child welfare officers are also responsible for responding to social problems and juvenile offences amongst young people as this is not considered the responsibility of the criminal justice system (Price Robertson et al, 2014). There has been increasing privatisation of the welfare system (Backe-Hansena, 2013). The aim of this system change was to increase choices those who use welfare systems and to save public money, however, privatisation has led to very little economic gain (Hartman, 2011 in Backe-Hansena, 2013).	Family Services with a mandatory reporting element) (Price-Robertson, 2014).	Sweden has a holistic child welfare system, meaning it treats prevention, support and protection responses as part of the whole system. It has been noted Swedish welfare is a combination of controlling and supportive in nature (Khoo et al, 2012). Placements tend to be voluntary	Sweden has the following types of foster homes (kinship, non-kinship and emergency foster homes). Three quarters of those in out-of-home care are in foster placements (Anderrson, 2006 in Price-Robertson et al, 2014). Whilst Swedish legislation sets no time limits on care, if a child has lived in a foster family for more than three years, transfer of custody to the child's foster parents should be considered.	A quarter of those in out-of-home care are in residential facilities. It has been noted that the pattern in Sweden is unusual in that there has been an increase in the use of residential care since the early 1980s for new entrants to care aged 13-17 years, thought to be due in part to the active marketing by providers and few restrictions on opening homes (Sallnäs, 2009 in Hart et al, 2015). Unlike other countries, Sweden (and Spain), have residential care establishments specifically for babies and young children (sometimes with parents also resident). This type of residential care is used to assess family functioning or to enable permanency planning (Hart et al, 2015).	Leaving care in Sweden is stipulated by law at the age of 18 (or 21 in cases of mandatory care orders).
Switzerland	There is no single defined support or welfare body of legislation for children and youth (Gabriel et al, 2013). No federal Ministry of Child, Family or Welfare exists. In Switzerland, children and youth questions are primarily dealt with at canton- and region-level, and they encompass different policies and branches (Gabriel et al, 2013). Cantons can legislate themselves. There is considerable variation between territories – cantons – in Switzerland (Gabriel et al, 2013). There is no national data available on: • the total residential care population • care leavers • children in need • on placement types • lengths of stay in care, or • on the age profile of looked after children (Gabriel et al, 2013).	Family service – the upbringing of children is understood as a right *and* an obligation of the parents. Supporting help is preferred when problems in occur, as opposed to taking children out of the family (Gabriel et al, 2013). Decisions with regard to the different forms of placement in care are not clearly regulated leading to many differences between canton and regions (Gabriel et al, 2013).	Out-of-home care is perceived to be avoided as much as possible. The rights of the parents are taken into account as well as the rights of the child; further even when children are placed in OOHC parents do not completely lose their parental prerogatives. In the early 2000s, Switzerland was criticised for its poor safeguarding of the wellbeing of Swiss children (Gabriel et al, 2013). Swiss foster care has two main aims: a) long-term placement (maximum stability), especially for young children with no prospects of returning to the home family b) short-term placement (maximum 'normality'), seeking to find a solution for a crisis or prospects for the child. (Gabriel et al, 2013).	Types of placements are: permanent placement, short-term placement, day care and week fostering, before adoption. Types of foster families: traditional foster family, kinship foster care, professional foster families, semi-professional foster families, adoption families waiting for legal status of adoption. (Gabriel et al, 2013).	The growing emphasis on de-institutionalisation has led to the following: • the decline of residential care (understood as placement in institutions), and • the development of smaller institutions in the children's former environment (instead of huge residential homes). (Gabriel et al, 2013).	Unclear regarding out-of-home care but parental responsibility ceases at 18.
UK England	Local authorities – sometimes referred to as a 'corporate parent'.	Child protection (adopted some components of a family service orientation).	Placements tend to be involuntary. Children in care are referred to as 'looked after' in the UK (adapted from Berg and Vink, 2009).	In England foster care includes both kinship and non-kin care. Foster carers are reviewed every year by the local council or fostering agency (and training is provided if needed). Placement options include emergency (days), short-term (weeks to months), short break (planned respite care), remand, fostering for adoption (babies or small children),	Residential care in England includes placements in children's homes, secure units, hostels (generally as part of the process of leaving care) and residential schools (Narey, 2016). Residential care is only used for a small proportion of looked-after children in England (around 9%) (Hart et al, 2015). Residential care in England is mostly	Transition planning starts at 16 years, leave care at 18 years and continue to be supported by local authority until 21 years.

				long term fostering (foster child or young person until they are adults), 'family and friends' or 'kinship' carer (people related to, or known by the child), specialist therapeutic (for children/young people with complex needs and/or challenging behaviour.	used by older children, those with more complex needs/behaviours, and also those with a history of failed placements (Narey [2016] noted a third in care had six or more previous foster placements).	
UK Scotland	Local authorities - sometimes referred to as a 'corporate parent'.	Child protection (adopted some components of a family service orientation).	Getting it Right for Every Child (GIRFEC) – is the national approach in Scotland to improving outcomes and supporting children and young people (right help, at the right time from the right people). Placements tend to be involuntary. Children in care are referred to as 'looked after' in the UK (adapted from Berg and Vink, 2009).	Types of home-based care include kinship care, foster care and private fostering. Private fostering describes any arrangement whereby a child is cared for by an adult who is not a close relative or an approved foster carer (>28 days). Local authorities must be informed of any private fostering arrangements two weeks before they commence. Placement options include permanent, long term (>24 months), interim (<24 months), emergency (must be reviewed within 3 days and not exceed 12 weeks) and short break (planned eg, respite care for carer). Foster care can end when a child returns to their birth parents or is adopted. Placements can be long term (if that is in best interests of child). There is a maximum foster care placement limit of three unrelated children (NB emergency placements and sibling groups may be exempt from this limit). There is a national learning and development framework for foster carers 'the Standard of Foster Care' (available on the Scottish Social Services Council website).	Most residential care homes are run by local authorities, but the voluntary and independent sectors also provide a range of residential services, such as residential schools. Residential care homes in Scotland offer young people (normally secondary school aged) a safe place to live together with other children away from home. Residential care provides young people with support, accommodation and sometimes education (mostly the child is educated nearby). Most residential services are run by local authorities but some are run by voluntary and independent sectors. All residential care is inspected to ensure they meet national standards. There are qualification courses and opportunities for continuous professional development for the residential care workforce.	Legal requirement to provide aftercare support until the care leaver turns 19, and to assess any eligible needs for aftercare support until they turn 26.
UK Wales	The Welsh Government is responsible for child protection in Wales. It sets out policy, legislation and statutory guidance on how the child protection system should work. Locally, regional safeguarding children boards co-ordinate, and ensure the effectiveness of, work to protect and promote the welfare of children. The boards are responsible for local child protection policy, procedure and guidance. Local authorities implement child protection services.	Child protection (adopted some components of a family service orientation)	Placements tend to be involuntary. Children in care are referred to as 'looked after' in the UK (adapted from Berg and Vink, 2009).	Foster care can be provided by the local authority or by an independent agency. Additionally, there is private fostering.	Residential care includes care homes, residential schools and secure facilities. Most residential care homes are run by local authorities, but the voluntary and independent sectors also provide a range of residential services, such as residential schools.	Young people who have been looked after for more than 13 weeks are entitled to support until at least the age of 21.

| United States | The United States uses federally mandated regulations and minimum standards to address out-of-home placements. These are implemented by each state; state systems may have similar structures but much variation in terms of services and processes.

The child welfare system is not a single entity, rather it is made of many organisations in each community working together to strengthen families and keep children safe. The wellbeing approach the USA has requires inter-agency working to develop a plan for oversight and coordination of services for children in foster care (Katz et al, 2016).

There is both legal and physical custody of children. For example, a kin carer may have physical custody of a child but their biological parents or the state may have legal custody of the child when it comes to decision making. | Child protection (Katz et al, 2016). The goal for children in care is wellbeing and permanency with caring parents. | Placements tend to be involuntary.

Children in care live in a variety of placement settings and may move among or between settings while in care (eg, from group care to residential care).

The USA has been able to reduce numbers within the child protection system by developing differential responses at the time of referral and alternative responses post investigation. The system aims to assess those reported to the system and provide alternative or family support service response to referrals for families with children in need but who do not require OOHC (Katz, et al 2016). Those assessed as not requiring an investigatory response include problems assessed as arising from a lack of supervision, educational or medical neglect, poverty or parental drug and alcohol abuse (Katz et al, 2016). | Most children in foster care are placed with relatives or foster families. Pre-adoption is another type of foster care. Kinship care may be formal, informal or voluntary (state involved but does not have legal custody of the child). Kinship care is prioritised over other types of OOHC.

When in foster care, connections with biological parents and siblings are encouraged. Review hearings are held after six months to see how parents are progressing with their service plan and how the child in care is doing.

A permanency hearing is held 12 to 14 months after a child is removed from the home and every 12 months after that. If reunification looks unlikely a concurrent permanency plan is developed. | Residential care is intended to be temporary.

Around one in ten (13%) of children in out-of-home care have a residential group placement (group home or institution) (Kids Count data centre, 2015 data). | Children leave foster care between 18-21 years.

Nineteen US states have extended foster care support to age 21. |

REFERENCES

Arney, F., Iannos, M., Chong, A., McDougall, S., & Parkinson, S. (2015). *Enhancing the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle: Policy and practice considerations* (CFCA Paper No. 34). Melbourne: Australian Institute of Family Studies. https://aifs.gov.au/cfca/publications/enhancing-implementation-aboriginal-and-torres-strait-islander-child

Backe-Hansena, E., Højerb, I., Sjöblomc Y., and Storød J. (2013) *Out-of-home care in Norway and Sweden – similar and different.* Psychosocial Intervention 22. 193-202 https://www.sciencedirect.com/science/article/pii/S1132055913700231

Berg, T. and Vink, C. (2009) *Child and Youth Social Care Systems Abroad Lessons on strategies and systems from England, Germany, Norway and Sweden.* Report by The Netherlands Youth Institute. November 2009. 1-58. https://www.nji.nl/nl/Download-NJi/Publicatie-NJi/ChildandYouthSocialCareSystemsAbroad.pdf

Blakey, J., Leathers, S., Cronin, M., Washington, T., Stewart, C., Strand, T., & Walton, Q. (2012). *A review of how states are addressing placement stability.* Children and Youth Services Review, 34(2), 369–378.

Boddy, J., Statham, J., McQuail, S., Petrie, P. and Owen, C. (2009) *Working at the 'edges' of care? European models of support for young people and families.* Research Brief. June 2009. Department for Children, Schools and Families. (UK)

Child Family Community Australia, (2017) *Children in Care*. Resource Sheet. October 2017. https://aifs.gov.au/cfca/publications/children-care

Child Welfare Information Gateway, (2008) *Systems of Care.* February 2008. 1-13.

Cohen, B. (2005) *Reforming the child welfare system: competing paradigms of change.* Elsevier, Children and Youth Services Review 27, 653-666.

Conn, A., Calais, C., Szilagyi, M., Baldwin, C., and Jee, S. (2014) *Youth in out-of-home care: Relation of engagement in structured group activities with social and mental health measures.* Children and Youth Services Review. Vol. 36, issue C, 201-205

Connolly, M. (2003) A kinship care literature review. Social Work Now: September 2003. 24-30a. http://thehub.superu.govt.nz/sites/default/files/Kinship.pdf

Courtney, M., Flynn, R.J., and Beaupré, J. (2013) *Overview of out-of-home care in the USA and Canada*. Psychosocial Intervention, Volume 22, Issue 3, 2013, pp. 163-173. https://ac.els-cdn.com/S1132055913700206/1-s2.0-S1132055913700206-main.pdf?_tid=f625291a-f742-11e7-b80c-00000aacb361&acdnat=1515725443_132c15ac25d4b1167bdfba44e3c03f4b

del Valle, J.F, Canalib, C., Bravoa, A., and Vecchiatob T. (2013) *Child protection in Italy and Spain: Influence of the family supported society.* Psychosocial Intervention 22. 227-237. https://ac.els-cdn.com/S1132055913700267/1-s2.0-S1132055913700267-main.pdf?_tid=418c2c82-f5db-11e7-93f7-00000aacb361&acdnat=1515570950_b2417bbfcde0e79291d26603111025fe

del Valle, J. (2015) *Out-of-home care in Europe: an overview.* Reception and Living in Families Conference. Amsterdam 22-23 Jan 2015.

Fallesen, P. (2014) *Identifying divergent foster care careers for Danish children.* Child Abuse Negl. Nov 38(11). 1860-71.

Fernandez, E. (2009) *Children's wellbeing in care: Evidence from a longitudinal study of outcomes.* Children and Youth Services Review 31. 1092-1100.

Fernandez, E. and Atwool, N. (2013) *Child protection and out-of-home care: Policy, practice and research connections in Australia and New Zealand.* Psychosocial Intervention 22. 175-184.

Gabriel, T., Keller, S., Bolter, F., Martin-Blachais, M., and Séraphin G. (2013) *Out-of-home care in France and Switzerland.* Psychosocial Intervention, Volume 22, Issue 3, 2013, pp. 215-225

Gilbert, N. (2012) *A comparative study of child welfare systems: Abstract orientations and concrete results*. Children and Youth Services Review 34. 532-536.

Hardera, A.T., Zellerb, M., Lópeza, M., Köngeterb, S., and Knortha, E.J. (2017) *Different sizes, similar challenges: Out-of-home care for youth in Germany and the Netherlands.* Psychosocial Intervention. Volume 22, Issue 3, December 2013. 203-213 https://ac.els-cdn.com/S1132055913700243/1-s2.0-S1132055913700243-main.pdf?_tid=2590c4ca-fb3a-11e7-84eb-00000aacb360&acdnat=1516161470_a35d55803bfc3c6a036c39189fe7cdd3

Hart, D., La Valle, I., Holmes, L. (June 2015) *The place of residential care in the English child welfare system Research report*

Hestbaek, A. (2014) *Trends in child protection in the Nordic Welfare states – Denmark as case.* Key Note Presentation at EUSARF 2014 in Copenhagen.

Katz, I., Cortis, N., Shlonsky, A., and Mildon, R. (2016) *Modernising child protection in New Zealand: Learning from other jurisdictions.* May 2016 Report for Superu.

Keshavarzian, G (2016) *The place of foster care in the continuum of choices: A review of the evidence for policy makers*. Report prepared for Family for Every Child.

Khoo, E., Skoog, V., and Dalin, R. (2012) *In and out of care: a profile and analysis of children in the out-of-home care system in Sweden*. 2012. Children and Youth Services Review. Vol. 34, no 5, 900-907.

Lopez, M. and del Valle, J.F. (2015) *The waiting children: pathways (and future) of children in long-term care.* British Journal of Social Work. 45. 457-473.

McLean, S. (2016) *Report on Secure Care Models for Young People at Risk of Harm*. Report to the SA Child Protection Systems Royal Commission. 20th January 2016. https://www.agd.sa.gov.au/sites/g/files/net2876/f/report_on_secure_care_models_for_young_people_at_risk_of_harm.pdf?v=1491456552

Narey, M. (2016) *Residential Care in England Report of Sir Martin Narey's independent review of children's residential care.* 1-82.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534560/Residential-Care-in-England-Sir-Martin-Narey-July-2016.pdf

Office of the Children's Commissioner, (2016) *State of Care 2016*. June 2016.

Pine, B.A., Spath, R., Werrbach, G.B., Jenson, C.E., and Kerman, B. (2009) *A better path to permanency for children in out-of-home care*. Children and Youth Services Review. 31 (2009), 1135-1143.

Price-Robertson, R, Bromfield, and L, Lamont, A. (2014) *International approaches to child protection. What can Australia learn?* Child Family Community Australia (CFCA), Australian Institute of Family Studies No.23, 1-11.

Rubin D.M, Downes, K.J., O'Reilly A. L.R., Mekonnen, R., Luan, X., and Localio, R. (2008). *The Impact of Kinship Care on Behavioural Well-being for Children in Out-of-Home Care.* Arch Pediatr Adolesc Med. 2008 Jun; 162(6): 550−556. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654276/

Safer Scotland, *2015 Preventing offending. Getting it right for children and young people.* Report published by The Scottish Government, June 2015. http://www.gov.scot/Resource/0047/00479251.pdf

Scott, D (2009) *"Think Child, Think Family".* Family Matters No.81. Australian Institute of Family Studies 37-42.

Stott, T. and Gustavsson, N. (2010) *Balancing permanency and stability for youth in foster care.* Children and Youth Services Review 32. 619-625.

Thoburn, J. (2010) *Towards knowledge-based practice in complex child protection cases: a research-based expert briefing.* Journal of Children's Services. Vol 5. Issue 1. 9-24.

Wise, S. (2017) *Developments to strengthen systems for child protection across Australia.* Child Family Community Australia Paper No. 44. November 2017 https://aifs.gov.au/cfca/publications/developments-strengthen-systems-child-protection-across-australia