“Who Cares”
The Impact of Carer Trauma and Resilience Profiles on Capacity to Support Young People with Complex Support Needs

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School of Social Sciences & Psychology
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For Don and Sue, Brendan, Emma, Kearney, Angus and Zara

A Light in the Attic

There’s a light on in the attic.
Though the house is dark and shuttered,
I can see a flickerin’ flutter,
And I know what it’s about.
There’s a light on in the attic.
I can see it from the outside,
And I know you’re on the inside…. Lookin’ out.

Shel Silverstein
UNIVERSITY OF WESTERN SYDNEY

The undersigned Faculty Committee Approves the
Dissertation of

Dr Lisa Fahey

“Who Cares”
The Impact of Carer Trauma and Resilience Profiles
on Capacity to Support Young People with Complex Support Needs

Chair

Second Member

Community Member

Approval Date
Author’s Notes

This thesis has brought together core experiences and reflections related to challenges in my clinical practice over two decades of fieldwork within human services, specifically within the sector of care for children who are unable to live with their families of origin, in both Queensland and New South Wales, Australia. It has been a personal privilege to work in a range of roles across various agencies. It has been the challenge of working directly with those who have the responsibility to provide care, the carers, in consideration of the complex needs of those children and young people they support, that I have found most compelling.

Further, throughout my career I have maintained both a professional and vocational interest in current and applied research in this field. Interacting with the thoughtful and incisive work of committed others has, equal with my own direct experience, compelled me to pursue this line of research in order to recognise the functional elements of the associated challenges, and generate a way forward in the topic. Accordingly, my interest builds on the work of both international and Australian research in these areas of understanding carer capacity.

In the context of Out-Of-Home Care and, more broadly, trauma recovery intervention, the carer is the key ‘player’ or critical variable in the efforts towards child protection. The carer becomes the child or young person’s practical guardian and is responsible, around the clock, for the wellbeing of the child or young person. While assisted by the state government department charged with child protection, the carer has, for the most part, the sole responsibility (with or without a partner) for the child placed with them. In most circumstances, the responsible department or non-government support provider, in conjunction with the carer, develop active support
practice documentation in the form of an implementation plan and/or a support plan, varying in their relative complexity as matched to the level of need in the child, and in the degree to which they are followed or supported. The capacity of the carer to effectively implement these supportive plans, along with recognising and responding to the behavioural and lifestyle contingencies of the child, is obviously crucial to the maintenance of the primary relationship between the carer and the child and, more generally, the development/recovery of the child or young person in care.

These plans, or prescribed interventions, for the most part present many aspects of ‘optimal’ parenting models, which are well worn, and from the perspective of one who has designed them with carers, encompass relatively simple and straightforward demands, such as routine, safety, clear boundaries, reinforcers and consistency. However, in the practice of the daily caring for a high needs child, something goes wrong.

It appears that the profile of children and young people coming into care is becoming more complex, both systemically and clinically. The political and systemic policy pressure for families to be supported to stay together, despite significant difficulties, is increasing, and we are seeing the age of entry to Out-of-Home Care services often rising, along with the sustained exposure to abuse or neglect. Moller-Leimkuhler and Wieshu (2012) have clearly described the challenge of the exceptional nature of the current demand on carers to respond to very complex needs of children and young people in care. There is also an alarming picture emerging of the high risk of Post Traumatic Stress Disorder (PTSD) diagnosis (Salazar, Keller, Gowen & Courtney, 2012) and mental health problems within the population of children and young people in the OOHC sector (Tarren-Sweeney & Hazell, 2006).
In terms of investigating this context, most recently the focus for both research and practice literature has been on extracting greater insight into specific emotional and developmental needs of children and young people who have suffered trauma and abuse, along with the construction of theoretical models to support assessment and intervention design. However, the other side of the ‘care’ equation, the profile of the carer and their capacity, is emerging as a dynamic and necessarily concomitant field of enquiry. Seeking to better understand the profile and capacity of carers to implement and sustain support, in the context of caring for trauma affected children and young people against a backdrop of the OOHC placements, is a research target that requires investigation (Fraser, Lloyd, Murphy, Crowson, Zolotor, Coker-Schwimmer & Viswanathan, 2013). In essence, this thesis seeks to investigate key aspects underpinning carer capacity, with the ambition that through this knowledge we will be more able to shape supports and improve outcomes for both children and carers.

‘Parenting’ has been an area of significant research focus. The elements of the ‘optimal’ parent, mentioned above, have been variously researched and critical elements accepted in a range of hierarchical models (Redshaw, 2010). Barriers or deficits to positive parenting have similarly been identified (Wolfe & McIsaac, 2011). It is widely acknowledged that child abuse has its causes located in a complex and interactive web of both protective and risk factors, including issues that may arise at the level of the individual, the family, the community, or society. Of those factors identified as most threatening and predictive of poor parenting capacity is the impact of trauma or a parental history of child abuse and neglect on carer capacity (Pears & Capaldi, 2001; Barlow, MacMillian, Macdonald, Larkin & Bennett, 2013).
The work of current researchers such as Hawes, Dadds, Frost and Hasking (2011), highlights the impact and interactive nature of the carer and cared for. Their work is seeking to trace the trajectory of the vicarious impact of the caring role, and how the nature of the child, the demands of the care role, and the development of the carer/child relationship evolves over time and across experiences.

The current study seeks to complement the work of Hawes et al. (2011), through the investigation of the primary psychological profile of carers, as it impacts on their capacity to care and to respond to the support needs of those they care for. A central question the study poses concerns the carer’s personal experiences of trauma and psychological distress. A corollary to understanding carer’s distress or trauma is to explore carer resilience (Hernandez, Gangsei & Engstrom, 2007). What personal resources do carers of children in out-of-home care bring to their role? How does the personal resilience of a carer interact with the responsibilities, performance requirements, and sustainability of caring? And what do these relative attributes mean in terms of the functionality of the broader and systemic caring context?

In order to further build the profile of this care dynamic, the study also seeks to respond to research that suggests that the attitudes that carers hold regarding the capacities of those they care for has a substantial impact on the trajectory of the care relationship. These carer attitudes may be formed by either carers’ personal experience or their general, acquired assumptions of children’s general ability, nature, support experiences and capacity for overcoming difficulties (Akakpo, 2008; Rozoni & Dogra, 2012; Geiger, Hayes & Leitz, 2013). The goal of this study is to further explore these aspects of the carer profile, bringing together trauma attributes, resilience, and the expectations and attributions of carers, in order to assist in determining an informed way forward that meets challenges in practice, one that
makes a real difference to the quality of life of all those committed to the caring process.
Abstract

The focus of the study was the investigation of the psychological profile of carers engaged in the support of young people with complex needs in the OOHC settings in NSW. Specifically, the study assessed the relationship between primary trauma, resilience and expectations, and how these factors impact on aspects of capacity to care. The study builds on the work of practitioners and researchers exploring the support required to facilitate trauma recovery, the impact of vicarious trauma, the nature of resilience and aspects of carer capacity; but currently stands as unique in its particular focus on the psychological profile of direct carers. The study used a mixed methods model, and was divided into two major sub-projects, including the administration of three normed psychological scales, and carer interviews delivering both qualitative and quantitative data. A total of 125 participants were involved representing foster carers, birth relatives or kinship carers, and paid staff carers, with one third (34) of the sample identified as Aboriginal. The key finding of the study has been the discovery of a profile of the OOHC carer population as one that reflects a significant experience of primary trauma, while also reporting positive resilience. The study also discovered that the carer sample as a whole held expectations that tend to under-estimate the support needs of the children and young people they cared for, and that variations in carer expectations appeared driven most by carer type. It was found that Aboriginal carers shared the identified psychological features of the broader sample. This research has begun to address the ‘gap’ in the established literature related to knowledge of the psychological features of the carers, and how this links to capacity to care. The findings highlight both the vulnerabilities and strengths of carers who are charged
with looking after the most distressed and challenging children and young people in our community.

*Keywords:* Primary trauma, OOHC, carer, resilience, expectation, capacity to care

**Statement of Authentication**

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

________________________________

(Signature) Lisa Fahey
Acknowledgements

It would not have been possible for me to complete this thesis without the assistance and support of so many wonderful people, a few of whom I would like to mention here. I would like to thank above all my husband Brendan, whose belief in my ability and the importance of the project has never faltered even when I did; my parents for their inspiration and opportunity, and my brother Nick for his wise, thoughtful and unequivocal support throughout.

This thesis would not have been possible without the vision and patient support of my principle supervisor, Dr Jo Milne-Home. The advice and support of Professors Nigel Bond and Natalie Bolzan has been critical and much appreciated in their roles as secondary supervisors. I would like to acknowledge the academic and technical support of the University of Western Sydney and its staff. I would like to thank those agencies and individual carers who supported this research through their participation. I hope that this thesis and its findings support the valuable work they undertake every day to improve the lives of children and young people. I would particularly like to thank Janice Carroll, Michael Cashin, Shelley Wall, Barbara Hardman, Jenni Mae Clissold, and Deb Munro, my friends and colleague who have over recent years supported my work in this area, and share a deep commitment and concern for the future of OOHC.

I wish to thank my friends and family for their amazing emotional support, practical assistance and endless tolerance. There have been so many times when I have received much needed encouragement, respite and timely inspiration.
For any error or inadequacies that may remain in this work, of course, the responsibility is entirely my own.

**Glossary**

The terms used throughout this thesis, while often in common use, are defined here for the specific meaning they have in the OOHC sector.

**Out-of-home care (OOHC)**

The Australian Institute of Health and Welfare defines Out-of-Home Care as 'alternative accommodation for children under 18 years of age who are unable to live with their parents, where the State or Territory makes a financial payment or where a financial payment has been offered but declined'. The Australian Institute of Health and Welfare data does not include children who are living in Out-of-Home Care outside the child protection system, such as placements made in disability services, medical or psychiatric services, juvenile justice facilities, overnight childcare services or supported accommodation assistance services FaHCSIA (2010).

The numbers of children in care include all children admitted to out-of-home care for the first time, as well as those children returning to care who had exited care more than two months previously. Children admitted to out-of-home care more than once during the year were only counted at the first admission. If a child was on more than one order, the highest level of intervention was recorded (guardianship or custody orders being the highest level of intervention while interim and temporary orders were lowest level) (Australian Institute of Health and Welfare, 2012, p. 22).

**Children and young people (Intensive support, High needs)**
Legally, a “child” is generally defined as a person aged under 18. For the purposes of the Children and Young Persons (Care and Protection) Act 1998 (NSW), a “child” is a person under 16 and a “young person” is under 18 but 16 or older (i.e. 16 or 17). Taken from the United Nations Convention on the Rights of the Child, which Australia ratified in 1990. It should be noted that the term ‘Ward’ has been used historically to refer to both children and young people in OOHC.

**Intensive Support Services (Community Services)**

The eligibility criteria for children or young people to be considered for Intensive Support Services include the child/young person is assessed as having high needs by the Regional Panel, which consists of the regional government authorities responsible for child protection, and that they are in Statutory Out-of-Home Care (i.e. under the Parental Responsibility of the Minister for accommodation on a Final Order). This means they require placement in a residential service, specialist foster care, or require intensive support working towards independent living. The child/young person may require intensive case management to support and stabilise a vulnerable placement and avoid entry into a residential or other specialist setting. An additional criterion suggests that a child or young person is described as having high and complex needs when they: exhibit challenging and/or risk taking behaviours of such intensity, frequency and duration that they place themselves and others at serious risk of harm; and/or have mental health presentations that impair their ability to participate in an ordinary life and reduces access to services, activities and experiences; and/or have a disability with high level challenging behaviours or complex health issues that are life threatening or require continuous monitoring and intervention (Department of Human Services, Community Services, Intensive Support Services Manual, 2010).
Carer Roles

A carer may be a family member, friend, neighbour, or other community member who provides care and assistance to a child or young person, in a regular and ongoing manner. In the context of this study, the care relationship will include the undertaking of formal agreements, and payment as negotiated based on role or employment agreement through an agency or government department.

Carer roles refer to the nature of the relationship that the individual carer holds in the context of the service system. Specific roles referred to in this study include Birth Relative (a person who is related to the child or young person through family), Foster Carer (a person who has been approved as a substitute carer for either short, medium or long term care of a child or young person) and Paid Carer (a person who has been recruited by an agency to provide care on a rostered basis to a child or young person).

Clinician

A clinician in the context of this study refers to an individual who has responsibility to provide clinical assessment and support, and has a qualification background in psychology.

Mediation

The concept of mediation and mediated variables has its origins in psychological situational analysis and statistics. The Mediational Model refers to the analysis of the impact of variables and their impact on total outcomes (Baron & Kenny, 1986). In the context of this study, mediation is discussed in relation to the act of adapting programs and plans to the reality of circumstances in which the carer provides care. The notion of assessing and working with carer profiles and the
context or environments in which they are caring is referred to as “mediation” (LaVigna & Donnellan, 1986).

**Kinship care**

Kinship care is defined as care with a person who is not a relative of a child or young person, but who shares a cultural, tribal and/or community connection that is recognised by that child or young person’s family and community. DoCS (2007)
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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABA or BA</td>
<td>Applied Behavioural Analysis or Behavioural Assessment</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychological Association</td>
</tr>
<tr>
<td>ARC</td>
<td>Attachment, Resilience and Competence</td>
</tr>
<tr>
<td>ASP</td>
<td>Acute Stress Disorder</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CSI</td>
<td>Carer Structured Interview</td>
</tr>
<tr>
<td>CF</td>
<td>Compassion Fatigue</td>
</tr>
<tr>
<td>DAPS</td>
<td>Detailed Assessment of Post-Trauma Symptoms</td>
</tr>
<tr>
<td>DOCS</td>
<td>Department of Community Services</td>
</tr>
<tr>
<td>DSM</td>
<td>The Diagnostic and Statistical Manual for mental Disorders</td>
</tr>
<tr>
<td>FACS</td>
<td>Department of Family and Community Services</td>
</tr>
<tr>
<td>FAHCSIA</td>
<td>The Australian Department of Families, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>JIRT</td>
<td>Joint Investigation Response Team</td>
</tr>
<tr>
<td>MRG</td>
<td>Mandatory Reporting Guide</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>OOHC</td>
<td>Out-of-Home Care</td>
</tr>
<tr>
<td>PMT</td>
<td>Parent Management Training</td>
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<tr>
<td>PPP or TRIPLE P</td>
<td>Positive Parenting program</td>
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<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RS</td>
<td>Resilience Scale</td>
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<tr>
<td>STSD</td>
<td>Secondary Traumatic Stress Disorder</td>
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<tr>
<td>TSI</td>
<td>Trauma Symptom Inventory</td>
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<tr>
<td>VT</td>
<td>Vicarious Trauma</td>
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<tr>
<td>VR</td>
<td>Vicarious Resilience</td>
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Chapter 1: Study Introduction

1. Introduction

In Australia, from 2007-2008 to 2011-2012, the number of children with substantiated cases of abuse and neglect rose from 31,527 to 37,781 (AIHW, 2011) resulting in a 3% increase in the number of children admitted to care on protection orders (AIHW, 2011). During this time, there has also been an increase in the numbers of children and young people identified as at risk, (AIHW, 2011, pp. 105-106), creating a significant and ongoing challenge to the Out-Of-Home Care (OOHC) sector, the sector charged with providing care for children and young people displaced from their family.

Numerous reports and reviews into the OOHC system identify chronic limitations within the system to meet fundamental client needs, and a lack of capacity to provide a functional and progressive level of care to children and young people in need of such care (see, for example, Cashmore, Higgins, Bromfield, & Scott, 2006). This widespread failure is discussed in numerous inquiries into the circumstances of management or problematic incidents in care within institutional, family-based, and residential care across the country. Redshaw (2009a) lists the following examples of reviews and inquiries where issues of unmet need were among the concerns and findings highlighted: Churches Community Services Forum 2001; Crime and Misconduct Commission Queensland 2004; Department of Family and Community Services 2004; Department of Health and Human Services 2006; Department of Human Services 1998b; Forde 1999; Human Rights and Equal Opportunity Commission 1997; Mendes 2005; Northern Territory Government
2010; NSW Community Services Commission 2001; Senate Community Affairs References Committee 2004, 2005. Over the last decade, there have been fifteen reviews specifically concerned with the investigation of the management and nature of child abuse and protection systems within Australia (Libesman, 2013). Announced in January 2013, the national Royal Commission into Institutional Responses to Child Sexual Abuse (http://www.childabuseroyalcommission.gov.au/) is anticipated to provide perhaps the most comprehensive review of Australia’s historical management or mismanagement of child abuse by agencies, churches and service providers.

This failure of the system has persisted, despite the national recurrent expenditure on child protection and OOHC services having risen by $137.7 million (5.1%) to approximately $2.8 billion from the 2009-10, to 2010-11 period (AIHW, 2011). Across Australia, this area of welfare has experienced rolling reform agendas, usually involving proposals for model or systems redevelopment, and extensive recommendations. These reforms, restructures and reviews reflect an ongoing concern with how to efficiently care for the increasing number of children and young people requiring child protection intervention and OOHC.

Analysis of the nature of these reforms reveals a narrow focus by government bodies on the quest to identify ‘optimal’ models or targeted demographic-based solutions (McHugh, 2002), or attempts to shape community interventions and legislation (Libesman, 2013). Despite substantial financial resources being provided for the delivery of models, or systemic solutions to the issue of how to provide OOHC to children and young people, there is fragmented and weak practice evidence of success (Libesman, 2013) or gains in ‘real world’ settings (Michelson et al., 2013).
This thesis sits within the context of Australia’s increasing demand for OOHC services, and chronic dissatisfaction with the outcomes being achieved for children, families, carers and our community. This introductory Chapter provides a précis of relevant contextual factors impacting on the current Australian care environment. The initial discussion seeks to provide an overview of the evolution of OOHC systems within Australia and NSW, and a focus on historical and current policy. It identifies a gap in current research in the field of OOHC in terms of a lack of focus on the carer, and in particular on the psychological profile of those engaged in the caring role. The following chapter then discusses the context of research and practice in the area of carer profile features specifically related to trauma and resilience, and expectations in relation to the capacity of carers in the OOHC system, and concludes with the research questions and a summary of the thesis chapters.

2. OOHC Systems Within Australia

OOHC services in Australia include accommodation (placement) for children and young people who find themselves effected by family breakdown, legislated interventions (for a range of special circumstances), and case support to manage issues to achieve a safe or protective environment for children and families (Libesman, 2013). Factors identified in families where children might require OOHC include low income (poverty), substance abuse, mental health issues, sole parenthood, domestic violence, or a combination of any or all of these (Sultmann and Testro, 2001). Researchers have found that the interaction of these factors is often chronic and complex (Butler, 2009), and reflects the presence of both risk and protective factors in each case (MacDonald, Piquero, Valois, and Zullig, 2005).

Children or young people under the age of 18 assessed as experiencing abuse or neglect, and requiring an OOHC placement are placed in one of the following
models of support currently operating within Australia: home-based care (including relatives/kinship care), family group homes, residential care with rostered staff on site, independent living in private boarding arrangements, and various other variations of these models tailored to meet needs as required securing the child’s wellbeing, matching family and carer resources. Variations in policies and practices across the nation are outlined in Appendix 5: *Policy and practice differences in states and territories* (AIHW, 2012, pp. 96-100). The following table provides numbers of children admitted to OOHC across Australia since 2004-5.
Table 1 - Trends in the number of children admitted to OOHC: States and Territories, 2004-05 to 2011-12.

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-5</td>
<td>3,105</td>
<td>3,301</td>
<td>3,198</td>
<td>795</td>
<td>1,257</td>
<td>293</td>
<td>297</td>
<td>285</td>
<td>12,531</td>
</tr>
<tr>
<td>2005-6</td>
<td>3,309</td>
<td>3,166</td>
<td>3,129</td>
<td>713</td>
<td>1,271</td>
<td>426</td>
<td>269</td>
<td>263</td>
<td>12,546</td>
</tr>
<tr>
<td>2006-7</td>
<td>4,334</td>
<td>2,994</td>
<td>2,897</td>
<td>990</td>
<td>728</td>
<td>372</td>
<td>207</td>
<td>384</td>
<td>12,906</td>
</tr>
<tr>
<td>2007-8</td>
<td>4,467</td>
<td>3,027</td>
<td>3,146</td>
<td>855</td>
<td>652</td>
<td>301</td>
<td>167</td>
<td>276</td>
<td>12,891</td>
</tr>
<tr>
<td>2008-9</td>
<td>4,564</td>
<td>2,936</td>
<td>3,015</td>
<td>797</td>
<td>660</td>
<td>349</td>
<td>194</td>
<td>318</td>
<td>12,833</td>
</tr>
<tr>
<td>2009-10</td>
<td>3,922</td>
<td>3,112</td>
<td>2,618</td>
<td>838</td>
<td>644</td>
<td>334</td>
<td>168</td>
<td>366</td>
<td>12,002</td>
</tr>
<tr>
<td>2010-11</td>
<td>3,542</td>
<td>3,067</td>
<td>2,644</td>
<td>879</td>
<td>582</td>
<td>298</td>
<td>244</td>
<td>358</td>
<td>11,613</td>
</tr>
<tr>
<td>2011-12</td>
<td>3,407</td>
<td>3,526</td>
<td>2,671</td>
<td>1,088</td>
<td>618</td>
<td>284</td>
<td>247</td>
<td>399</td>
<td>12,240</td>
</tr>
</tbody>
</table>

Note: adapted from AIHW Child Protection Collection 2010 (AIHW, 2011, p. 41; AIHW, 2012, p. 66)

The reported statistics require some qualification. While national statistical data indicates a marginal overall increase in the numbers of children admitted to OOHC in most states and territories, it is notable that the 2010-11 period was an exception; the reasons for this are not clear (AIHW, 2011; AIHW, 2012).

The figures reported above are largely considered to be an underestimation of those seeking or requiring care, as individuals and families who exceed allocated accommodation within services have their requests declined (AIHW, 2010) and are not recorded. Furthermore, a range of placements funded by disability services, medical or psychiatric services, juvenile justice, overnight child care, or supported accommodation placements, or placements with parents financed by the jurisdiction are excluded from the Child Protection 2010-11 figures (AIHW, 2011, p. 31). Statistics on placements are also influenced by changes in an accommodation service’s response capacity or policy around child protection intervention. States and
territories cannot be compared accurately or reliably on performance using OOHC statistics alone (Bromfield & Higgins 2005; Bromfield & Holzer, 2008). Furthermore, data over time even within states and territories cannot be relied upon to give a true picture of trends in child protection demand. Statistics may indicate either positive or negative trends depending on how they are interpreted; however, The Australian Institute of Family Studies’ (AIFS) projections are pessimistic across all jurisdictions, with rates of reporting anticipated to grow. It is apparent that the need for child protection is persistent and endemic. In the current study, the focus will be on sample carers of those children and young people who are placed in the OOHC system.

In terms of understanding which children and young people are coming into care, analysis of the current AIHW data shows that, nationally, approximately 2/3 (8,121) of the children admitted to OOHC in 2011-12 were aged nine years or below, and that there is an approximately even split between boys (21,149) and girls (19,806). The highest number of children in OOHC currently live in NSW, and this number of placements is largely made up of foster or relative care. Despite the high use and policy-based preference for relative or foster care OOHC placements, there is evidence of these arrangements resulting in high financial, emotional and physical costs to carers, which challenge their sustainability (Mason et al., 2002). NSW has the third highest number of residential OOHC placements, that are institutional or congregate-based care, (455) behind QLD (653) and VIC (478); however, the proportion of children and young people in this form of care is relatively small (2,042) when mapped against the total numbers of children in care (see Table 2).
Table 2 - Trends in the number of children in the current placement types: States and Territories, 2011-12.

<table>
<thead>
<tr>
<th>Type of Placement</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster care</td>
<td>7,026</td>
<td>2,166</td>
<td>4,579</td>
<td>1,386</td>
<td>1,087</td>
<td>547</td>
<td>218</td>
<td>265</td>
<td>17,274</td>
</tr>
<tr>
<td>Relative/kin</td>
<td>9,586</td>
<td>2,832</td>
<td>2,767</td>
<td>1,465</td>
<td>1,104</td>
<td>306</td>
<td>292</td>
<td>163</td>
<td>18,515</td>
</tr>
<tr>
<td>Other home</td>
<td>0</td>
<td>690</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>82</td>
<td>22</td>
<td>162</td>
<td>961</td>
</tr>
<tr>
<td>Total home</td>
<td>16,612</td>
<td>5,688</td>
<td>7,346</td>
<td>2,851</td>
<td>2,196</td>
<td>935</td>
<td>532</td>
<td>590</td>
<td>36,750</td>
</tr>
<tr>
<td>Family group</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>170</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>55</td>
<td>272</td>
</tr>
<tr>
<td>Residential</td>
<td>455</td>
<td>478</td>
<td>653</td>
<td>150</td>
<td>246</td>
<td>27</td>
<td>33</td>
<td>0</td>
<td>2,042</td>
</tr>
<tr>
<td>Independent</td>
<td>88</td>
<td>38</td>
<td>0</td>
<td>13</td>
<td>26</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>175</td>
</tr>
<tr>
<td>Other/unknown</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>216</td>
<td>80</td>
<td>22</td>
<td>0</td>
<td>54</td>
<td>382</td>
</tr>
<tr>
<td>Total</td>
<td>17,192</td>
<td>6,207</td>
<td>7,999</td>
<td>3,400</td>
<td>2,548</td>
<td>1,009</td>
<td>566</td>
<td>700</td>
<td>39,621</td>
</tr>
</tbody>
</table>

(AIHW, 2011-12, p. 78)

The available data across Australia in relation to Aboriginal children and young people in OOHC is similarly inconsistent as there are also variations between states and territories in the methods of recording and validating this aspect of data capture. Overall, however, the national rate of Indigenous children in OOHC placements is 10 times that of non-Indigenous children (13,299). NSW has the highest number of Indigenous children (5,991) placed in OOHC of any Australian state or territory. While nationally there has been some slowing of the increase in the number of new placements for non-Indigenous children, the increase in movement to OOHC placement for Indigenous children has maintained its upward trajectory (AIHW, 2011-12, p. 46).

No clear single reason for why there has been an increase in the numbers of children entering the OOHC system has emerged. Butler (2009) concludes that the
reasons for the increase in children placed in OOHC across Australia are complex, diverse and challenging to differentiate. In the data on families in NSW with children in the OOHC sector, there is an over-representation of single parent families, those from lower socio-economic status areas, families where one or both parent are Indigenous, culturally and linguistically diverse (CALD) families, parents who did not progress beyond Year 11 at school, families experiencing mental health issues, and families living in urban environments (Butler, 2009). A regression analysis in the NSW Department of Community Services (DoCS) *Stronger Families Stronger Communities Annual Report* showed that domestic violence, drug and alcohol abuse, as well as being situated in housing that was provided by the state, were also associated with increased rates of referral to OOHC (DoCS *Annual Report*, 2006).

McHugh (2002) noted that changes to mandatory reporting laws and penalties for non-reporting, along with increasing pressures on families have been key factors. Changes in legislative frameworks, increased knowledge and police involvement in domestic violence, mandatory reporting by professionals, as well as the increased opportunities for those abused or neglected to speak out and seek protection can be understood as adding to the growing numbers of children and young people in the OOHC, and impact on reporting and substantiation statistics (DoCS *Annual Report*, 2006). Noted in the current NSW Family and Community Services 2012-2013 *Annual Report*, the increase in the number of reports of significant risk of harm to a child or young person, and referrals for Joint Investigation Response Team (JIRT) continues to challenge service responses (FaCS *Annual Report*, 2013, p. 29). This increase in child protection issues and specifically OOHC placement is notably
mirrored in similar demographic data in other developed countries (Barlow et al., 2012).

Perhaps the most concerning trend across Australia is that fewer children were discharged from care (7,480) than were admitted (13,830); a pattern observed across all jurisdictions. In 2010-11 there were estimated to be more than 39,000 children in care, which is 7.6 per 1,000 Australian children (AIHW, 2012, p. 22). It should be noted that, in the main, transition of young people from the care systems is the result of their ‘aging out’ of the support by turning eighteen, rather than being established in alternative living arrangements no longer requiring a care order. McDowall (2012) also identified that one of the fundamental practice problems in Australia underpinning the failure of children and young people moving from care across jurisdictions, was the lack of evidence of the establishment of a successful individual ‘leaving care plan’ as part of the case management process. Given the poor rates of discharge discussed above, the process of permanency planning and restoration is acknowledged as a critical area for greater and continued focus (FaCS Annual Report, 2013).

2.1 Care systems within New South Wales. The analysis of national child protection data provided by the AIHW (2011-12) identifies NSW as the state or territory registering the highest rate of child protection reports, substantiations, and placements of children into OOHC. The profile of the nature of the abuse or neglect, along with trends related to the age or gender of children reported, appear nationally consistent. Emotional abuse is the most common substantiation type, closely followed by neglect and physical abuse, sexual abuse is the least prevalent. NSW distinguishes itself from other states by the significant weight of its numbers of children in care, and importantly the high proportion of Aboriginal children and
young people in placements. NSW has the second highest number of children entering the OOHC system under orders in the current AIHW data (3,017), and the numbers of discharges (2,238) suggests a bottleneck in the system. NSW has the second highest rate behind SA for continuous placement extending over 5 years with over 30% (6,514) of the total of 17,192 children and young people in OOHC in placements extending over 5 years.

The context of care provision in NSW has evolved through a number of milestones that have had an influence on the nature of service providers, and the resultant carer population. Early approaches to child welfare intervention were aimed at rescuing and reforming the children of ‘deficient’ parents, based on notions that criminality and immorality were clearly linked. The objective was to remove children as early as possible, limit parental contact, and educate the children to behave in socially acceptable ways (Mason & Noble-Spruell, 1993).

The ‘Aborigines Protection Board’ was established in 1883 to protect the lives and manage reserves of the estimated 9,000 remaining Indigenous people in NSW (HREOC, 1997). The Board’s main policy agenda was to remove Indigenous children from their families and merge them into the non-Indigenous population. The Aborigines Protection Act 1909 gave the Board power to assume full control and custody of the child of any Aboriginal person if a court found the child to be neglected. The Aborigines Protection Amending Act later gave the Board total power to separate children from families without having to establish in court that they were neglected (HREOC, 1997).

In 1939, the Child Welfare Act in NSW led to the establishment of the Child Welfare Department and made legislative provision for the payment of the ‘27A Allowance’ to carers of state wards (HREOC, 1997). This was intended as a
‘contribution’ towards costs of care and not a fee or wage. This new Act also brought Aboriginal children under its jurisdiction and increasingly saw them placed with white foster families. However, the practice of forced removal of Aboriginal children continued (HREOC, 1997). The Association of Child Caring Agencies was established in 1958 to secure government funding for residential care services operated by non-government providers. In 1969, the NSW Aborigines Welfare Board was abolished, leaving over 1000 Aboriginal children in institutional or foster care. The first Aboriginal children’s service in NSW was opened in Redfern in 1975.

In 1977, mandatory reporting of suspected child abuse was introduced as well as the establishment of the Family Support Services Scheme, among others, with a more preventative focus, and the introduction of Temporary Foster Care (Coalition for Children in Care, 2010).

‘Boarding out’ of children to foster parents became a desirable alternative to institutional care as a result of a number of reviews into care provided to children in congregate care barracks and industrial schools. Marketing strategies used to sell the idea of foster care or family-based care included the opportunity for children to enjoy a country life, better health, and integration into the public school system. However, it was the assessment that it “offered lower costs than institutional care” that made foster care an attractive alternative to institutionalization (Dickey, 1980). In 1881, the ‘State Children’s Relief Board’ was established and brought the ‘boarding-out’ of children under state control in NSW, ensuring the provision of relevant services as the State had access to consolidation revenue to pay allowances to carers, and was also able to pay an allowance to the child’s mother if she was destitute or widowed. In 1982, based on the initiation of a two-year inquiry into the quality of OOHC in NSW, a final task force report known as the Dalton Report was
released. This report identified a number of significant systemic issues along with the sector’s inadequate funding of services (Coalition for Children in Care, 2010).

During 1983, a report *Directions for Residential Care: a Report to the Minister for Youth and Community Services* (The Vardon report), saw the focus shift from residential care to family-based or foster care. At the end of 1987, it was recorded that there were 328 wards (including both Indigenous and non-Indigenous children) in departmental residential care (12% of the total ward population) and 119 wards in non-government residential care (4-5% of the total ward population). Around the late 1980’s increased pressure was being felt to progress deinstitutionalization, and preference was given to the placement of wards with foster families. The Children (Care and Protection) Act 1987 replaced the 1939 Act, and the concept of ‘permanency planning’ was gaining acceptance.

In August 1990, the Department of Community Services (DoCS) Minister, the Hon. John Hannaford, MLC, ordered a restriction on placements into residential care facilities and announced the Review of Substitute Care. Fr. John Usher was appointed chairperson to oversee the work of a committee charged with making recommendations to propose strategies for alternative care for children in order to reduce the numbers of children in residential placements. The review returned a compelling report 12 months later, making a total of 53 recommendations for change (Coalition for Children in Care, 2010).

In 1992, *The Usher Report* recommended the outsourcing of all OOHC services to the non-government sector as new government policy. Usher concluded that the government Department within NSW should not continue to undertake to be the provider of substitute care services, and that all care needs should be re-contracted to non-government providers within the following three years.
Underpinning this change was a strong recommendation that the structure of services should be modified to reflect individual therapeutic needs of young people, and that options for congregate care be removed. Central to the findings of the review was the recognition that the quality of care and skills or capacities of carers were critical considerations for both the modelling and monitoring of OOHC service provision (Standing committee of social issues. Legislative counsel, 2002, p. 110).

The implementation of the Usher report recommendations resulted in the emergence of ‘for profit’ and ‘not for profit’ funded agencies (Coalition for Children in Care, 2010). These funded agencies were to rely on individual funding packages around a specific child or young person, and target the provision of both foster/kinship or residential placements. The model for such placement support varied based on both the individual child’s needs and the style of support or carer type offered by the agency. In essence, the support offered under this reform and continuing today is based on a continuum of care needs that is meant to provide capacity for the system to respond to the particular needs of each individual child coming into the system. Costing of such support is broadly related to the intensity of the support required by the child. In practice, a young person may experience a combination of care models during their time in OOHC.

The Report of Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008), completed by the Hon. James Wood, offered a number of significant recommendations for change in the OOHC and child protection in NSW. Key principles guiding the report’s recommendations focused on the need for integration of government systems, and role clarity, along with the pro-active engagement in the non-government sector to expand capacity and the continuum of services available within OOHC. Reforms included raising the threshold of reporting
from ‘risk of harm’ to ‘risk of significant harm’ and a greater focus on early
decision-making related to permanency planning. The report also pressed for a
greater focus on the assessment of children to better understand their individual
needs, and timely information being provided to carers to inform their role. A
specific priority of the report was that Aboriginal children in OOHC be pro-actively
connected with their family and community through the case management and
support planning process.

New South Wales developed a *Mandatory Reporter Guide* (MRG) in 2009,
which stipulated procedures for reporting suspected child abuse or neglect. From
January 2010, anyone who delivers health care, welfare, education, children’s
services, residential services, or law enforcement to children under the age of 16 is
required to report suspected child abuse; this also applied to people who hold
management positions over those who have direct responsibility for the previously
mentioned workers. An online guide was also made available to assist with decision
making before contacting the NSW Child Protection Helpline, and this information
and screening has been seen as potentially contributing to a rationalization in
reporting numbers.

Current legislation and policy within NSW has the core ambition of keeping a
child with their family of origin wherever possible, and where children do need to be
removed from the home, that they are supported to return to their parents’ care as
quickly as possible (The NSW Liberal and Nationals. *Recovering Children at Risk*,
2011, FaCS Annual Report 2012-2013). One of the key platforms underpinning work
within the field over the last few years has been the notion of family recovery and
the restoration of children to their family of origin. The goals of aligned support
model(s) include, but are not limited to, the following (FaCS Prevention and
Access to a suitable (safe) stable accommodation setting, matched to needs; Setting with capacity for restriction and/or containment at times; Access to assessment and program design services; Trained staff/carers with a high level of supervision and knowledge of developmental needs; Staff/carer contingencies that support physical management of high risk behaviours in a safe and ethical manner; Intense, targeted therapeutic support that is multi-element and delivered consistently over time and across all settings; Complex and intensive case management services; Support around Court processes and permanency; Active engagement of specialist services and professionals; Support that is not time-limited, but structured around client needs and the outcomes achieved.

The current AIHW 2011-12 data reports that NSW currently hosts the largest number of foster carers (4,787) for any state or territory in Australia. NSW also reported the highest number (572) of new households commencing foster care roles, and the highest number of carers engaged in relative of kinship care (6,875). It is critical that the nature of the state-based profile for NSW is clearly understood as both unique and holding particular characteristics around size, types of care offered and composition of those in care that inspire a particular direction for research and investigation in relation to carers and their capacity.

3. The Stakeholders

Three primary stakeholders in the OOHC field can be identified: the state or funder, the child or young person, and the carer. Each of these stakeholders has varying, although linked, investment in the outcomes of the OOHC program.

3.1 The State – the politics of care. Most recently, as part of the ‘Keep Them Safe’ strategy, based on the report by the Hon. James Wood in 2008, Community Services New South Wales developed a voluntary early intervention program, which
supports and helps prevent families from entering or escalating in their care needs. In 2008, this program had achieved the employment of 350 caseworkers dedicated to early intervention work, and continues to be progressively implemented across the state (Bromfield, Higgins, Higgins and Richardson, 2007). The Keep Them Safe Report was formulated into a comprehensive five-year plan, for implementation by both government and non-government agencies. It preceded and set the framework for the decision for the State to retain primary responsibility for those children with the most complex and demanding care needs and transfer the provision of most OOHC services from the State to a range of non-government agencies. The current State Liberal Government has increased the focus on the transition of OOHC services from government to non-government; a move that was first recommended by the Usher report from the early 1990’s.

A number of significant reports into the projected challenges for the provision of OOHC in NSW have been undertaken. Many of the reviews and attempts to reform the sector in the past few years have been concerned with the high cost of OOHC. As such, there has been a strong focus on administrative and cost related concerns. Capacity is discussed in terms of that of the system rather than of those working in it (Cashmore et al., 2006). In recent years, possibly the most significant review undertaken of the OOHC sector was conducted by the Boston Consulting Group (BCG, 2009), as part of the NSW Cabinet in Confidence review. The Boston Consulting Group is a management consulting firm contracted to provide advice on business strategy. The key findings presented in that comprehensive study related to the scope and nature of projected needs and costs for services to children in the NSW OOHC sector. Key findings included predictions related to a cost ‘blow-out’ under the existing framework of delivery. The findings, based on an estimation of the
comparative costs for transfer to the non-government sector, and the minor practice improvement of a reduction in casework ratios, were anticipated to push funding requirements to an even more extreme level. They also found that estimated costs could reach approximately $790m by 2013/14 at current average caseworker ratios, while scenarios of transfer to the current NGO system and improved caseworker ratios estimate 2013/14 costs at over $800-900m (BCG, 2009). This report (BCG, 2009) was framed around the critical fiscal escalation in projected delivery of OOHC services in NSW. It did not seek to measure child welfare benefits or value-adding in relation to placement sustainability or therapeutic outcomes, and has served as the report most influential in affecting State policies around the provision of OOHC. The implementation and impact of the Brighter Futures program of reforms (discussed below) were not covered by the report.

Potential challenges to the report and its findings include considerations that its forecasts were based on the following assumptions: an assumed, sustained high entry into care rate of approximately 4,700 children per year—a figure based on 2007/08 entry figures of 4730, anticipating nil impact of current interventions, including the impact of the Permanency Planning policy introduced by Community Services NSW; that Community Services would maintain the existing ratio of caseworkers to children in care; and that the number of foster carers would double from 2007/08 to 2013/14. The BCG report was also firmly based on a model by which Community Services retains management of placements without any further transfer to the non-government sector, along with the transfer of existing agency agreements related to commitments to funded placements (BCG, 2009, p. 10).

These assumptions have not been realized and current data suggests there has been an increase in lengths of stay in the OOHC sector as a result of permanency
planning, i.e. 80% of kinship care placements are still in care after two years in 2006/07 compared to 60% before 2006/07 (BCG, 2009); the system has not been able to substantially increase the number of carers it recruits and there has been a steady increase in the transfer of placements to the NGOs, from 2200 in 2008/09 to 4200 in 2012/13, along with a substantial drop in individual client funding agreements (AIHW, 2011-12).

Importantly, the BCG report described for the NSW Government the ‘worst case scenario’ from a funding perspective. Clearly the efficacy of the report was challenged by many of the underpinning assumptions, but efforts to respond at some level to the findings of the report can be seen in the recent transfer of core responsibilities for casework and service provision from Community Services to the non-government sector, and the refreshed focus on family support and the prevention of family breakdown (FaCS Annual Report, 2012-2013). It is significant, however, to note that this substantial report paid scant attention to placement sustainability or to care outcomes, and the overlay between OOHC and the Juvenile Justice and Children’s Court systems or activity (Sheehan & Borowski, 2013).

Other reviews into the OOHC system that focus on quality of service provision to children offer a different perspective on the issues currently confronting the system. According to Bromfield, Higgins, Higgins, and Richardson (2007), the challenge for service providers, both government and non-government in ensuring they are able to sustain placements is attributed to a combination of factors, including (a) The reduction in placement options; (b) An inability to recruit adequate numbers of foster carers or care staff in general; (c) The challenging characteristics of children entering care; (d) The emphasis on a child’s need for stability and the difficulty under the current funding models to project longitudinal placements. There
has been a range of smaller reviews of OOHC provision within NSW (Schmied & Tully, 2009). Critical in understanding these reviews and the focus of the resultant recommendations has been the nature of the respective terms of reference. For example, the BCG had a clear target of the business analysis of cost, where the Wood Review focused on mechanisms to promote child protection. Few of the reviews undertaken over the last 10 years were specifically concerned or attempted to measure outcomes for children and young people, and none provided any comprehensive analysis of those who provide the care, beyond a concern with recruiting adequate numbers of carers (Schmied & Tully, 2009). At some level, the exception to this was the Report of Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008), which resulted in the NSW Government developing a five-year plan of reforms to child protection, via the Keep Them Safe: A Shared Approach to Child Wellbeing (DoCS, 2009) which incorporated 106 of the 111 recommendations from the Wood report. While economic imperatives are a key focus of the report, the Brighter Futures program that emerged as a response to the recommendations had as its focus a concern for the experience of children in care and an acknowledgement of the support needs of carers. Through the Brighter Futures program, additional family placements and care alternatives with 14 non-government agencies (Lead Agencies) were planned.

The implementation of the recent Liberal Government ‘Expression of Interest’ in 2011 for agencies seeking to provide accommodation support to children and young people in OOHC, and the resultant service tendering process has seen the signing of 26 contracts with more pending, including a significant list of ‘new’ providers to the State. Under these contracts, unit costs have been set and matched to assessment of children’s needs (FaCS OOHC service specification template, 2012).
This action has been the direct result of responses to the enquiries and reports discussed above, and reflect the government progress towards building capacity in the non-government sector.

3.2 Children entering the OOHC system. The profile of children and young people entering OOHC has been described by many researchers and has been the focus of significant operational consideration in recent years (Barlow et al., 2013). The client characteristics outlined in the annual Child Protection Report (AIHW, 2011) include children placed on a voluntary or court ordered arrangement, and those who have been unsuccessful at being supported in a family setting. Children in this group were noted as potentially presenting health issues, psychological trauma and attachment challenges, along with disabilities, mental health and behavioural difficulties (Tarren-Sweeney, 2010).

Trends in the numbers of children in OOHC published in the AIHW Child Protection Collections (2010) showed that between 2004-05 and 2009-10, the net national figures have gone from 12,531 to 12,002. However, in NSW the figures rose from 3,105 in 2004-05 to 3,922 in 2009-10. Of these, 19% of the children and young persons in care were under one-year-old, and 8.2% were 15 to 17 years old. Almost 74% of the OOHC populations in NSW were between one and 15 years old. At a national level, the figures were similar, with an average of 17% of represented children and young persons under one-year-old, 73% between one year and 15 years old, and 10% between 15 and 17 years. The majority (93%) of children and young people in OOHC are in home-based care (AIHW, 2011, p. 33; Johnston, 2011).

There is variation in the age in relation to accommodation service type: younger children (12 to 15 years) are more likely to be receiving care from relatives or foster carers, and older young people (15 to 17 years) more likely to live in residential,
private board or lead tenant arrangements (AIHW, 2011, pp. 105-106). Over the last four years, the number of children younger than 12 years of age who are currently receiving support through residential placements within the non-government sector has vacillated between 25 to 32 (NSW Community Services, *Intensive Services Placement Data*, April 2012). Of this group, approximately one third has a diagnosed disability, and the majority have challenges related to behaviour management. These placements for children younger than 12 years of age require the endorsement of the Minister due to their age, and there is a clear Community Services policy imperative to seek non-residential options for younger children (FaCS Prevention and Pathways Directorate, 2012).

A further characteristic of children entering care is the over-representation in the care system of children who have had dealings with the law (Sheehan & Borowski, 2013). Juvenile justice orders are governed by different policies in each Australian jurisdiction; however, it is clear that young people in trouble with the law are over-represented in any reading of OOHC figures. Kenny and Nelson (2008) indicated that children in OOHC comprised 0.6% of the general NSW population, yet twenty-four percent (24%) of young offenders have a history of OOHC, illustrating the high vulnerability of this cohort of young people.

As discussed above, in the national statistics, Indigenous children and young people are disproportionately represented in the OOHC statistics. The welfare system inherits the legacies of past policies and cultural differences in caring and child rearing practices, as articulated in *Closing the Gap on Indigenous Disadvantage: the Challenge for Australia* (2009). There is a chronic and growing over-representation of Aboriginal and Torres Strait Islander children in the national statistics of child protection (Trewin & Madden, 2005). This cohort was 7.7 times
more likely than non-Indigenous children to be subject to substantiated notifications of abuse or neglect received in 2009-10, and 10 times higher for admission into OOH C 2011-2012 (AIHW, 2011, p. 35, 116). The rate of Aboriginal and Torres Strait Islander children on care and protection orders has increased steadily, from 34.8 to 51.4 per 1,000, for the period from June 2007 to June 2011, while the rates for non-Indigenous children remain relatively stable at 5.4 per 1,000 (AIHW, 2011, p. 30). The factors that heighten the risk of abuse and neglect are further brought into relief when considering issues of intergenerational trauma as cited in the Bringing Them Home report (HREOC, 1997).

The focus on kinship placements has grown as an emphasis guiding practice in the responses to Aboriginal children in care (Atkinson, 2013). A DoCS Issues Paper (Cashmore & Paxman, 2006), acknowledges that while there are no reported advantages in outcome focused evidence for the use of kinship placements in OOH C, the balance of prioritizing cultural sensitivity and problem solving is justified in shaping the direction of care. Similarly, Department of Community Services Multicultural Strategic Commitment 2008-2013 (DoCS, 2009), outlined principles regarding welfare and wellbeing for children and young persons removed from Culturally and Linguistically Diverse (CALD) homes. Language, religion, family and cultural ties must be preserved to the extent that this is possible when children are the subject of the Child and Young Persons (Care and Protection) Act 1998.

A few key organisations champion the needs of young people currently in, or who have experienced, the care system. Two with a substantial profile are The Forgotten Australians and CREATE. In November 2009, the Australian Parliament acknowledged and apologized for the experience of Forgotten Australians and child
migrants, making specific reference to the hardship, trauma and neglect they had suffered (Harrison, 2011). The CREATE Foundation is a peak body, a unique organisation designed to support disadvantaged children placed in OOHC, providing tangible help by supplying entering care kits. While in care, CREATE provides “clubCREATE” where children and young people in care can access programs and services available to them, including social events (http://www.create.org.au/). It also undertakes regular evaluation and comment on support systems and outcomes.

Chronic failures in the management of transition between entering and leaving OOHC are highlighted by CREATE’s Report Card (2013). McDowall (2012), in reflection on the lack of ‘leaving care’ plans, also raised concerns related to the challenges to achieving suitable and supportive care in the over-burdened OOHC system. Other issues related to the engagement of children and young people currently receiving attention in the OOHC literature, include the participation of young people in OOHC in the decisions affecting them and an evaluation of ‘life outcomes’ (Bessell, 2011; McDowall, 2012)

3.3 Caring – the carer role in OOHC. The current emphasis in children’s services, in relation to service design and carer context or role, is clearly centred on what is required to best meet children and young people’s needs through support to the primary family (birth relative or family of origin) structure and early intervention (FaCS Annual Report, 2013). Driven by the compounding costs, logistics of management and the challenges of poor outcomes, any decision for a OOHC placement is viewed as the last resort. As a result, the children and young people now entering care are generally those who have suffered chronic and persistent neglect or maltreatment, along with years—often many—of significant family
disruption (Victorian Department of Human Services, 2003). As noted in the chapter above, in essence, children and families now ‘fail’ their way into care.

The challenge of locating, training, matching and sustaining long-term carers to provide high quality care across all models of service provision to young people and children in OOHC is acknowledged as the pivotal variable in service management (Foote, 2013). Issues identified as impacting on the numbers or availability of carers to the OOHC system included limited capacity of carers to meet eligibility standards, carer preferences for young people and children without high and complex needs, an ageing carer population being attracted to the role, carer overload and burnout, and limited flexibility in the design of care arrangement (Bromfield, et al., 2007).

A common value or aspirational goal expressed in the recruitment of carers is a focus on promoting the potential healing and transformational experience to the children and young people they care for, with a focus on the child’s right to quality care and relationships that are enduring. Carers are often recruited with marketing that focuses on the ‘giving’ or nurturing nature of the caring relationship rather than the costs or challenges of this commitment (See Appendix 1).

3.3.1 Carers in OOHC in New South Wales. The increase in the numbers of children coming into care has led to significant pressure on the NSW OOHC system to meet this demand with an increase in the number of available placements. A range of factors have led to this heightened demand, including the reduction in the placement options (as residential options are no longer deemed generally suitable), the increasingly demanding characteristics of the young people and children entering care, and the emphasis on children’s need for stability (Bromfield, et al., 2007). This is compounded by the problem of recruitment, retention and training of appropriate
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carers for young people and children in care; a problem recognised as an international challenge (Barber & Gilbertson, 2001; Victorian Department of Human Services, 2003; Young, 2004; FAHCSIA, 2008; Family Relationships Australia, 2008). A range of factors have been identified as contributing to this chronic difficulty including the return of women to the workforce in greater levels of participation (i.e. reduction in traditional personnel sources for carer work), the poor carer remuneration, the increase in expectation and accreditation standards for carers, and the attrition of existing carers (McHugh, 2003; Siminski, Chalmers, & McHugh, 2005).

“It is of concern that the trend in foster care, particularly in NSW, is to use the least trained and resourced persons (kin) to foster. In the light of the persistent and widespread findings on the level of increasing need of children coming into care and the inequitable financial and social supports provided to kin carers it would appear that ‘less care’ is being taken by statutory authorities to provide the best possible option for children and young people requiring OOHC”. (McHugh, 2003)

Agencies (both government and non-government) in NSW providing OOHC have a responsibility to meet legislated standards related to the selection and management of carers (i.e.: foster/kinship carers or paid residential workers). These standards are monitored through the accreditation process auspicied by the NSW Office of the Children’s Guardian. Essentially these standards provide direction on the minimum and enhanced standards for a range of service related delivery processes and actions. These activities in relation to selected carers include the recruitment of appropriately qualified and experienced carers, along with the provision of suitable training, debriefing, supervision and professional development matched to the demands of their role. The standards also particularly mention the
need for carers to have access to clinical consultation to ensure that appropriate structures and resources are in place to adequately support carers in their work (http://www.kidsguardian.nsw.gov.au/accreditation/nsw-out-of-home-care-standards, 2013).

As a result of the Report of Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008) and the work of the Children’s Guardian in mandating standards for carer selection, there are varying screening systems for carers within NSW. These varied systems however share common reference to, among other indices, social and emotional history, personal resources (living and social environment) and problem-solving capacity. Specific tools for the screening and assessment of carer profiles are often discussed within the context of a broader framework of placement and intervention support. Most current frameworks for screening and assessment of carers promote a structured judgement approach (Robinson & Moloney, 2011). Screening currently is completed by the agency (either government or non-government) providing the service at the point of recruitment or placement determination. It may be completed by one or more professionals, and usually relies on a combination of gathering historic information, reference checking and interview.

The NSW Department of Human Services’ (Department of Families, Housing, Community Services and Indigenous Affairs (FAHCSIA), 2008) current eligibility requirements for foster carers specify that anyone who is over the age of 18 years, an Australian citizen or permanent resident, and in good health can apply to become a foster carer. FAHCSIA (2008) specifies that eligibility criterion requires individuals to be: (a) single, married or in a de facto or same-sex relationship; (b) renting, buying or owning your home; (c) working (full- or part-time) or not working; (d)
from any ethnic or cultural background and with a diverse range of life experience; (e) a parent or have a strong interest in helping children and young people; and (f) younger or older (FAHCSIA, 2008). Age requirements are flexible as long as health, energy, maturity and desire to foster are assessed as suitable to meet the needs of the child.

The primary screening processes for paid staff within NSW relate to agency interviews targeting knowledge of work role and values compatible to the provider, along with police checks for criminal history (Office of Communities; Commission of Children and Young People, 2013). In general the practice has been for carers to be encouraged, once selected by an agency, to develop desirable characteristics in their relationships with young people through the exposure to an agency’s policy or ‘code of conduct’ material, or electing to participate in targeted training. The carer populations most difficult to recruit and retain include those living in rural areas, males and Aboriginal carers (Cortis, Chan & Hilferty, 2009).

Many aspects of the existing screening systems are noted as problematic, and a number of tools have yet to be evaluated (Robinson & Moloney, 2011). Key dilemmas identified by Robinson and Moloney in evaluating the use of screening and assessment tools include: validity, and cultural sensitivity; inter-rater and rater reliability of the measurement; and accountability and effectiveness. Clinical practice and research in the area of carer screening are currently hindered by a lack of quality evaluations of the psychometric properties and standardised procedures of existing tools (Rabin, Jennings, Campbell, & Bair-Merritt, 2009).

Currently, there is no independently maintained evidence-based monitoring of carer assessment or capacity tracking within NSW. Furthermore, even though a
growing number of tools have been tested for their validity and reliability, few have been tested independently (Hanson & Poston, 2010). There is no industry agreement on a “gold standard” of measures and procedures by which to test sensitivity, specificity and overall effectiveness of such tools to accurately predict the capacity of carers to care against measurable outcomes (Rabin et al., 2009). The call for more refined ‘screening’ remains a discussion within the industry, and most particularly during 2012 in the wake of ongoing restructuring of the NSW OOHC sector funding and agency contracting process (ACWA conference forum, 2012).

Anecdotal evidence suggests that family relationship and child service providers are drawing on experience and judgement to create and implement a range of tools that meet the varied needs of their clients (Robinson & Moloney, 2011).

Despite the current issues and challenges related to the direction and validity of the use of screening tools within the OOHC sector, at its core, screening systematically acts to cull carers in relation to alerts related to incompatible reported lifestyle choices, legal status or belief systems, rather than profile information related to the specifics of caring capacity. Currently, none of the carer screening tools specifically addresses aspects of the carer’s psychological profile. In terms of tool development, there is some practice evidence of psychological screening tools gradually being introduced within the residential or paid staff sector of youth services by some agencies linked to broader ‘human resource recruitment’ tools.

These moves appear driven by the combined pressure of Workplace Safety legislation, along with agencies’ desires to be competitive.

### 3.3.2 Aboriginal carers.

The problem of the high demand for carers is exacerbated in the area of Aboriginal and Torres Strait Islander children, who are 10 times more likely to be placed in OOHC (AIHW, 2011-12). There is a shortage of
culturally appropriate placements to support Indigenous children. Even with intensive recruitment efforts, undertaken by various government and non-government agencies, sufficient numbers of carers cannot be located to meet demand (Fejo-King, 2012).

In the context of supporting children and young people in OOHC, and especially those who are Aboriginal, the importance of maintaining connection with the culture of the family of origin is widely acknowledged despite limited research evidence (Atkinson, 2013). It has been argued that families (birth relatives) mediate personal identity, community and culture, and that community membership and a feeling of cultural belonging assists to build resilience of individuals. It is also broadly recognized in research evidence that families, irrespective of culture affiliation, share key goals and aspirations for their children related to their health and survival, teaching skills in economic survival and imparting cultural beliefs (Le Vine, 1988 in Kolar & Soriano, 2000, p. 5).

The importance of promoting Aboriginal placement options for Aboriginal children and young people acknowledges that there are a number of differences in the ways that Aboriginal and Torres Strait Islander families interact compared with non-Aboriginal families. These differences need to be understood within an historical and cultural context (Libesman, 2013). It is important to view these differences in family functioning and family relationships or parenting styles, as culturally specific issues that are influenced by history, geography and experiences (Kolar & Soriano, 2000; Atkinson, 2013). Aboriginal and Torres Strait Islander families view their structures and relationships differently from Western traditions; for example, each child can have several "nannas", and each female in an extended family can be "nanna" to many children (Walker & Shepherd, 2008). The majority of
non-Indigenous families within the Australian context do not express themselves in this way.

When looking at the structure of the Indigenous family functioning there is also a need to recognise the extreme diversity that has been a feature of the majority of communities, in terms of trauma, disruptions to family structures and geographic isolation (Walker & Shepherd, 2008). An estimated 50% of Aboriginal families in areas of extreme isolation live with two original parents, compared with 3% in the Perth metropolitan area (Silburn et al., 2006). Aboriginal families are generally more mobile than other families (Australian Bureau of Statistics [ABS], 2001), with complex mobility patterns, particularly in rural and remote areas (Memmott, Long, & Thomson, 2006). For example, Aboriginal children in Western Australia are estimated to have lived in an average of 3.2 homes by six years of age (Silburn, et al., 2006; Walker & Shepherd, 2008).

The importance of placing Indigenous children in culturally appropriate homes has been identified as a key policy guiding Australian child protection; however, the challenge of recruitment of Indigenous carers is consistently raised in the research and statistics around family support and caring services (Australia Catholic Welfare [CWA], 2006; Cortis, Chan, & Hilferty, 2009; FAHCSIA, 2007; Family Relationships Services Australia, 2008). Difficulties in recruiting Indigenous carers is reported throughout child and family services, and across community services, suggesting shortages may be so widespread as to be chronic in nature (Australian Services Union, 2007; Flaxman, Muir, & Oprea, 2009). One of the primary contributing causes to the challenges in engaging carers and more generally addressing the increasing rates of Indigenous children in OOHC, was presented by the Aboriginal Child, Family and Community Care State Secretariat (AbSec) in their
submission to the Wood (2008) *Special Commission*, as the lack of state funding of ‘community controlled Aboriginal agencies’ (AbSec, 2007). The AbSec submission highlighted it’s perception of NSW as a State that had fallen behind Australian standards, through pro-active divergence of funding in the OOHC sector to non-Aboriginal or church-based agencies resulting in a neglect of the needs of the Indigenous children and families. Retention of Indigenous carers is another area of significant concern. The suggestion that workloads and community expectations combined with limited informal support combine to create problems around retaining Indigenous carers who simply burn out (CWA, 2006; Flaxman, et al., 2009).

An added layer of complexity in trying to establish how to best structure OOHC for Indigenous peoples relates to a long and fraught history with white researchers. There has been a wide distrust of researchers by Indigenous communities worldwide (Cochran et al., 2008). Research processes are often based in Western methodology that fail to recognise trans-generational and historical trauma (Cochran et al., 2008; Hill, Lau, & Sue, 2010; Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011). The concern around the potential for Indigenous people to be damaged by the process of participating in research appears to be a barrier for engagement, which has deterred and in effect limited research activity (Libesman, 2013). Within the field of research into OOHC, Indigenous carers have been viewed as particularly vulnerable, as many carers may live with the trauma of having been removed from their home, and the process of research triggering older and deeper traumas (Quirk, 2012). Brown (1995, as cited in Quirk, 2012 p. 50) puts it clearly, “How many layers of trauma are being peeled off by what appears initially to be only one traumatic event or process?”
Research investigating areas which problematise any population have particularly low quality data and poor statistics, and this is the case across various Indigenous communities (Cochran et al., 2008 p23). As Cochran et al. (2008) sum up, “No community wants to have the reputation of having the most alcoholics or the most people with mental disorders.” In Australia, early research with regard to Indigenous communities constituted classifying and labelling in an attempt to manage Aboriginal people (Cochran et al., 2008). It is not surprising then that researchers are viewed suspiciously and the ability to collect reliable and consistent data is compromised (Kendall et al., 2011; Libesman, 2013).

None the less, some mainly qualitative research projects have been undertaken to better understand the dynamics and contributing elements for Indigenous peoples in “building stronger families and individuals” (CRCAH, 2008). One of the consistent and reoccurring findings from such studies is the attribution of awareness and practice of cultural traditions as a protective and supportive element to individuals. It is clear that there exists significant variation in the experience of Indigenous children and families (Butler, Hopkins, & Nivison-Smith, 2009). Within the research around the variable demographics and the profile of unmet need, one of the essential gaps in current understanding of the carer population is the psychological profile of Aboriginal carers in the same way that it is missing in our understanding of carers in general.

3.3.3 Male carers. Men as carers are difficult to attract to the sector, deterred by the ‘sex-typing’ of work involving emotional engagement, and the associated pay penalty (Cortis, Chan, & Hilferty, 2009). The practical implications linked to the limitations of male participation in the carer roles are significant when looking at the ‘raising’ of children in OOHC systems. There is clearly the need for children to
experience the formation of positive, safe attachments and role models with carers of both genders (Redshaw, 2010). This is a particular challenge for children who are working to recover from traumatic childhood experiences, or who have specifically experienced domestic violence (Hattery & Smith, 2012). An undersupply of male carers or professionals has implications for service delivery, often compromising capacity to offer specialised educational and therapeutic programs for fathers and other male carers (Meagher & Healy, 2005; Young, 2004).

The benefit and correlated profile variables of males with high resilience has been explored by Andersson and Ledogar (2008) who focused on the linkage between reduced engagement in violence and personal volatility, and high resilience scores in males. This trend has been investigated from an international perspective with comparative assessments across cultures (Andersson & Ledogar, 2008). This work linking higher resilience scores to reduced expressed aggression appears to hold interesting implications for the screening and support of male carers in the context of OOHC.


The existing continuum of OOHC service options within NSW are currently funded by Community Services to meet the needs of the children and young people requiring OOHC. Ageing Disability and Home care, another NSW Government Department, provide OOHC for children and young people with a disability aged from birth to 18 years. The following range of OOHC options exist in NSW.

Foster Care: In 2010-2011 the majority of children (93%) in care in NSW were in home-based care, being either foster care (45%), or relative/kinship care (46%) (AIHW, 2011). Foster care is provided by a range of people and includes families, single parents, Indigenous carers, men and women as well as same sex
couples, and a broad range of family group arrangements. A foster care household is a private household containing one or more foster carers, who have undergone appropriate screening, have received authorization and reimbursement, and participate in reviews of the relationship on an ongoing basis (AIHW 2011-12). The existing models for foster care in NSW are multi-dimensional and range from short to long term and from low support care to foster care delivered by professionals on a fee for service or contract basis.

**Relative/Kinship Care:** Relative or kinship care arrangements are a form of OOHC where the carer is a relative (other than a parent), considered to be family or a close friend, or is a member of the child or young person’s community, who is reimbursed for the care of the child. For Aboriginal and Torres Strait Islander children, this definition may apply to other Indigenous persons who are members of their community, or a similar community or from the same language group (AIHW, 2011-12).

The term Home-Based OOHC can be applied to both of the above groups (foster, relative or kinship care), and can be applied whether or not reimbursement has been accepted. McHugh (2003) examined the issues around the financial management of Home-Based OOHC, and found options for government subsides limited and inadequate. McHugh linked her findings to that of other international researchers, warning that this apparent exploitation of carers was placing children in care at risk of greater neglect by placing them with families without adequate resources (McHugh, 2003, p. 4).

**Residential Care:** In NSW in 2010-2011 approximately 7% of children in care lived in residential placements (AIHW, 2011). The numbers of children and young people in OOHC residential services in Australia is substantially lower than in other
Western developed countries (Bath, 2002-3), due to the reform agenda described above, and specifically linked to perceived costs savings to government (McHugh, 2003, p. 5). The decision to place young people and children into residential placements is currently usually based on the level of complexity in their presentation, and the capacity of carers to sustain support. Essentially residential care is defined as being provided in a building whose purpose is to provide placements for children, and where support is provided by paid staff (AIHW, 2011-12).

It is also important to note that, although they are not specifically funded as therapeutic programs, a number of the residential services have adopted an integrated framework for intervention into the residential program. These examples vary greatly in relation to effectiveness and the applied level of comprehensive implementation and clinical monitoring, and currently do not operate under a shared framework (FaCS OOHC service specification template, 2012).

*Intensive residential:* The range of residential models established within the states and territories should also be noted as variable, with staff ratios, environments and co-resident numbers differing between services and specific funding agreements. Within NSW, the intensive residential placements tend to be designed around the needs of individual young people who have returned an assessment that prescribes specified criteria of funding.

*Therapeutic Intensive Residential Care:* The NSW Government has described Therapeutic Intensive Residential Care as one element of its comprehensive suite of options in a comprehensive OOHC service model. At this stage it should be noted that there currently exists a specific service gap in relation to the funding of such a facility. Currently the ‘High Needs Program’ fills this gap by providing a funding program over and above the conventional residential program, targeted at support of
young people assessed as having high and complex needs (FaCS OOHC service specification template, 2012).

Disability support services: For children and young people with a disability a parallel OOHC system exits administered by Ageing Disability and Home Care (ADHC). Current accommodation models offered by ADHC for children and young people with a disability aged from birth to 18 years include: family/kinship placement—placement with the child or young person’s birth family or kinship group; shared care where support is shared between the child or young person’s birth family and an alternative family or group home; foster care—placement with an alternative family; specialist foster care—placement with an alternative family with the provision of additional support services for the child or young person and the foster carers; group home accommodation support—accommodation for 4-6 people with a disability in a community setting; specialist accommodation support—community-based accommodation for children and young people who have very high and complex needs requiring specialist support services. These last two options may be available to children less than 12 years of age, dependent on discussions involving the Regional Director, the Deputy Director-General and the Children’s Guardian (Prevention and Pathways Directorate, 2012). The NSW Children’s Guardian is established under the Children’s and Young Person’s (Care and Protection) Act 1998. The Guardian reports to the Minister for Family and Community Services, and regulates the provision of OOHC, regulates non-government adoption service providers, registers agencies that provide voluntary OOHC and authorizes paid employment of children under 16 years (The Children’s Guardian – Annual report, 2011-12, p. 4).
Children’s respite services have been established within each of the Aging Disability and Home Care (ADHC) regions, providing periodic and regular short-term respite accommodation to assist families who have children with a disability. These services are often services that are charged with initial short term care of a child or young person with a disability when their family situations are no longer tenable (FaCS ADHC Stronger Together 2 Annual Report, 2011). The current models of support for children and young people within ADHC have essentially evolved in response to the needs of specific children and young people with a disability as their requirement for suitable permanent care has emerged, generally through family breakdown. The placement of children and young people into respite as part of their movement into care is acknowledged as often traumatic and difficult. ADHC respite services are not designed with capacity to meet these specific placement needs and consequently the regions in which these placements occur often seek partnership with NGOs to support the placement of children and young people. The range of programs available varies significantly between regions within NSW (FaCS ADHC Stronger Together 2 Annual Report, 2011).

The current study is concerned with investigating the psychological profile of carers who provide care within the Foster Care, Family or Kinship Care, and Residential Care options for OOHC within NSW. The following section discusses the theoretical context in which care in NSW is currently understood.

5. Theoretical and Practice Models in OOHC in NSW

The acknowledgement of the importance of Attachment Theory in understanding child and adolescent development has existed as a key driver of the theoretical and practice models across the NSW OOHC sector (Schmied & Tully, 2009). There is evidence across both government and non-government agencies of
programs designed to support and guide carers through the implementation of relational models to facilitate child attachment. For example, The Circle of Security and Circle of Repair (Dolby, 2007) builds on Attachment Theory as a way of training parents and carers in responses that will support the child’s recovery. At the core of these models is a focus on training carers to support the child’s ability to regulate emotions, thoughts, and behaviours. To assist the child to achieve his or her own regulation, these approaches maintain it is critical that those in parenting roles observe and model regulation in their own conduct as well as in the conduct of adults around them. Ideally in this approach, carers receive adequate counselling and training to manage their own anxiety and intense emotions in order to remain calm, take charge of situations, remain positive and available while any issues or events are problem-solved to resolution. What is, however, common in the analysis of the literature, is the consistent focus on the formulation of a model to reflect the related theory, rather than systematic evaluation of the application in practice (Michelson et al, 2013). Many of the researchers acknowledge this gap in evidence of measureable outcomes for either carers or the children and young people they care for, and reference the need for such assessments or longitudinal studies (Kazdin, 2008). It appears in analysis of the literature discussing the importance of emotional regulation, the specific context of the carer’s psychological profile is not explicitly examined, but rather their capacity inferred through interaction skills or deficits.

In terms of related activities within NSW, a number of significant models that combine elements of cognitive behaviour therapy (CBT), applied behavioural analysis (ABA), dialectical behaviour therapy (DBT), attachment theory, and related theories, have been implemented in non-government and government agencies. The following intervention models have received varying levels of attention and use
within the sector: Therapeutic crisis intervention (Holden & Powers, 1993; Nunno, Holden & Leidy, 2003); Life Space Interviewing (Brendtro & Long, 2005; Long, Fecser, & Wood, 2001); Collaborative problem-solving (Greene & Ablon, 2006; Greene, Ablon, & Goring, 2003; Greene, Ablon, Goring, Fazio, & Morse, 2004; Greene, Ablon, & Martin, 2006); Applied Behaviour Analysis (LaVigna & Willis, 1995; LaVigna & Donnellan, 1995); Resilience and Strength-based frameworks (Atwood, 2006; Dearden, 2004; Gilligan, 2006; Legault, Anawati, & Flynn, 2006; McCreanor & Watson, 2004); Parent management training (Bloomquist, 1996; Kazdin, 1997; 2005; Webster-Stratton & Herbert, 1995) and Parent-Child Interaction Therapy (Barth, Crea, John, Thoburn, & Quinton, 2005; Borrego, Urquiza, Rasmussen, & Zebell, 1999; McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Fernandez & Eyberg, 2009; Timmer & Urquiza 2014; Timmer, Ho, Urquiza, Zebell, & Fernandez, 2011).

Schmied and Tully’s (2009) practice review guide paper suggests that from the perspective of the NSW Department of Community Services, the practice models could be described as falling into three categories: Adolescent focused intervention (individual therapeutic approaches – Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Group interventions.); Parent focused interventions/programs (parent supervision and training); and Family focused interventions (Functional Family Therapy (FFT), Brief Strategic Family Therapy (BSFT), Multidimensional Family Therapy (MDFT), and Multi-systemic Therapy (MST). Significantly, none of the interventions canvassed in the review acknowledged any direct or targeted assessment or support/intervention to address carer psychological profile or needs. The discussion around options for Family
Therapy centred on the identification and management of behavioural dynamics and interactions, and all interventions highlighted focused on brief short-term engagement.

Although notably absent from the meta-analysis consideration discussed above in the context of such programs in NSW, it appears that the role of applied behavioural analysis and intervention design, particularly in the context of multi-element intervention models, remains consistently acknowledged within FaCS policy (FaCS *Brighter Futures Practice Guide Paper*, 2008), as a prominent clinical framework to guide practical support to many therapy and intervention programs. It is however notable that applied behavioural analysis and intervention is generally presented as most applicable in the form of ‘carer discipline models’, the treatment of anti-social behaviour in children, fundamental in the framework of psycho-educational packages and parent management training (Kazdin, Siegel, & Bass, 1992; Stewart et al., 2012).

Related to the three practice models (Adolescent, Parent and Family focused) that have demonstrated efficacy according to Schmied and Tully (2009), are a range of trauma recovery systemic models including the Sanctuary (Bloom & Farragher, 2010) and ARC model, the latter of which has been adopted in several services offering OOHC in NSW over recent years (e.g.: Impact Youth Services, Sherwood House and Catholic Care Broken Bay), and which has as a pivotal component a focus on carer’s capacity, along with intervention skills. Developed in 2005, the Attachment, Self-Regulation and Competency Framework (ARC model) model has evolved from the work of influential clinicians, including Kagan (2007a), Lieberman and van Horn (2008) and, as the name implies, identifies three core areas that are impacted in traumatized youth, and which are understood to be directly linked to
future resilience (Kinniburgh et al., 2005). Because of its growing presence in the NSW OOHC sector, it will receive separate attention.

The ARC approach is seen to be of benefit to the client population in the OOHC sector, because it is understood that many of the children and young people who have come into the system have often done so as a result of traumatic circumstances. It also focuses on the development of resilience, a quality understood to be a protective factor in the face of adversity (Ungar, 2010). Furthermore few models of intervention combine the need for treatment and trauma recovery processes for the individual, in concert with strategies to assist in enhancing the capacity of the “caregiving system” (Blaustein & Kinniburgh, 2007, 2010). As for many of the models discussed above, the ARC framework focuses attention on the functional impairment and emotional deficits created by trauma exposure in childhood. It provides a menu of strategies under the framework of achieving 10 core “building blocks”, within the three broad domains (Attachment, Self-Regulation and Competency). The model clearly itemises the elements of importance required in “re-building” safe relational systems. “In the context of the safe system, the model focuses on skill-building, stabilising internal distress and enhancing regulatory capacity in order to provide children with generalisable skills which enhance resilient outcomes” (Blaustein & Kinniburgh, 2007). A diagrammatic representation of the ARC Model follows.
Figure 1 - Adapted from Kinniburgh et al., 2005 p 426.

Figure 1 demonstrates the integrated nature of the ARC Model, and the core elements or building blocks for targeted intervention. The concept of the need to address the needs of not only the individual but also the family and the system supporting the intervention is expressed.

As illustrated in the diagram above, the three domains are made-up of both content and process elements. Many of the specific elements of both impairment focus and process development noted within the ARC model are common to other theoretical models or practice manuals discussed above. Within the ARC model the Attachment domain targets the caregiving system, with a focus on four key elements:
(1) The caregiver’s ability to recognise and regulate their own emotional experience; (2) The carer’s ability to be attuned to appropriately read and respond to the child’s cues; (3) The ability of the carer to appropriately manage the child’s behaviour in the context of their current skills and capacities; and (4) The carer’s ability to provide consistent routine and rituals (Blaustein & Kinniburgh, 2010, p. 37).

The Self-regulation domain focuses on assisting the child to re-build their ability to cope with emotions and feelings. There are three key elements in the model to be attended to: (1) The child is assisted to identify emotions, where they come from and how they impact daily; (2) The child is supported to develop a capacity to tolerate and modulate their emotional arousal; and (3) The child is assisted to establish networks for sharing their feelings and thoughts, in safe sustainable ways (Blaustein & Kinniburgh, 2010, pp. 38-39).

The Competency domain has a focus on reclaiming the child’s skills in many areas of skill and developmental milestone development. There are three key areas of focus: (1) The child is supported to develop problem-solving skills (central to this work is the establishing of an understanding of actions and outcomes, and the evaluation of choices); (2) The child is supported to build a positive and unique sense of self; (3) The child is supported to achieve life skills development matched to their age and stage, with a focus on achieving mastery and confidence (Blaustein & Kinniburgh, 2010, pp. 40-41).

The intervention models discussed above, along with a number of specific models of therapist directed treatment, including Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT), Schema-Focused Psychotherapy (SFT), Transference-Focused Psychotherapy (TFP), Mentalisation Based Therapy (MBT), and Cognitive Analytic Therapy for Youth (CAT), share the ability to yield
positive outcomes, but no single treatment type emerges as superior (Grenyer, Helyer & Bargenquast, 2013).

The model or theoretical frameworks provide a ‘road map’ and language to support intervention. In essence, the models, in the main, attempt to simplify the care demands or expressed needs of the child, and the targets (signposts) for achieving safety and recovery of the child in care. The system models expressed in the context of NSW OOHC are generally in practice eclectic, and practitioners are encouraged to be inclusive of therapeutic orientations, and to use multi-element and collaborative care planning (Schmied & Tully, 2009). The common focus of most models to a greater or lesser extent, is to integrate aspects of in-situ skills development and practice (Grenyer, Helyer & Bargenquast, 2013). This active context practice requirement with a focus on the ‘tools’ of the carer, in application of skills, clearly draws the focus again to the nature, and capacities of the carer to care.

5.1 Facilitating trauma recovery in the context of OOHC. In recent years, evolving practice has seen the establishment of overt linkages between various psychological and neurological theoretical frameworks showing the impact of trauma over the long term. This has resulted in intervention models such as the ARC Model, which are concerned with ‘trauma-focused’ or ‘trauma-sensitive’ care. There is currently great interest in applying trauma and attachment theory to clinical and out-of-home care settings (Blaustein & Kinniburgh, 2010; Cairns, 2002; Cloitre, Koenen, Cohen, & Han, 2002; Cohen & Mannarino, 2004; Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, Murray, & Igelman, 2006; Crenshaw & Hardy, 2007; Hardy, 2001; Hardy & Laszloffy, 1995; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; Terr, 1992; Perry, 2010; Kazdin & Rotella, 2009).
At the core of these frameworks is the imperative to design interventions that respond to the child or young person’s trauma responses (e.g. anxiety, dissociation, hypersensitivity) and an awareness of the impact of early trauma on brain development (e.g. sensory impairment, cognitive delay, emotional dysregulation). The common target of these programs is to achieve secure and stable attachments, within safe and responsive environments. The underlying belief is that with the achievement of stability the child will be able to ‘recover’ their functional skills and learn enhanced capacities (Blaustein & Kinniburgh, 2010).

In the case of children and young people in OOHC, particularly those who display a range of complex and challenging behaviours (primarily those identified as having high complex needs), it is acknowledged that intensive support will be needed by carers to enable them to manage these young people, and also by the young people themselves to help them manage their anxiety, grief and loss (Redshaw, 2010). The way this ‘intensive support’ is characterized within meta-analysis reviews of the literature suggests support to carers in the form of packaged ‘skills focused training’ or broader family or community intervention (Villarruel, Borden & Lerner, 1994; Karabanow & Clement, 2004; Schmied & Tully, 2009).

The models examined in these studies are often limited by their narrow experience of program type and the time limited focus on outcomes. These studies also seek to report outcomes based on demographic evidence of outcomes such as program attendance or completion, intervention program being sustained. The clear gap in the evidence provided by these studies is research that seeks to describe the nature of the carer psychological profile and targeted supports or intervention to address these specific needs as a means to achieve positive gains in capacity.
6. The Current Study

In acknowledging the current pressures on the OOHC sector and the complexity of issues facing care for vulnerable children and families, the current study seeks to better understand the actual capacity of carers through the investigation of their psychological profile. The current study is particularly concerned with the impact of trauma, the importance of resilience, and understanding how these relate to carer expectation. The study is focused on the carer, their experience and beliefs, premised on the assumption shared with many of the current models of care, that these relate to carer capacity to care.

As outlined through this introduction, the issues facing government and welfare agencies charged with the task of responding to the growing number of family breakdowns involving child protection issues is alarming. It is clear that NSW is in a difficult situation related to the large numbers of both Indigenous and non-Indigenous children in care, and with a nuanced history of reforms having a profound impact on the shape of OOHC services. To date, much academic and policy attention has been concerned with the growing cost of providing care and the development of theoretical models that might be able to respond to the diversity of needs of children in care. Research has sought to profile the needs of children and young people, and design supports and interventions to meet these needs. However, to date, very little attention has been focused on the capacity of those charged with the responsibility of caring, and taking up the significant responsibility of raising these children in our community. The following chapter outlines how the thesis seeks to build on the current literature in relation to the questions of what impacts on carer capacity to care, and frames the key research questions for investigation.
Chapter 2: Carers and Capacity to Care

What we know so far, and what remains to be investigated.

1. Introduction

This study is primarily concerned with the exploration of the psychological dimensions of carers in relation to capacity to care for children in the Out-Of-Home Care (OOHC) sector. The core focus is to examine the relationship between psychological primary trauma, resilience, and expectations of people providing care to children and young people with complex care needs in Australia, and specifically New South Wales.

The role of the carer is pivotal in OOHC provision and a considerable body of literature correlates characteristics of carers with longitudinal impacts on the lives of children and young people in OOHC, stressing the functional importance of the carer role (Redshaw, 2009a; Budd, 2005; Cleaver, Unell & Aldgate, 2011). Children and young people want carers who are empathetic, affectionate, and spend time with them (Mason & Noble-Sprull, 1993); recognize their uniqueness, their skills and needs (Meichenbaum, 2012); and are tenacious “… willing to ‘hang-in-there’ regardless of the child/young person’s behaviour” (Redshaw, 2009a, p. 33). The critical elements of parenting capacity that would support achieving the needs of children as being carer resiliency, parenting skills and knowledge, ensuring safety, ability for attachment and bonding, and the ability of the parent to provide guidance and supervision to the child (McConnell & Llewellyn G, 2000).

The centrality of the caring role has seen increasing resources directed toward family support services in many jurisdictions (McConnell, Breitkreuz, & Savage,
2012). As discussed in the previous chapter, in the first instance, support responses are directed at keeping the family together. However, when the family of origin is unable to care for a child or young person, the OOHC sector must care and protect those children most vulnerable in our community. As explored in the previous chapter, despite increased resources and development of programs to support families, the number of re-notifications and re-substantiations continues to rise in Australia (AIHW, 2011). Thus, current interventions are not resolving the range of problems that affect the abilities of some parents or carers to provide a sustainable level of care. US research conducted by Geiger, Hayes and Lietz (2013) on the retention of fosters carers found that support, locus of control and systemic issues were key, as was the need to take carers and their needs seriously by researching how best to tailor relationships between support services and carers. In particular, research is needed that better understands intentions or expectations of carers, and what is needed to support and retain those carers in this essential role (Geiger, Hayes and Lietz, 2013).

Prominent researchers have highlighted variables related to the carer role in a number of recent studies that have identified the significant impact of carer mental health, alcohol and substance use and abuse, carer disability, the presence of domestic violence in the home (Cleaver, Unell & Aldgate, 2011), and the impact of intergenerational trauma experience (DeGregorio, 2012). Further, the importance of carer experience, along with their expectations or perceptions of those in care, have been acknowledged as critical (Ayalon, 2011; McElroy, 2009; Moller-leimkuhler, Weiss, 2012; Wiesheu, 2012; Meichenbaum, 2012). There is an emerging awareness of the potential limitations of a system where the sole focus of programs is managing and responding to the expressed needs of the children and young people. It is
increasingly clear that the nature or quality of the relationship between the carer and the child is pivotal and the foundation of any intervention. Barlow and colleagues (2013) in a meta-analysis of factors associated with the capacity to care or be successful parents, found that the ability of carers to form positive stable attachments through the display of empathy and emotional regulation, resilience, and nurturing skills in the carer role are pivotal in capacity to care, and similarly that indicators such as a history of primary trauma, challenges to mental health and wellbeing issues were factors seen to diminish caring capacity.

Evidence-based treatment models of care consistently refer in their parenting guides and training modules to the challenges confronting the processes of better shaping the nature of parenting, parenting styles and carer behaviours that improve observable behavioural outcomes in children and the parent-child relationship (Kazdin, 2009; Sanders, 2008; Cleaver et al., 2011; Meichenbaum, 2012). Much attention within OOHC programs internationally is currently given to parenting skills, while neglecting to include a focus on who the carer is or what their psychological profile of strengths and challenges might be. It is interesting that emerging recent (Ali, 2012) and proposed studies within the context of the NSW OOHC sector are focusing on the impact of case worker (secondary support/consultants to primary carers) profiles on capacity to care related to their reported trauma profile. This focus of recent work has largely been born out of concerns regarding vicarious trauma, mental health issues, burn-out, and high staff turnover, and as such, align as similar pointers to the necessary investigation of the underpinning resources of those charged to provide frontline intervention or primary care to high needs children and young people.
Those researchers and practitioners concerned with parenting have tended to focus screening and assessment around the nature of the carers’ reported current life situations or home contexts, the nature of the models of intervention and checking for those skills necessary for adequate parenting (Kazdin, 2003; Kazdin & Rotella, 2009, 2010; Meichenbaum, 2012). Essentially, the capacity of the carer to provide the care suitable to meet the needs of the child, along with those factors that circle dysfunctional family systems or high risks of harm or neglect, have been the factors driving preventative support and intervention modelling (Ungar, 2010; Meichenbaum, 2012).

There are serious gaps in the research regarding the understanding of what drives and maintains carer capacity to care, and further a scant focus on the impact of psychological states, or actual functional behaviours, or abilities to carry out practices expected in caring relationships. Kazdin (2003) highlights the ongoing need for studies that explore the moderators in the capacity of carers to benefit from and incorporate the resources, programs and plans designed with and for them, toward successful outcomes for children and young people in their care. It is clear that Kazdin links the capacity of carers and their assessed abilities to the opportunity to improve outcomes by educating, training and developing optimal, research supported, effective parenting skills.

This study takes as its starting point, current research on essential psychological characteristics that have been found to enhance or hinder capacity to care for children in general, and children in OOHC in particular (Redshaw, 2009a; Kazdin, 2003; Kazdin & Rotella, 2009, 2010; Cleaver et al., 2011; Meichenbaum, 2012). Once the profile of essential child needs is established, it is the process of meeting those needs across the diversity of contexts that remains as the critical
challenge in equipping carers adequately and enhancing their ability for placement sustainably. In short, this study acknowledges the vulnerability of children and young people in care, while focusing on the capacity of their carers to care across the different placement categories of OOHC in NSW.

Understanding carer profiles within broader ecological contexts of any functional behavioural analysis or support intervention is referred to as “mediation” (LaVigna & Donnellan, 1986; Blaustein & Kinniburgh, 2010; Cairns, 2002; Cloitre, Koenen, Cohen, et al., 2002; Cohen & Mannarino, 2004; Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, Murray, & Igelman, 2006; Crenshaw & Hardy, 2007; Hardy, 2001; Hardy & Laszlof, 1995; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; Terr, 1992; Perry, 2010; Kazdin & Rotella, 2009). Mediation involves adapting or tailoring interventions to the real world contexts in which people live. The notion of mediation is common to the majority of the theoretical and intervention frameworks discussed in the previous chapter, and drawn from research into trauma recovery and support to OOHC placements (ARC, Family Therapy, CBT, etc.). The plans or interventions workers develop with carers need to be carefully designed so as to be practical, functional and possible for the carer to administer in the context in which they and their charges live (Meichenbaum, 2012). The child or young person focus is obvious. However, in order to most effectively mediate an intervention, knowledge of the carer and their context is essential. The concept of mediation is understood as integral to best practice and has been discussed in terms of evidence-based practice.

A fundamental consideration for the practitioner when reviewing any practice model is the concept of Evidence-Based Practice (EBP). EBP integrates current research and clinical experience with client profiles, ethnicity or cultural
membership, orientations, attitudes and values (Mesibov & Shea, 2010 Mozdzierz, Peluso, & Lisiecki 2010). Kazdin (2008) extended this definition to include evidence-based treatments (EBTs) to highlight the divide between research and practice and the extent to which we can actually infer and use research outside the experiment/laboratory, and amongst individuals cognizant of their differences (Mozdzierz & Peluso, 2011). According to Kazdin (2008; 2011), greater investment in understanding how mechanisms and moderators of change vary between groups and individuals would narrow the gap between research and practice. He recommends the addition of qualitative and mixed methods research to maximise contributions to best practice outcomes, including culturally sensitive EBTs. The divide between research and practice could be closed by adhering to the scientist-practitioner model (quantitative and qualitative) while remaining open-minded and flexible in practical EBTs (Kazdin, 2008; Machado & Silva, 2007).

Without evidence-based treatments (EBTs), intervention would lack predictable outcomes, and practitioners would lack continuity, validity and reliability in treatment standards options. The widespread practice of EBTs has enabled ongoing consistent care across agencies (Dizon, Grimmer-Sommers, & Kumar, 2012). This can be seen in practice, in the diagnosis, case formulations and quality of treatments for learning disabilities and behavioural issues (Berninger & May, 2011). When reviewing the literature around efficacy intervention for traumatised and neglected children there is a stark contrast between theoretical modelling and the limitations of ‘real world’ outcome-based research (Michelson et al., 2013).

To better understand how carers could access the information, support or learning offered through the various evidence-based support programs, the process of mediation requires information about the life histories and the experience of the
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carers. Often, little is known about the qualities or the experience of the individual carers, and how this experience has impacted on them, in comparison to the research on what characteristics are optimal in parenting or caring relationships. The psychological profiles of carers has not been thoroughly investigated beyond broad based statutory screening processes, which as discussed in the previous chapter, are ad hoc and variable. Information regarding adjustments that might need to be made or carer strengths that could be harnessed have been similarly limited in both practice and research. In exploring carer psychological profiles, the current study will contribute to the knowledge available to assist in best mediating plans for carers, their families and their support settings. Moreover, it is the intention of this study to investigate beyond the superficial expressions of carer demographics, contexts and functions to uncover key psychological profiles of carers’ capacity in the OOHC system; particularly the presence of trauma, resilience, and expectations in carer profiles.

2. Needs-Based Care

Australian policies concerned with the care and protection of children are clearly child centred, focused on the ‘needs’ of children and young people. These needs, at base, incorporate the Rights of the Child (Office of the United Nations High Commission for Human Rights, 1989), and the UN Declaration on the Rights of Indigenous People (Office of the United Nations High Commission for Human Rights, 2007), which does not include additional standards but an interpretation that is culturally appropriate and informed.

Brazelton and Greenspan (2000) listed the essential needs of children and by extension, qualities necessary for those with the capacity to care, as the ability of the carer to adapt to and supply ongoing nurture, protection from harm, be adaptable and
able to cater for individual and cultural differences in developmentally appropriate ways, and provide limit setting, structure, and a set of consistent expectations. Critical in their consideration of a child’s essential needs is the achievement of a stable, supportive community or network and the support of an experience of cultural continuity.

Having established these needs as fundamental to a child’s wellbeing and critical to their development, within a rights approach such as that promoted by the United Nations it is imperative to underpin interventions where needs assume the status of rights. Meeting the needs of children and young people in care requires particular planning and the continual application of attunement and resources. Like all children, the needs of children in OOHC match those expressed in the list presented above. However, they also have needs over and above those children who live with their own family. Their additional needs include stability and continuity, healing from the effects of the abuse, trauma and/or neglect they have experienced, connectedness with their family-community-culture (Ungar, 2010), and transition from care and aftercare support (Redshaw, 2010).

Redshaw (2008, 2009a) arrived at three essential conclusions regarding management of the OOHC experience. Firstly, that children and young people in care have a complex range of needs; secondly, they have little or no capacity to meet their own needs; and thirdly, they can experience significant harm (currently in their placement, on returning to their family or moving into independent living, and later in their adult lives) if their needs are not met. To ensure that the needs of the child or young person are met, a clear understanding of the range and scope of support requirements is critical. Many theoretical models have been framed around systems that address the needs of individuals and client groups. Redshaw (2010, pp 14) refers
to the Taxonomy of Needs summative tables that provide useful references for profiling the range of needs and intervention frameworks. Although, in practice, there is a growing general understanding and high field-based awareness of the dangers of OOHC services failing to meet the needs of children and young people and sustain appropriate support, there remains only limited investment in model implementation monitoring or individual child wellbeing assessment to track outcomes. Further, the process and tools of intervention mediation through the case plan and casework relationship (Dufour & Chamberland, 2004), environment (Brofenbrenner, 1986), and most importantly the carers and their capacity to care (Cleaver et al., 2011) are areas where limited work and evidence have been produced.

The Department of Community Services NSW has formulated protective factors in children and adolescents that highlighted the importance of connectivity to peers, schools and community networks, along with family functioning (Schmied & Tully, 2009; Villarruel & Lerner, 1994). This current trend in analysis acknowledges the importance of family and carers but does so within a systemic context of broader variables related to population resilience, while failing to discuss the prioritization or hierarchical framework of needs that support interventions for individual carers. Despite the notions of ‘parent or family focused’ interventions being raised by the government agency, there is only limited reference to interventions directed towards assessing and responding to the specific psychological profile or presenting context features of the individual carer (FaCS Annual Report, 2012). The attention to localised training or skills-based programs ignores the understanding of the primary personal and psychological qualities of carers. Recommendations yielded from program reviews clearly direct a proactive move away from intervention directed to
the individual, towards ‘community or neighbourhood’ or model-based approaches, with outcomes measured through tracking group profiles via demographic data and replication (Schmied & Tully, 2009).

3. Capacity to Care

The qualities of a competent and skilled carer have been variously listed through the development of many of the theoretical and practice models for parenting and child support outlined above. The essence of carer capacity is described as either assisted or diminished by various features. The capacity to care subsumes the ability to appropriately manage relational attachment, resilience, and self-regulation (Blaustein & Kinniburgh, 2007; Cleaver et al., 2011; Crawford, 2011), along with predictably and consistently demonstrating an ability to respond adequately and appropriately to the needs (i.e.: physical, safety, environmental) of children and young people (Redshaw, 2010).

“There is consensus that for the task of parenting to be performed effectively, parents need to demonstrate a mixture of warmth, control and stimulation of development in their behaviour towards children. For parents to do this most effectively, they need to be adaptable. This involves the ability to be perceptive, responsive and flexible in addressing their child’s needs” (White, 2005 p. 1).

Care as it is understood in the OOHC sector is concerned with; identifying family strengths and services needs, factors related to family risk of reduced parenting capacity, and help inform clinical judgment of practitioners performing parenting capacity assessments for forensic purposes (Crawford, 2011). Guidelines are most commonly used to assess parenting capacity and are designed to support the clinical judgment of caseworkers and clinicians. They include obtaining information from interviews, observation, and case histories and administering psychological
tests to assess various aspects of parent and/or child functioning (White, 2005). The capacity of the carer can be understood in terms of the resources carers have available to them both personally and structurally. In screening carers, agencies are concerned to ensure that structural resources such as accommodation, education, and physical needs can be met by the carer (Crawford, 2011).

Increasingly, attention is being paid to the resources the carer brings to their role in terms of personal qualities (Cleaver et al., 2011). The relationship of the carer with a child or young person is clearly critical and necessarily organic as it evolves through the milestones of personal, individual and family development. Hawes, Dadds, Frost, and Hasking (2011) and their colleagues have undertaken a number of research projects to better describe the interaction between parent and children with dysfunctional behaviours and presentations, a relationship not uncommon in OOHC.

In their recent work investigating the impact on children of carers described as having “callous-unemotional (CU)” traits, Hawes et al. (2011) identified a discernible impact and variation in and upon parenting style resulting from the experience of caring for these complex and high needs children and young people. In essence, carers’ interactions and expectations became negatively and defensively shaped by the experience of caring for children with damaged attachment or deviant behaviours (Hawes et al., 2011; Pasalich, Dadds, Hawes, & Brennan, 2011). The work undertaken by these researchers builds on the work of Kazdin and peers in seeking to describe optimal parenting behaviours or aspects of home context to match a continuum of children’s needs. In recognition of the centrality of the role of carer in the developmental lives of children and young people, there is evidence in both practice and research of efforts to develop the skills of carers with a particular
focus on parenting styles and teaching skills (Kazdin & Rotella, 2009, 2010; Blaustein & Kinniburgh, 2010; Sanders, 2008).

In analysis of the research related to parenting styles, and carer impact, the key goal has the common theme of identifying ever refined elements of the ‘needs’ of children and young people, and articulating the demands for specific and sustained carer presentation. In this sense, scholars and practitioners have been working to ever reduce the complexity of benchmarks for healthy, positive child development to be correlated to a set of optimized carer behaviours or characteristics that can be articulated, trained or coached, measured and replicated. Examples such as Triple P and the Kazdin Method represent two highly influential samples of research practitioner models designed to offer such a package of approaches to direct carer intervention. Currently, the work of Meichenbaum (2012) has added to the manualisation of critical training and intervention factors to be addressed in responding to and supporting trauma recovery. In the context of the study, the current challenge when approaching such packaged manuals or solutions is clear. What is missing is an understanding of who the carers are. The question around the underpinning psychological profile of the carers appears to be the obvious gap in the story, or the potential unknown moderator to support implementation of support services.

One of the most prominent intervention models that has gained traction in Australia has been the Triple P parenting training system (Sanders, 2008), (also known as Positive Parenting Program, and PPP) (Hoagwood, Cavaleri, Olin, Burns, Slaton, Gruttadaro & Hughes (2010); Sanders, 2008; http://www.triplep.net/glo-en/home), which targets parent or carer skills and behaviours via a facilitated practical educative course. Triple P is an evidence-based, multi level preventative
and treatment program for children up to 12 years. For children between the ages of 12 and 16 years there is the Teen Triple P.

Triple P has evolved over the last thirty years and, more recently, has expanded to target parenting of children and young people with high and complex needs. The key to this framework has been the program’s focus on observable behaviour, an understanding of the principles of human learning, Cognitive Behavioural theory (CBT), and a strong emphasis on empirical and evidence-based practitioner review. Although there continues to be debate in the research literature in regard to the efficacy of the intervention model (Fujiwara, Kato, & Sanders, 2011; McConnell, Breitkreuz, & Savage, 2012), the core elements focus on the proactive engagement of carers, both individually and in groups, supported through helpful practice. There is ongoing research around efficacy and effectiveness of the program.

The Triple P and other parent management systems have grown out of practice experience and research into what works to deliver outcomes for positive parenting. The Triple P program is based on a Trauma Focused Cognitive Behavioural Therapy model well supported by NSW Government review of therapeutic interventions, along with other current international authors (Kazdin, 2003; 2010).

3.1 Assessing capacity to care. The ability to assess and describe a carer’s capacity to care and meet the needs of a child or young person in a safe and sustainable way, has been a core challenge for practitioners and clinicians. The link between carer capacity and expectations of the care experience, above the profile or complexity of the person to be cared for, has been well established in research (Wells & Kendig, 1996; Geiger et al., 2013). Most of the current literature in this area focuses on assessments of parenting capacity in two contexts: case planning including service delivery, and court decisions about custody arrangements for
children. For case planning and service delivery, it appears that assessments tend to consider the needs of the child and the family within their context, and for court decisions, assessments focus on the more direct impact of familial and societal factors on the capacity of the parents or caregivers to meet the needs of the child (White, 2005).

A review of the literature shows there exists a range of frameworks conceptualizing the carer features necessary to support a child or young person. These conceptual frameworks or models have been largely built on the analysis of the developmental needs of traumatised children. Predominantly, assessments and practice tools focus on the role of parent/carer as that of ‘socialiser’. Identified tools are noted to be generally designed to capture the holistic review of the carer’s ‘socialisation’ capacity, social risk management, and access to support resources, or more specifically directed psychological assessments targeting specific symptoms and attitudes (Reder, 2003). The practice experience of the interaction between results from assessment tools, the focus on field-based practice decision-making, and the relative complexities of these being able to either describe or build any rationale for these frameworks, have led practitioners and researchers to question if comprehensive parenting capacity assessments are feasible in practice (Azar, Lauretti & Loding, 1998; Benjet, Azar & Kuersten-Hogan, 2003; Cann, 2004; Saunders & Goddard, 1998).

Although assessment is a core task in the practice of family support and working with children, there is very little literature that provides compelling research around how adequately current parenting capacity assessment models and practices inform carer screening assessment decisions (White, 2005). White (2005) discusses the challenges in achieving ‘definitional clarity’ surrounding the concept of
parenting and caring, as being fraught in both the fields of research and practice. The challenge to identify the critical elements defining ‘good enough’ parenting and caring, and the utility of these to the needs of the individual child have led to the majority of tools evolving as supports to clinical judgment (White, 2005). Importantly, the process of carer assessment tends to be used to support a judgment or recommendation on the suitability of placement, and related to attempts to describe carer potential or capacity to develop appropriate skills to support child development and protection (Reder, 2003; Crawford, 2011).

Parenting or carer capacity should not be understood as static, nor independent of context. It is dependent on distal factors such the socio-economic surroundings of the family, housing, culture, and societal values, as well as more proximal family skills, incidents, or events and relationships (Belsky & Vondra, 1989; Woodcock, 2003; White, 2005). Both field practitioners and researchers have identified the need for more evaluative studies in this area; specifically, a focus on behavioural evaluation of core carer skills, longitudinal measures on outcomes of interventions, refinement of the understanding of cultural variability of parenting styles, beliefs, and their impacts, and interactive matching of carer profile and children’s needs (Azar, Lauretti & Loding, 1998).

Similarly, the gaps identified in carer primary trauma, have parallels in the study of resilience. Research has focused on identifying and supporting criteria for the development of resilience in children and young people within the context of OOHC or school settings (Fuller, 2012) rather than the carers. Clearly resilient carers are essential, but measures targeting resilience tend to form only a very limited aspect of the existing fragmented screening process, and despite a recognition of the need for these qualities to sustain placements, support ‘optimal’ parenting models
(Redshaw, 2008; Michelson et al., 2013) and family structures, there are significant gaps in supports to assist in its identification and development (Geiger et al., 2013).

The current study draws on and seeks to begin to respond to a number of these identified gaps in research from the perspective of understanding many of the challenges facing carers as being inextricably linked to aspects of their individual psychological profile. This approach seeks to more specifically hone the notion of carer or family ‘strengths and needs’ from a psychological perspective, by working to describe trauma and resilience features of both the individual and group across a number of demographics (Trivette et al., 1990; Perosa & Perosa, 1990). White (2005) concludes in her paper that because individual workers often apply a battery of tools to make clinical judgments they need to have robust carer and parental assessment processes. The focus on the development of better assessment of carers and their profiles in this case, is important as it emphasises the gaps in knowledge of carer strengths or needs. In essence, this study seeks to progress the field’s understanding of the carer’s psychological profile and capacity to care, for the mediation of intervention, planning and implementation.

3.2 Support to the care role. Across Australia, there are many examples of agencies or peak bodies providing support or guidance to carers. A consistent theme in the training, support and guidance offered by agencies involved in OOHC across NSW and other jurisdictions is the focus on placement sustainability; the maintenance of a relationship with family of origin and the developmental or intervention aspect of the caring role.

One of the critical features consistently highlighted in the practice of supporting carers working to support young people and children in OOHC placements is the need for the implementation of strategies to avoid carer
breakdown, and to avoid carers becoming overwhelmed by the extra demands of caring for high needs and complex children. There has been acknowledgement of the need for carer support such as through the resources available through funded agencies or Association for Children’s Welfare Agencies ACWA (www.acwa.asn.au, 2014). The nature of support however, tends to reflect the above discussion around the focus on training and coaching optimal parenting skills (i.e.: Center for Community Welfare Training, CCWT; Triple P) rather than directly addressing individual carer’s personal support needs. It is also notable that the carer supports available are generally time limited and directed to the specific needs or challenges of the child in care, rather than longitudinal supports tailored to address carer wellbeing or evolving needs.

4. Applied Theoretical Practice – Trauma, Resilience and Carer Expectations

The centrality of trauma recovery models in the clinical and systemic work concerned with meeting the needs of children and young people in care has emerged as a growing field of interest (Blaustein & Kinniburgh, 2007; Redshaw, 2010; Meichenbaum, 2012). The role of trauma recovery models in the treatment and support of people suffering adverse life events has been significant since 1985 when The Society for Traumatic Stress Studies was founded (Figley, 2006). The range of models offered and methods to effectively respond and treat trauma have evolved over time, as has the research targeting evidence of efficacy. Practitioners and researchers have worked through a range of psychological theoretical perspectives to outline and combine intervention models or guides. A common theme of many models has been the recognition of the client or patient need to be ‘stabilized’ or ‘safe’ prior to attempting to ‘process’ the traumatic experience, which would then be followed by strategies to assist the person to ‘re-connect’ to the world and their
current relationships (Henman, 1992). It is clear that many current trauma focused recovery models draw heavily upon these historic frameworks.

Within these established frameworks, and while cognizant of the importance of neurological, bio-social, and behavioural psychology, stand the interactive clinical concepts of Trauma (primary and vicarious), Attachment, Regulation and Resilience (Redshaw, 2009). Attachment as a model, and as a concept in practice, has garnered significant focus and attention. Fundamental to the evolving theoretical framework for understanding trauma symptoms and intervention for children and young people in care has been the evolution of the concept of Attachment Theory. The works of Bowlby (1969, 1973, 1980, 1990), Stayton, Ainsworth, and Main (1973), Ainsworth, Blehar, Waters, and Wall (1978), and a range of other researchers, including Bretherton (1992), Burlingham and Freud (1942, 1944), Howe and Fearnley (2003), Tarren-Sweeney and Hazell (2006), Reebye (2010), and Greenberg, Cicchetti, and Cummings (1993), are seminal and influential. Reebye (2010), in particular, provides a modern overview of attachment theory and research, and its implications for practice.

Significant current research work has investigated the role of Attachment in the development of the child and carer relationship (Howe & Fearnley, 2003; Tarren-Sweeney & Hazell, 2006; Crittenden, 1992). Fahlberg (1991) provides a central framework to explain the cycle of attachment development using specific reference to the carer’s responsiveness to emotions expressed by the child. She notes that children who develop a strong attachment with a parental figure (Carer), are better placed to develop trust for others and self-reliance. These attachments have profound implications for the child’s psychosocial development and, critically, “... become the prototype for subsequent interpersonal relationships” (Fahlberg, 1991 p4). Our
understanding of the role of attachment is very well established in both research and practice. Attachment and relational security is acknowledged as one of the essential building blocks from which all human developmental activity grows, and where interference or damage is suffered in delivery of this primary need, the impact is recognized as potentially resulting in lifelong impairment to the individual (Ungar, 2010).

Similarly, vicarious trauma has been investigated in light of the trauma recovery in the field of OOHC. In the support and treatment of children suffering trauma, it is acknowledged as imperative to seek timely and functional solutions (Cameron & Karabanow, 2003). However, there has also been a substantial research focus on the effect of vicarious traumatization (Pearlman & Saakvitne, 1995, p. 31) within the helping professions. It is common for the issue of trauma to be considered in relation to the secondary or vicarious trauma experienced by those working with traumatised people. Vicarious traumatisation, as originally conceptualised by McCann and Pearlman (1990), appears to be accepted as the most comprehensive account of trauma profiling presented to date (Sexton, 1999). “Vicarious traumatisation is the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material” (Pearlman & Saakvitne, 1995, pp 31). A key feature in this concept is that vicarious traumatisation results from many contacts and longer-term involvement, and that the impact on the therapist or counsellor further impacts on relationships beyond that with the identified client, and into the person’s professional and personal life (Sexton, 1999).

Pearlman and Mac (1995) used a questionnaire to survey trauma therapists exposed to traumatic material and measure the therapists’ psychological wellbeing.
They found that those therapists who had a personal experience of trauma in their lives reported greater vicarious traumatisation than did those without a personal trauma history. Therapists with personal trauma history were more adversely affected by length of time doing this work and by the percentage of trauma survivors in their overall caseload. Pearlman and Saakvitne (1995) suggest that therapists with a history of trauma may be attracted to working with trauma survivors. One of the central questions the current study seeks to explore through the analysis of carer psychological profiles is the degree to which there is a similar trend across the carer population, and within carer role types within the NSW OOHC sector.

It has been acknowledged that the impact on therapists working with trauma survivors is unavoidable, though it may be ameliorated by proactive strategies of support and training (Hernandez, Gangsei, & Engstrom, 2007; Sexton, 1999). Sexton (1999) summarises such support strategies to include the following elements: the involvement in specialist trauma training programs; creating an agency culture that encourages the normalisation of vicarious trauma reactions and offers practical support; and opportunities for therapists to process the impact of client trauma on themselves. The option for planned reflection time for workers to enhance self-awareness, coupled with structured supervision, supportive leave and recreational arrangements, and regular team contact were all noted critical elements of an environment structured to sustain staff support exposed to trauma survivors.

There are a range of studies that examine the impact of working with people with complex needs, or suffering in traumatic circumstances on care staff in general, that is, individuals whose role may not be defined as that of “therapist”. Kurtz (2005) examined the capacity of those working within healthcare services to manage persons suffering personality disorders, and found significant evidence of the need
for specific intervention to prevent “therapeutic pessimism” evolving in staff attitudes (pp. 1-11). Collins and Long (2003), conclude that healthcare workers who work with trauma victims are subject to significant stress and are vulnerable to what is now known as “secondary traumatic stress.” Such stress was clearly linked to workers making poor professional judgments when compared to those who remained unaffected by the trauma context. Importantly, emerging literature has focused on the reactions of those working with survivors of trauma (Danieli, 1998; McCann and Pearlman, 1990): as Figley (2002) noted, “there is a cost of caring” (p. 1).

The demands on the OOHC carer role have evolved in recent years. As discussed in the previous chapter, there is now recognition of the needs of young people and children requiring care reflecting significant complexity and trauma. Increasingly, carers are being called upon to respond to trauma symptoms and associated behavioural presentations that represent an experience outside that understood within the general community and usually beyond the traditional/historic expectations of community-based care. This is coupled with the gradual recognition of the need for practical application of ‘therapeutic’ intervention in each child’s day-to-day experience, managed in the main through the role of the carer (Möller-Leimkühler & Wieshu, 2012). For example, contemporary carers are often required to develop protective physical management skills to prevent injury to themselves, the child, or others, and to become skilled in delivering and sustaining demanding behaviour management strategies, recognizing mental health symptoms and/or the administration of psycho-active medications.

The capacity of an individual carer, or a demographic of people providing care, has been a theme of significant research over the last couple of decades. As discussed in the previous chapter, much of the effort in relation to research and
practice review in this area has focused on the development of assessment and screening tools, but there have been only limited evaluative or outcome-based reviews (White, 2005). The ability to assess and describe the nature of a carer’s capacity to care for a child or young person in a way that is able to meet their needs in a safe and sustainable way, has been a core challenge for practitioners and clinicians. It forms the basis of the current study’s research questions.

Recent research has predominantly focused on secondary traumatic stress disorder (STSD), vicarious trauma, compassion fatigue and ‘burnout’ symptoms as experienced by carers either in informal (relative carer) or formal roles as caseworkers. Meadors (2008) has provided two articles systematically examining the various definitions of these often erroneously interchangeable terms, along with an extension of a study of the impact of secondary trauma in a paediatric healthcare setting. Meadors’ (2008) articles direct us to the importance of focusing on the practical improvement of agency culture to ‘care for the carers’ to manage the impacts of STSD. Importantly, Meadors (2008) has highlighted the range of psychological measures critical in any intervention modelling or evaluation. This work, when viewed in the context of the current NSW OOHC carer screening and support processes, flags the importance of there being a specifically targeted manner of assessment, along with that assessment being linked to the broader issue of the support offered by the agency. The current study seeks to explore the specific expression of primary trauma in the target carer population, and through this understanding substantially build on current work around secondary trauma and burnout.

The importance of emotional regulation of carers has also been investigated in relation to the context of OOHC and work with traumatized children and young
people. In the context of carers who themselves are challenged by primary trauma, the carers’ ability for regulation becomes important for consideration, both for the implications in relation to attachment potential through availability and attunement to the child, but also from the perspective of sustainability and the availability of suitable coping strategies. Emotional awareness and regulation is a key feature consistently highlighted in Parent Management Training (PMT) for the intervention to support high needs and disruptive children and young people (Michelson, Davenport, Dretzke, Barlow & Day, 2013). Interventions aimed at effectively reducing and managing the regulation of carer’s personal anxiety, and which provide realistic and sustainable direction to carers under considerable ongoing pressures in our communities (Golding, 2004) have shown significant gains for traumatized children and youth (Terr, 1992; Perry, 2010; Blaustein & Kinniburgh, 2010).

The capacity for emotional regulation has been presented as closely linked to the concept of resilience. Resilience is often defined as competence in the context of adversity (Masten, Hubbard, Gest, Tellegen, Garmezy, and Ramirez, 1999). In the interest of responding to trauma, and creating resilient populations, researchers have been seeking to better understand how resilience evolves. The nexus of debate in this area has for many years centred around the duelling influences of environmental factors (socio-economic environment; poverty, schooling, parenting, sporting or cognitively stimulating activities, life and social experiences, and experience of adversity (Fuller, 2012), IQ and biological factors that refer to genetic predispositions (susceptibility to illness) or characteristics that guide behaviour, and genes that promote certain characteristics (Caspi, McClay, Moffitt, Mill, Martin, Craig, Taylor and Poulton, 2002).
Resilience relates not only to developmental psychology, as it investigates the development of human characteristics, but also to biology as it investigates the role of genetics on resilient behaviour, and socio-cultural psychology as it investigates the role of social encounters and culture on the development of resilience. Resilience is generally identified in terms of protective factors that nurture the development of positive outcomes and healthy personality characteristics of individuals exposed to adversity (Bonanno, 2004; Ungar, 2010). There are, however, variations in the definitions of resilience including a psychological process developed in response to intense life stressors that facilitates healthy functioning, and the absence of adverse symptoms following trauma (Ballenger-Browning & Johnson, 2010). Many identify resilience as a fixed, stable personality trait, while others advise against this, believing that strong resilience is a collection of multiple traits (Windle et al., 2011). This variation in definition and understanding has resulted in some ambiguity in the literature and in practice in the use of tools for the measurement of resilience (Windle et al., 2011).

The understanding of the key elements or presenting beliefs or behaviours showing desirable aspects of resilience tend to include the ability to be attuned and appropriately attend to others, the ability to make accurate interpretation of social cues (reading intentions, empathy), the ability to label feelings and identify emotions accurately, the ability to realistically problem-solve and anticipate consequences, the ability to be socially adaptive to varying norms, showing developing habits of self-efficacy and optimism (i.e.: regularly seeking out positive experiences), emotional regulation (developing habits of concentration, focusing and calming), personal mastery and linking with people to create a sense of belonging (connectedness) (Fuller, 2012). Fuller overtly connects the concepts of resilience with emotional
intelligence, and further offers an analysis of a schema of resilience enhancing or diminishing factors (Fuller, 2012, p. 4).

Concepts of resilience are seen as the protective, evolving or adaptive foil to the harm imposed by trauma and neglect (Meichenbaum, 2012). People who are resilient often have stronger connections to family, community and friends, and with those established links are less likely to develop negative, high risk thoughts or behaviours (Resnick, Harris & Blum, 1993; Fuller, Wilkins & Wilson, 1998, D’Aprano, Carapetis & Andrews, 2011). Resilient individuals are also noted to be equipped with a range of coping and problem solving skills that allow a focus on the future (Hawton, Arensman, Bremner et al., 1998).

In similar ways to the gaps identified in the study of primary trauma, the study of resilience has been largely limited to identifying key criteria for identifying and supporting the development of resilience in children and young people within the context of OOHC or school settings (Fuller, 2012). Clearly, resilient carers are essential, but measures targeting these associated criteria tend to form only a very limited aspect of the existing fragmented screening process, and despite a recognition of the need for these qualities to sustain placements, support ‘optimal’ parenting models (Redshaw, 2008; Michelson et al., 2013) and family structures there are often significant gaps in supports to assist in its development (Geiger et al., 2013).

While acknowledging the critical contribution of both Attachment theory, emotional regulation and vicarious trauma, the specific focus of this study will be on investigating the profile of primary trauma and resilience, as two areas which are emerging as worthy of investigation in understanding of the impact of carer relationships in the OOHC context.
5. Managing Trauma Experience – Primary Trauma

5.1 Primary trauma experience. Trauma has been described as a form of damage or impairment that has been the result of the subject’s experience (Perry, 2008a, 2008b; Perry, 2009), or a psychological wound (Schneider, Scales, Bailey, & Lloyd, 2010). Post-traumatic Stress Disorder (PTSD) is a complex anxiety disorder that develops in response to a traumatic event or experience involving actual or threatened death or serious injury experienced or witnessed by an individual whose response involves intense fear, helplessness or horror. The disorder is characterised by core symptomatic features persisting for more than 1 month including intrusive re-experiencing (e.g., flashbacks or nightmares), avoidance (e.g., emotional numbing or efforts to avoid traumatic reminders), and hyperarousal (e.g., heightened startle response or insomnia) in addition to cognitive impairments such as poor concentration and difficulty recalling aspects of the traumatic event, suggestive of a neurobiological basis for the disorder (American Psychiatric Association [DSM-TR-IV], 1994; [DSM-V] 2013). The DSM-V includes paediatric PTSD and extends criteria for diagnosis.

There have been significant developments in the understanding of the features and nature of trauma and PTSD along with the recognition of its origin potentially being primary, secondary or vicarious (Figley et al., 2006, p. 145-257). The current study seeks to explore the specific expression of primary trauma in the target carer population, and through this understanding substantially build on current work around secondary trauma and burnout. The most significant early work on primary trauma was undertaken with populations exposed to war. Military veterans in particular have long been tracked and studied for evidence of PTSD and trauma symptoms. This group is often used as a benchmark for discussions and research.
around populations that have experienced primary trauma. According to Kelly et al. (2008), among Vietnam veterans approximately 15% of men and 9% of women were found to have PTSD at the time of their study in 1983. However, previous studies indicate that approximately 30% of men and 27% of women veterans had PTSD at some point in their life following Vietnam (Schlenger et al., 1992). The study by Kelly and colleagues found that rates were much higher than those found among non-Vietnam veterans and civilians. High levels of physical and mental health problems were also reported by veterans of the Persian Gulf War that ended in 1991. Studies examining the mental health of these veterans have found that rates of PTSD range anywhere from almost 9% to approximately 24%. Rates of PTSD measured within the population of soldiers engaged in the ongoing conflict in Iraq and Afghanistan have been reported to be around 12.5% (Read, Ouimette, White, Colder, & Farrow, 2011).

Several studies have been published that examined rates of PTSD as a result of the 9/11 terrorist attacks in New York City. One study of 2,733 people across the United States, conducted in October and November of 2001, found that 11.2% of New York City residents had PTSD, while 4% of U.S. residents had PTSD. Another study of 998 adults in New York City, undertaken five to nine weeks after the attacks, found that 7.5% had PTSD (Bonanno, Galea, Bucciarelli, & Vlahov, 2006). Post-traumatic stress disorder rates were found to peak in women later than they do in men, with men most vulnerable to PTSD between the ages of 41 and 45 years, and women most vulnerable at 51 to 55 (Ditlevsen and Elklit, 2010).

Tolin and Foa (2006) raise an important systemic challenge in the process of achieving a diagnosis of PTSD. Through a meta-analysis of studies between 1980 and 2005, they found that males experience more traumatic events on average than
do females, yet females are more likely to meet diagnostic criteria for post-traumatic stress disorder (Tolin & Foa, 2006). The researchers hypothesised that it was the nature of the assessment tool and its focus on emotional indicators that may result in skewed results. So that even though men may experience more traumas, they do not seem to have the same emotional responses to traumatic events, and therefore don’t receive the same rate of attributed diagnosis (Tolin & Foa, 2006).

In terms of children’s association with PTSD, a number of studies have concluded that PTSD is rare in children, even for those who have experienced significant primary exposure to traumatic events. Often under 1% of a child population tested will exhibit symptoms. However, even though a person does not have a diagnosis of PTSD, he or she may still experience symptoms of PTSD following exposure to a traumatic event. The researchers found that around 9% of children had distressing memories about a previous traumatic event, and 2% had multiple symptoms of PTSD but not a diagnosis of PTSD, (Copeland, Keeler, Angold, & Costello, 2007). Researchers have examined a number of factors that may increase the likelihood that a child develops PTSD symptoms following the experience of a traumatic event. They found that age (being older), having another anxiety disorder, and multiple traumatic experiences increased the likelihood that a child would develop PTSD symptoms after a traumatic event (Copeland, et al., 2007).

Recent studies in the United States have focused on the health linkages between individuals with a diagnosis of PTSD and the nature of their trauma history. Telomeres are DNA-protein complexes that cap the ends of chromosomes and protect them from damage and mutations. Short telomere length is associated with an increased risk of cancer, cardiovascular disease, and autoimmune and
neurodegenerative diseases, as well as early death. Studies have found that, among the subjects with PTSD, the more childhood trauma a subject had experienced, the higher the risk of shorter telomere length. The finding within this study gives us a potential mechanism for why people with PTSD tend to have a greater disease burden and more problems with aging (O'Donovan et al., 2011).

Clustered in these considerations has been the consideration of PTSD in the elderly and as part of the normal ageing process. Strong claims about an interaction between PTSD and ageing have been difficult for researchers to make due to sample heterogeneity. Further research must integrate the investigation of trauma with the biological, psychological, and social changes already associated with the ageing process (Lapp, Agbokou, & Ferreri, 2011).

A range of studies have highlighted challenges in the function of individuals with PTSD or high indicators of trauma symptoms. Issues related to deficits in learning and memory capacity due to alterations in brain organic state and functions (Woon & Hedges, 2008), along with concerns around sensory capacities and function, like pain sensitivity (Geuze et al., 2006; Geuze et al., 2008), have been cited as directly linked to trauma experience. These studies offer a number of insights for further research. Of particular interest to this study, are the findings related to the variability of experience across roles within a single situation.

McElroy (2009) found that the way an individual constructed meaning as a result of their traumatic experience held implications for their future capacity to manage difficulties, and demonstrate post-traumatic adaption. McElroy (2009) categorised the methods of making meaning or reacting to experienced trauma into three categories: ‘constructive’, and two ‘non-constructive’ meaning-making approaches (absorption or avoidance). Through her study, the researcher was able to
demonstrate that the capacity of the individual to manage future trauma events, and achieve post-traumatic adaptation, was significantly influenced by the selected meaning-making approach. This study presents the importance of individual attribution and belief models in supporting future formulation of identity and functional capacity following traumatic incidents.

5.2 Trauma impacts on carer capacity. Research literature focused on the trauma profile and impact on carer capacity is, as mentioned above, very limited. As such, all identified research in this area is primarily concerned with Secondary Traumatic Stress Disorder (STSD), and in most cases focuses on those in secondary support roles to those concerned with direct care. Insights from research that has examined the effects of secondary trauma on caseworkers who supported trauma survivors, found that there was limited evidence of gender bias or variation in either the questions related to duration of exposure or symptom reporting (Garrett, 2009). Both male and female workers essentially demonstrated similar profiles of symptoms and reporting despite strong hypotheses and predicted variations.

Weiss (2011) studied the phenomenon of Compassion Fatigue (CF) in the field of welfare casework. This study provided secondary data analysis on previous work targeting secondary traumatic stress completed in 1997. His particular approach was to ‘mine’ the data to gain an enhanced understanding of the impact of demographic variables on the reported experience of CF. A number of interesting results emerge from Weiss’s findings. Weiss found that there appeared to be a difference in the level of reported CF depending on the role of the worker and the level of education. He found that workers in the direct casework role experienced greater levels of CF than their supervisors, and that those workers with the highest and most relevant (Social Work) training tended to report the greatest levels of CF. Mirroring the
findings of Garrett (2009), Weiss (2011) also found that there was no evidence of
gender influencing the trend for CF reporting, but there did appear to be some
inverse relationship for age and years of service.

Stone (2011) studied the phenomenological impact of STSD on a cohort of
foster care caseworkers. This study clearly focused on the context of diminishing
resources with the United States welfare system, and resultant pressure on retained
workers to maintain their carer roles. Stone’s (2011) study flagged the ‘gap’ in the
academic literature in relation to the mental health or psychological capacity of
professionals who were foster care caseworkers. Of particular interest to Stone was
the evidence of symptom profiles of STSD, and how these symptoms express
themselves in the daily functioning of workers in their professional roles, but also
more generally in their personal lives. Ali (2012) has also examined the prevalence
of trauma and ‘burn-out’ in casework populations within NSW. Ali (2012) found
that some aspects of primary trauma history, years of service provision experience,
and the nature of self-care practices appeared to actively contribute to STSD, VT and
CF.

The current study seeks to investigate the psychological profile of carers
involved in the care of children with complex care needs, in light of specific
understandings of carer primary trauma history. Given the findings of Pearlmann and
Saakvitne (1995), it is anticipated that, as is the case with people attracted to the
helping professions, many carers may have traumatic backgrounds. The
understanding of the connection of this history and expressed psychological profile
has formulated one of the core research questions. This study also builds on the work
of Cleaver and colleagues (2011) and DeGregorio (2012), in acknowledging the
impact of trauma experience and symptoms on capacity to care or parent.
5.3 Building resilience and the relationship to capacity. The assessment of resilience is an inference about someone’s life based on a past or current adversity, and identifying a pattern of positive adaption to challenges (Masten & Coatsworth, 1998). ‘Resilience’, in psychological terms, is the positive capacity of people to cope with stress and adversity. Resilience is most commonly understood as a process, rather than a trait of an individual (Rutter, 2008). Resilience is often associated with the individual’s ability to “bounce back” to a previous state of normal functioning, or the individual using the experience of exposure to adversity to produce a “steeling effect” and function better than expected (much like an inoculation gives one the capacity to cope well with future exposure to disease) (Masten, 2009). ‘Hardiness’ is often considered an important factor in psychological resilience or an individual-level pathway leading to the development of personal outcomes and attributes associated with resilience (Bartone & Hystad, 2010; Bonanno, 2004).

The manner by which hardiness confers resiliency to the individual appears to be a combination of cognitive-behavioural mechanisms and biophysical processes, rather than any concept of personality trait. In fundamental terms, as stressful circumstances mount, so does the physical and mental strain on the individual, and, if this strain is sufficiently intense and prolonged, breakdowns in health and performance are to be expected. The personality ‘element’ of hardiness is proposed to have a moderating effect on this process by encouraging effective mental and behavioural coping, the spontaneous building and utilising of social supports, and engagement in effective self-care and health practices (Maddi, 2004).

Many variables have been noted to contribute to an individual’s capacity to develop resilience or to make positive adaptations to challenges. These variables include: access and strength of participation in social networks (Garmezy, 1991); the
continuously evolving interaction between the person and their environment (familial, communal, and social) (Luthar & Cicchetti, 2000); the opportunities experienced in childhood to learn and be reinforced for using adaptive behaviours across contexts (Bernard, 2004); the family systems and process experienced by the individual that support the development of resilient qualities (Walsh, 2003); and the participation in strengths and relationship-based psychotherapies focusing on enhancing personal control (Seligman & Peterson, 2003).

The concept of resilience is clustered to similar ideas, such as that described by Stamm (1998), as compassion satisfaction. In her discussion, Stamm (1998, p11) defined compassion satisfaction as: “a feeling and acting with deep empathy and sorrow for those who suffer”. Stamm (1998) asserts that the linkage between the motivation of workers to continue to work with a client who is highly distressed is contingent on the experience of satisfaction. Further, Stamm and Pearce (1995) found that carers were more at risk of developing negative reactions to their client’s difficulties when their competency and control of their situation was threatened. This study and concept of satisfaction is interesting in the context of examining the impacting elements on resilience and the maintenance of carer engagement with high needs children or young people.

Importantly, Hernandez, Gangsei and Engstrom (2007) note the interaction between vicarious traumatisation and resilience as part of the natural human processes activated by stress. In particular, these researchers examined the relationship between vicarious traumatisation (VT) and vicarious resilience (VR). In their work with helping professionals they have advanced the idea that through working with trauma survivors a specific resilience process can occur, and that this is enhanced when they are supported to bring conscious attention to the positive
impact of their engagement with the individual client. Hernandez et al., (2007) argue that this common and natural phenomenon may be a unique consequence of trauma work, and may offer potential insight into the nature of such work to both fatigue and heal individual workers. The researchers further assert that the use of the concept of VR, and the employment of strategies to increase awareness of its evidence in trauma workers, offers a powerful counter to respond to emotionally fatigued trauma workers in settings that inevitably offer ever-present distress and suffering.

Many of the psychological concepts raised by Hernandez et al. (2007) are practically echoed in the ARC Model and other therapeutic frameworks discussed above. Given the critical nature of resilience as an indicator of an individuals’ ability to sustain engagement despite adversity, this investigation has paired carer primary trauma profiles with their resilience profiles. This study seeks to better understand not only the profile of the carer population but also the potential interaction between these two psychological presentations. The capacity for emotional regulation has also been presented as closely linked to the concept of resilience. In the interest of responding to trauma, and creating resilient populations, researchers have been seeking to better understand how resilience evolves and is sustained (Masten, Hubbard, Gest, Tellegen, Garmezy, and Ramirez, 1999).

6. Carer Beliefs/Expectations and the Impact on Practice

In an understanding of the personality and psychological profile of those involved in the care of children with complex needs in the OOHC system, the importance of understanding the beliefs of a person, and their world view, in particular on how it impacts on their care for the child or young person, cannot be ignored (Michelson, et.al., 2013). There is scarce information on the impact carers’
bias and expectations have on the children in their care (Donnelly, Renk, & McKinney, 2013; Hawes, Dadds, Frost, & Hasking, 2011). Akakpo (2008) completed an exploratory study involving paid staff working in a residential OOHC ‘treatment’ facility. Akakpo (2008) focused the research on the impact of staff attitudes and beliefs in relation to the children and young people’s families, and found that staff generally supported family engagement, particularly in cases where it was anticipated that the child or young person would return home to live. Those staff that held positive beliefs about the families were noted to actively support family involvement. In contrast, those staff holding negative beliefs about the families were not significantly correlated with providing support to those families’ involvement. It was interesting to note that there was no variation across age groups, gender, education or marital status in the trend of beliefs or attitudes of staff. Akakpo (2008) also checked for the variation of beliefs across agency roles, including administrative staff, clinicians and direct support staff. It was found that administrative staff and clinicians matched positively in belief profiles and were generally supportive of the engagement of the family of origin, while direct care staff and clinicians varied in their level of support for family engagement.

Ayalon (2011) targeted the examination of the beliefs and perceptions of two carer groups in the evaluation of neglect or abuse of those receiving care. In his study, the researcher examined the different ways family-based carers and home care workers understood the welfare of their common client group. It was found that the paid workers consistently reported significantly higher levels of neglect or abuse than either the family carer or the person receiving care, which were broadly matched in results. This study not only highlighted high levels of noted neglect and
abuse for the client group, but also specifically demonstrated the subjective and role-based perspective on capacity to identify concerns.

Rozoni and Dogra (2012) used children and parent/carer participants, to explore treatment outcomes and how parent/carer expectations impact on the children. Rozoni and Dogra’s (2012) results suggest children and their parents/carers vary in treatment expectations and satisfaction with outcomes of intervention. Additionally challenging the research in this area of projected prognosis or expectations, is a lack of understanding of the actual outcomes of children in different types of care situations/environments and the nature of the subsequent attachment-related or behavioural issues (Everson-Hock et al., 2012; Jones et al., 2011; Tarren-Sweeney, 2013).

The expectations of carers are clearly shaped by their experience of children and young people or the culture of OOHC more broadly. The actual experience of being in care has been found to exacerbate existing behavioural problems for children with a marked increase in self-harm and mental health challenges (Tarren-Sweeney, 2013; Grenyer et al., 2013). These findings have been linked to ‘cultural’ norms or expectation of the context of care and the norms around the OOHC client group. Furthermore, much of the data is driven by carer reports, such as the Assessment Checklist for Children (ACC), which have created a negative and deficit emphasis in a balanced picture of the experience of children in care (Tarren-Sweeney, 2013). Donnelly & Straus MA (2005), suggests that positive parental behaviour and projection of positive expectation predicts better life outcomes for children (also see Pasalich, Dadds, Hawes, & Brennan, 2011; Sanders, 2008).

Möller-Leimkühler (2012) completed a study targeting the interaction of characteristics between birth relative carers and those receiving care. She selected
subjects supporting a relative with a chronic mental health condition in the
community, and completed survey and assessment measures for psychological state,
subjective quality of life, and relative ‘burden’. This study yielded a range of
findings related to the practical implications of improvements to employment
options for people with mental health challenges and the significant enhancement to
family sustainability when able to be achieved, along with support for family-based
communication. Of particular interest to the formulation of the research questions for
this study are the specific references to the impact of carer negative disposition and
expectations/beliefs.

Möller-Leimkühler (2012) found that the scores carers achieved on the
psychological and emotional scales, current family communication and
understanding of the patient’s condition, degree of carer “neuroticism”, along with
their reported perception of the strength of their social support network, held variable
predictive relationships with their objective or subjective ‘burden’ or quality of life.
She suggests the need for family focused interventions, and intensive support to
manage carer dispositions and expectations and beliefs, as a critical focus of service
provision.

Positive parenting, with its emphasis on building on children’s strengths, is
notably supported by Parent Management Training (PMT) models, such as the Triple
P Programs discussed above. There are also other programs offered such as Stepping
Stones for the positive parenting of children with a disability; Family Transitions
which focuses on families during separations and divorce; Lifestyle offered for
parenting overweight children; and a program offered to Indigenous parents. Much
of the framework of these programs draws on a broadly Cognitive Behavioural
Model where the beliefs and expectations of both the child and the carer are engaged as part of the intervention process (Sanders, 2008).

The research described above has focused on aspects of expectation on carer capacity, and the manner in which the care relationship is sustained or evolved. Within this study, the question is explored on two levels to discover both the level of carer optimism around prognosis of needs of the child, and beliefs around the expression of exceptional behaviour.

7. Rationale for the Current Research Project

As discussed in the previous chapter, NSW presents with a unique profile of statistics related to the large numbers of both Indigenous and non-indigenous children in care, and with a challenging history of reform. To date, much academic and policy attention has been concerned with the growing cost of providing care and the development of models that might be able to respond to the diversity of the individual and demographic needs of children in care. Research has focused on the needs of traumatised children and young people, and described the optimal profile of placements that might assist their recovery and positive development. These needs reflect a demand for carers that are able to provide predictable, attuned and nurturing relationships to support relational attachment that will allow trauma recovery over time. However, to date very little attention has been focused on the capacity of those charged with the responsibility of caring, and taking up the significant responsibility of raising these children in our community.

There appear to be many factors influencing the capacity of a carer to be sustained in the caring role, and clearly there is significant advantage achieved where carers are supported (Cleaver, et al., 2011; Geiger, et. al., 2013), for the young person or child, the agency, community and the carer. The current investment in this
aspect of the work reflects a predominantly practical, systemic and ‘reasonable’
approach to carer coordination and support, linked predominately to the targeted
‘model’ of intervention, rather than a perspective that accounts for the primary and
chronic management of psychological needs of both carers and children together.
Funding enhancements or policy papers declaring practice restructures to sustain
well-worn but failing models of service need to be understood as distractions, or at
best short term solutions. There is a fundamental need to look seriously at alternative
interventions and clinical/psychological strategies to address the needs of children
and families, and to support those who put their hands up to be Carers (Golding,
2004).

A new perspective is required to more adequately address the balance between
how, ideally, a child should be nurtured and how parenting or carer skills can be
incorporated into the understanding of the capacity of carers. Collaboratively
therapeutic and PMT models identify the capacity of the carer as foundational to the
successful outcomes of children being cared for in a home other than their own. Core
aspects of these models, have yet to be fully explored with the population of OOHC
carers: the Carer experience of primary trauma, carer resilience, and how these
expressed psychological states impact on capacity to care. These two aspects of
psychological presentation have been selected due to the growing evidence of how
their presence in individuals directly shapes capacity to achieve the desirable carer
characteristics of attunement, emotional regulation, and attachment. Furthermore,
emerging research signals the importance of carer expectation and beliefs of the
child or young person in care. The current research will also explore the relationship
between carer expectations and attributions, and how these map to other features of
the carer role and psychological profile.
8. Thesis Research Questions

The process of bringing together clinical experience and a review of the literature has resulted in the formulation of research questions around three related areas of interest, trauma, resilience and expectation profiles of carers working with high needs children in the OOHC program within NSW.

The first area of investigation relates to Trauma and Resilience; specifically, what are the core trauma and resilience elements in the psychological profile of carers of high needs children and young people in OOHC, and possible relationships between them. The second area of investigation is the challenge to better understand the operating expectations, perceptions, or bias, which underpin carer relationships with the children and young people they care for. Of particular interest is what expressed expectations and attributions carers apply in their understanding of the function or meaning of the child or young person’s behaviour relate to the support dynamics and their capacity to care.

The third area of research is to better understand the impact of a range of demographic information on carer trauma and resilience profiles and expectation or attributions: carer types, Aboriginality, age and gender.

9. Overview of the Thesis

In the opening chapter, an overview of the study was provided as well as context and key elements of a literature review upon which the current research questions and hypothesis have been formulated. Outlined within the current chapter was the scope and significance of the thesis. The third chapter provides a comprehensive overview of the study methodology and design. It also deals with details of the sample and data management processes.
The fourth chapter, introducing the findings, has a focus on the profiles of the sample, and draws linkages between this work and that of parallel populations. In particular, this chapter explores the relationship between the concepts of trauma and resilience, both as experience and psychological symptom measures.

The fifth chapter deals with analysis of data emerging as a result of the measures targeting carer expectations and attributions. This chapter examines the range of carer responses to the expressed needs of children and young people in their care, along with specific aspects of expectation or bias. It reports the implications of qualitative trends in thinking and understanding emerging through the analysis of interview data. Chapter six provides the final analysis, and presents the study’s discussion of findings.

The final (seventh) chapter provides a summary of findings and conclusions of the thesis. This chapter revisits the contextual studies that the thesis is based on and reviews the research questions against the results discussed in the analysis chapters. Chapter seven concludes with a number of recommendations for practice development and areas noted for further research.
Chapter 3: Research Design and Methodology

1. Introduction

The study, consistent with peer research in the area of applied psychology, used a mixed methods design to examine the psychological profile of carers in relation to their capacity to care. Exploration and measurement of carer psychological profiles responds to an identified gap in the research and practice literature in relation to capacity to care, and aims to provide essential insights into how to better target intervention and support to enhance outcomes for both carers and those children and young people they support. The study is structured to examine the characteristics of the carer population from a number of specific carer groups, including foster carers, employed carers and birth relatives drawn from the broader community of carers supporting children in Out-of-Home Care, and sought participants from Indigenous and non-Indigenous carer populations.

1.1 Research ethics. Prior to the study commencing, an ethics submission was made using the National Ethics Application Form (NEAF) www.neaf.com.au. This application was reviewed by the National Health and Medical Research Council (NHMRC) www.nhmrc.gov.au, and the University of Western Sydney Human Ethics Committee. The study was commenced after both bodies approved the submission and granted clearance to commence (See Appendix 4b. Ethics Approval Notice H6893). This research project complied with all requirements of the NSW Privacy and Personal Information Protection Act 1998, and all specific requirements related to information storage and disposal.
A total of 5 researcher / clinician’s were involved in data collection. All clinicians/researchers involved in implementing the research project completed training in relation to the development of ‘cultural competence’ when working with Indigenous populations prior to conducting any assessment activity, had extensive work experience in working with carer populations and conducting assessment scales or interviews, and did not hold a longitudinal professional work role with participants.

The identification of Aboriginal carers took into account the relationship of the broader extended family and, where possible, included a number of family members in the survey pool. Where deemed appropriate, specialist Aboriginal staff were approached to support introductions, research briefings, and interviews. It was acknowledged that was potential for the participants to be triggered by the process of exposure to the assessment scales content, and as such aspects of the research context and use of the findings was made explicit to both participants and their supports.

All information and findings resulting from the research project are available to participating communities and individuals, where requested. In circumstances where the community identified requirements for factual amendment or enhanced culturally based analysis, this was negotiated. It was also noted that where any of the participant scores received through the study highlighted results of concern, while maintain confidentiality, the researched was able to flag ‘cohort trends’ to the referring agency or carer support for appropriate follow-up.

As described in the close of the previous chapter, the research has two objectives directed at achieving an enhanced understanding of carers’ capacity to care. The first area of investigation relates to the psychological profile of carers
around primary trauma and resilience. The second area of investigation is concerned with the operating expectations, perceptions, or bias, which carers have of the children and young people they care for. Demographics of age, gender Aboriginality and carer role were also collected.

2. Participants

Participants were invited to participate from carers identified by staff of the Department of Community Services or relevant agencies as supporting a child or young person who had been identified on the Family and Community Services Department criteria as having ‘high’ needs. Significant effort was made to select subjects across geographic regions to support the achievement of a representative sample matched to NSW carer demographics (see discussion Chapter 1), resulting in a broad spread of participant locations. Locations included large metropolitan centres (Sydney, Newcastle, Wollongong) and rural centres (Coffs Harbour, Port Macquarie, Kempsey, Wagga Wagga, Orange).

The sample completing all data collection phases totalled 125 OOHC carers (N=125), all residents of New South Wales. One hundred and eighty-four participants initially agreed to participate in the project but 28 Aboriginal carers, and 31 non-Aboriginal carers withdrew or submitted incomplete or invalid material. Consistent with the high proportion of Aboriginal children and young people and the focus on Kinship or Relative placements in the NSW OOHC system (AIHW, 2011), approximately one third of the sample identified as of Aboriginal origin. The tables below describe the subject sample role groupings.

2.1 Role. The high relative number of Paid staff involved in the study reflects the type of carer generally engaged in the care of high needs young people through agency-based residential or staffed team-based support services, although does not
directly reflect the OOHC carer population across needs. In this context it is important that the results generated through the study have been targeted in the context of the most challenged children and young people, and a context of care with the highest level of demand. Access to this group of carers was facilitated through an initial approach to agencies followed up by invitations to individual carers. Accessing Foster Carers and Birth Relatives held greater challenges, in that each engagement required an individual approach, and in order to collect the six-month follow up data, required the placement remain stable and in contact with a provider over the course of the study.

Table 3 - Study Participants Numbers Role and Ethnicity

<table>
<thead>
<tr>
<th>Role</th>
<th>N</th>
<th>Aboriginal</th>
<th>Non-Aboriginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid Staff</td>
<td>88 (70%)</td>
<td>18 (20%)</td>
<td>70 (80%)</td>
</tr>
<tr>
<td>Foster Carer</td>
<td>22 (18%)</td>
<td>9 (40%)</td>
<td>13 (60%)</td>
</tr>
<tr>
<td>Birth Relative</td>
<td>15 (12%)</td>
<td>7 (46.6%)</td>
<td>8 (53.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>125 (100%)</td>
<td>34 (27%)</td>
<td>91 (73%)</td>
</tr>
</tbody>
</table>

Note. The Role categories refer to the type of carer participant engaged in the study. Paid Staff were those employed by an agency, usually in residential settings, Foster Carers were approved carers providing family-based care, and Birth Relatives referred to those engaged in kinship placements. N refers to total numbers of carers in each category, and the numbers in the following columns relate to carer Indigenous or non-Indigenous status.

Notably, Table 3 shows that the achieved percentages of Aboriginal carers varied across the carer roles. The carers who were drawn from the paid staff group had the lowest percentage (20%) of Aboriginal participants, with foster carers and birth relatives achieving 40% and 47% respectively for an average across the sample of 27%.
2.2 Aboriginality. The recruitment of Aboriginal Carers was challenging due to the limited numbers of Indigenous carers currently engaged in the field as paid staff, the nature of the study topic and the need for an ongoing relationship with a provider. One of the study’s primary research questions targeted carer experience of primary trauma, and this topic area held specific issues for Aboriginal participants. This group of participants would often initially indicate an interest in being involved in the study, but then withdraw in response to completing the trauma scale, which they either found or anticipated finding confronting or distressing. In a number of cases (4), the support agencies themselves elected not to offer participants the opportunity to volunteer for the study, and declined the research invitation based on their belief that their carer group would be potentially re-traumatised by the experience of being exposed to the survey tools.

In response to this feedback, the research process used in this study was modified with the addition of enhanced personalised and supportive services to minimize re-traumatisation and to facilitate Aboriginal carer participation. Targeted additional supports made available included the offer of multiple meetings to explain and reassure carers about the purpose, function and confidentiality of the study, carer support to interpret and manage the survey process, extended interviews, and debriefing post-interview or post-survey. Of the total sample, 28 Aboriginal carers withdrew from the study as they were unable or unwilling to complete the survey component of the study; no data from this group is included in the study or analysis.

The challenge for this study has been to recruit a range of carers to approximate a representative sample of those involved in the OOHC system who were willing and able to commit to a relatively taxing, unfamiliar and potentially challenging set of data collection. As discussed below, implicit in the research
design was the planning for contingencies and extra support to maintain the 
participant sample. The participant numbers achieved are a direct reflection of the 
researcher’s use of her established practice credibility and professional reputation to 
garner support from clinicians and participating agencies.

2.3 Gender. There was a higher prevalence of participant female carers ($N = 80$) than male carers ($N = 45$). This gender profile clearly reflects the gender mix of 
primary carers in the field. The balance between males and females was almost equal 
within the Paid Staff role reflecting the gender breakdown occurring in these paid 
positions, but once moving into Foster or Birth Relative care the ratio greatly alters 
to female carer dominance, which is again reflective of the sample population 
demographic. The study sample population overall was predominately comprised of 
Non-Aboriginal, Female, Paid Staff as evident in Tables 4 and 5.

<table>
<thead>
<tr>
<th>Role</th>
<th>Total N</th>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Paid Staff</td>
<td>88</td>
<td>41</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Foster Carer</td>
<td>22</td>
<td>3</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>15</td>
<td>1</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

2.4 Age. The age profile of the carer sample ranged from 18 to 62 years. When 
divided into 10-year age cohorts there was an equal number of carers identified in 
the 26 to 35 years, and 36 to 45 years age groups, while the remaining cohorts were 
relatively smaller. The age group of participants achieved in the study was noted to 
be generally reflective of the working profile in the source sectors ($M_{age} = 37.5$, See 
Table 5.). The trend for both mean and modal ages being closely matched to the 
sample group mean was sustained across all carer types.
Table 5 - Descriptive Statistics Based on Age and Role

<table>
<thead>
<tr>
<th>Role</th>
<th>N</th>
<th>25 &amp; Under</th>
<th>26-35</th>
<th>36-45</th>
<th>46-55</th>
<th>56 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid Staff</td>
<td>88</td>
<td>7</td>
<td>32</td>
<td>25</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Foster Carer</td>
<td>22</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Birth Relative</td>
<td>15</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL (unknown 8)</td>
<td>125</td>
<td>9</td>
<td>38</td>
<td>37</td>
<td>26</td>
<td>7</td>
</tr>
</tbody>
</table>

As would be expected, there was a trend for Foster Carers to be associated with a more mature age profile. This trend is consistent with the requirement for Foster Carers to meet accreditation, selection and screening requirements; that is, to be assessed as suitable, stable and established carers. The sample is reflective of the broader demographic of the NSW carer population (AIHW, 2011).

The recruitment of Paid Staff within the youth service sector is also targeted in a similar way, in that it requires a worker to be over the age of 18 years. However, potential workers applying for these positions do not need to be Australian citizens or permanent residents. Paid Staff within this study in the under 25 year cohort self-reported to be predominately either students recently completing studies in the human services field, or individuals travelling or immigrating to NSW. The Birth Relative group had no externally mediated boundaries around age or indeed any specific screening, although modelled on the same standards as foster carers.

2.5 Combined variables of Aboriginality, gender, role, and age. Aboriginal and non-Aboriginal carers followed a similar pattern when broken down by age cohorts of ten years. The span of ages ranged from 20 to 62 years ($M_{age} = 36.7$, See Table 6.). The majority of Aboriginal carers were between 26 years and 35 years age
group, consistent with the broader study group. The mean age of the Aboriginal Paid Staff was approximately 1 year below the mean for the overall group.

It was noted that Birth Relatives and Paid Staff groups showed evidence of the engagement of younger carers, whereas the Aboriginal Foster Carers were drawn from an age span of 29 years to 53 years, reflecting the range in the broader sample. This demographic profile matches that described within the carer characteristics of kinship placements (Cuddeback, 2004; Geen, 2004; Harden, Clyman, Kriebel & Lyons, 2004; Paxman, 2006).

Table 6 - Descriptive Statistics Based on Age and Aboriginality

<table>
<thead>
<tr>
<th>Role/Aboriginal</th>
<th>N</th>
<th>Age</th>
<th>25 &amp; Under</th>
<th>26-35</th>
<th>36-45</th>
<th>46-55</th>
<th>56 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid Staff</td>
<td>18</td>
<td></td>
<td>3</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Foster Carer</td>
<td>9</td>
<td></td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>7</td>
<td></td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td></td>
<td>4</td>
<td>13</td>
<td>9</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

In the analysis of the age, gender and role profile of Aboriginal carers it is noted that the largest group of males aggregated in the 26 year to 35 years age group and tended to be Paid Staff. The largest age groups of female carers were between 26 and 45 years and tended to be Foster Carers. Apart from the slight bias within the male group towards the under 35’s, the profile of carers’ age variation was balanced for gender across the sample.

3. Instruments

A battery of five tools was used in this mixed methods study. The study used a battery of three published normed psychological tools developed and widely used to assess trauma—Detailed Assessment of Post-Traumatic Stress (DAPS), Trauma Symptom Inventory (TSI), and Resilience Scale (RS) Short version, presented in
Table 7, to collect data on trauma and resilience. A carer interview was developed and a standard behavioural assessment tool used in this study was modified specifically for this purpose.

A typical data collection episode consisted of a clinician administering the three normed tools, then conducting the structured interview in which demographic data was collected along with the carer’s understanding of the child or young person’s history. The prognostic scoring tool was then administered and a behavioural assessment undertaken. Six months later the same clinician or researcher undertook a follow up behavioural assessment of the child or young person.

Table 7 - Psychological Assessment Tools

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Author/Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed Assessment of Post-Traumatic Stress</td>
<td>John Briere (2001)</td>
</tr>
<tr>
<td>(DAPS)</td>
<td></td>
</tr>
<tr>
<td>Trauma Symptom Inventory (TSI)</td>
<td>John Briere (1995)</td>
</tr>
<tr>
<td>Resilience Scale (RS) Short version</td>
<td>Wagnild and Young (1993)</td>
</tr>
<tr>
<td>Carer Structured Interview (CSI)</td>
<td>Project-based Tool</td>
</tr>
<tr>
<td>Behavioural Assessment Report</td>
<td>Project-based Tool</td>
</tr>
</tbody>
</table>

*Note. See 5.2 for the internal reliability of the DAPS, TSI, and RS. DAPS adapted from Briere (2001). TSI adapted from the works of Briere (1995). RS adapted from Wagnild and Young (1993).*

**3.1 The Detailed Assessment of Post-traumatic Stress (DAPS).** The DAPS (Briere, 2001) has been selected as the primary tool for the assessment of carer primary trauma. The DAPS provides a comprehensive diagnostic and interpretative tool that can be used to administer, score and generate profiles and interpretive reports for the assessment of Post-traumatic Stress. The DAPS is a 105-item inventory that provides detailed information on an adult client’s history of various primary trauma exposure, as well as his or her immediate psychological reactions (cognitive, emotional and dissociative), enduring post-traumatic stress symptoms
(re-experiencing, avoidance and hyperarousal), and level of post-traumatic impairment in the context of identified events. The DAPS is event focused to support the diagnostic criteria requirements of the DSM-V (2013) for Post-traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD). The DAPS also includes two validity scales that capture under and over reporting of symptoms, along with three supplementary scales that assess event-related dissociation, substance abuse, and suicidality associated with client trauma experience (Briere, 2010). The DAPS tool has been standardized in studies involving a normative group (433) of adults who have experienced at least one DSM –V (2013) type trauma, a validity population (145), and university students (290). Across both samples, the participants were predominantly Caucasian, which varies from the population of the current study.

The DAPS tool is made up of five key components: Response Validity (16 items) that evaluates the subject’s tendency to present as either especially symptom-free (8 items) or overly symptomatic (8 items); Trauma Specification (14 items), which reviews all potential traumatic events the subject has been exposed to in his or her lifetime, and assesses which trauma has been the most distressing, and when it occurred – this scale gives an indication whether the subject’s experience of trauma was in the normative range (i.e.: At any time in your life, including your childhood, have any of the following happened to you?); an Immediate Trauma Impact (14 items), which reviews the client’s identification of eight immediate psychological reactions to trauma – fear, horror, helplessness, guilt, shame or humiliation, disgust, upsetness and expectation of death. This last component includes two scales: Peritraumatic Distress (8 items) measuring the level of distress experienced at the time of the trauma (i.e.: At the worst point, how much fear did you feel during this experience? 1 = None/ 5 = Very much), and Peritraumatic Dissociation (6 items), the
extent to which the subject experienced depersonalization, derealisation and other dissociative reactions (During this experience, did any of the following happen? You spaced out 1 = None/ 5 = Very much); as well as a Posttraumatic Response (35 items), which consists of four trauma symptom scales – Re-experiencing, Avoidance, Hyperarousal, Posttraumatic Impairment (i.e.: In the last month, how often have the following things happened? You have been frightened and upset when something reminded you of the experience 1 = Never 5= 4 or more times a week); it also has Supplementary Scales (24 items) that evaluate three clinical phenomena (trauma-specific dissociation, substance abuse, suicidality) that often occur in cases of PTSD, ASD, and other trauma-related symptoms (i.e.: During the last month indicate how often the following things have happened? Feeling like your use of drugs is starting to control your life 1 = Never 5 = Very Often.)

The probable diagnosis of PTSD generated by the DAPS has appropriate sensitivity (α = .88), as well as specificity (α = .86) with regard to the recognized ‘gold standard’ PTSD interview (the Clinician Administered PTSD Scale – CAPS) (Briere, 2001; Blake et al., 1995; Blake et al., 2000). In summary, the tool has demonstrated positive validity across all tests, with the only area of criticism relating to matching the DAPS with another self-report test Posttraumatic Diagnostic Scale (PDS), where there was a noted less robust ability to detect the absence of PTSD symptoms (Briere, 2001). However, it was noted by Briere that the use of the DAPS should be followed up by a confirmatory diagnostic interview before a definitive PTSD diagnosis is made.

The DAPS is recognized as efficient for administration and scoring of trauma. The DAPS consists of a Professional Manual and Item Booklet (Briere, 2001). The DAPS has been frequently used by researchers in recent years to identify adult
trauma symptoms and post-traumatic stress (Dietrich, 2007; Messer & Fremouw, 2007; Briere, 2006).

3.2 The Trauma Symptom Inventory (TSI). The TSI has been used in this study to provide a sensitising review of results achieved through the DAPS. The TSI is used for evaluation of acute and chronic post-traumatic symptomatology, and includes a range of scales that assess a wide range of psychological impacts on the individual. These include symptoms typical of post-traumatic stress disorder (PTSD) or acute stress disorder (ASD), along with those intra- and interpersonal difficulties often associated with chronic trauma. The TSI consists of a 100 item symptom questionnaire where clients are required to rate the frequency of the symptom experienced over the last six months, across a four point scale (0= Never, 3= Often). The TSI consists of a Professional Manual and Item Booklet (Briere, 1995). Unlike the DAPS the TSI does not generate a diagnosis but rather it evaluates the relative level of various forms of post-traumatic stress. The TSI scale requires approximately twenty (20) minutes to complete and participants require a functional reading age of 10 to 12 years.

The TSI is known to have a high internal consistency and was utilised for this purpose ($\alpha = .84$) (Briere, 2001). Notably, the TSI scales predicted PTSD with 90% reliability to the joint scoring of The Impact of Event Scale (IES) and Los Angeles Symptom Checklist (LASC) (Briere, 2010). The TSI has three validity scales – Response Level (RS) capturing under reporting of symptoms, Atypical Response (ATR) measuring psychosis or extreme distress and over-endorsement, and Inconsistent Response (INC) checking for congruence in question responses.

The TSI has ten clinical scales that report age and gender normed T scores. The clinical scales include a symptom list associated with trauma responses.
including Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behaviour (DSB), Impaired Self-reference (ISR) and Tension Reduction Behaviour (TRB), which includes self-harm or suicide threats. Each of the items offered for participant rating represent statements of a state (i.e.: *Your mind going blank. Feeling depressed. Wanting to cry.*) or experience (i.e.: *Starting arguments or picking fights to get your anger out. Sudden disturbing memories when you were not expecting them. Nightmares or bad dreams.*) that the participant responds to with the use of the 0-3 rating described above.

The TSI was standardized on a random sample (N=828) of men and women over the age of 18 years. The TSI results include separate norms for navy recruits. The TSI offers norms structured around age, gender and race. Studies indicate that the TSI scale is useful in the evaluation of a broad range of traumatic experiences including adult or child interpersonal violence, adult or child natural disaster, involvement in prostitution, and professional exposure to trauma (Brock & Petretic, 2006; Brock, Pearman & Varra, 2006; Browne & Winkelman, 2007).

**3.3 The Resilience Scale (RS).** The RS (short version RS 15) has been selected as the single measure of Resilience. The RS has been designed to measure the degree of an individual’s resilience represented by perceptions of personal competence or capacity and acceptance of self and life. In this context the authors of the RS conceptualize resilience as a positive personality characteristic that enhances adaption capacity of the individual (Wagnild & Young, 1993). The RS has been used in the evaluation of individuals and change over time. The RS has been designed for use in adult populations (16 years and over), is a self-report and consists of 15 items that participants are requested to score on a scale of one to seven, i.e., 1= Disagree
and 7= Agree). The measure is designed to assess five identified features as indicators of resilience; equanimity, perseverance, self-reliance, meaningfulness and existential aloneness. The measure is designed as a series of statements that the participant rates in relation to the degree of application to their situation. Sample test items include *My belief in myself gets me through hard times. I have self-discipline. I am determined. I can usually find something to laugh about.* The resulting scores are set in a data range suggesting categories as low, medium and high resilience (Windlet & Noyes, 2011).

Internal consistency has been reviewed as suitable ($\alpha = .94$) (Wagnild & Young, 1993), and ranged from ($\alpha = .72$ to .94) reliability of the Resilience Scale (Wagnild 2009).

The RS was selected for a number of reasons, highlighting its brief form and functional length in the context of the test burden within this study, its development population of middle-aged women roughly matching the study sample, and its strong results in meta-analysis review of resilience tools in relation to the accuracy in the provision of psychometric ratings. The RS was also reported to be the most widely applied resilience measure of those reviewed in a study by Windle and colleagues (2011).

**3.4 The Carer Structured Interview.** The carer structured interview (CSI) (See Appendix 4) was developed for the purpose of this study reflecting part of the process required for descriptive functional behaviour assessment involving direct observation of behaviour under naturally occurring conditions, and the understanding of the background factors contributing to the use of specific behaviours. It draws on many elements of mediator analysis common to a range of tools used within applied behavioural analysis, and specific to the process of
Functional assessment of behaviour provides hypotheses about the relationships between specific environmental events and both desirable and undesirable behaviours which are believed to be learned through interactions with the social and physical environment (LaVigna & Donnellan, 1995). Functional behavioural assessment is used to identify the type and source of reinforcement for challenging behaviours as the basis for intervention efforts designed to decrease the occurrence of these undesirable behaviours (Cooper, Heron & Heward, 1987).

There are a range of techniques for applying functional behavioural assessment (Cooper, Heron & Heward, 2007). In this case the clinician engaged in an assessment that involved directly observing the behaviour of the child or young person as it occurs in the natural environment, reviewing the outcomes for the person achieved through the use of the behaviour and/or potentially maintaining the use of a particular behaviour, and analysis of the setting event or context that may contribute to the behaviour occurrence.

In addition to the functional assessment, the CSI includes questions targeting the carer’s knowledge of the child or young person’s profile and background, along with specific information related to the nature of the behavioural presentation, the carer’s understanding of the context of the behaviour, its antecedents and consequences.

**3.4.1 The prognostic scoring tool.** The prognostic scoring tool has been developed for the purposes of this study and draws on previous models of clinician projective needs forecasting designed by the researcher and used within the Department of Human Services, Ageing and Disability in the last five years (See Appendix 7). This six point scoring tool offers a descriptive and scored continuum to
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quantify the prognostic beliefs of workers and clinicians. The tool has been designed to capture the carers’ and clinicians’ views on both the level of support (i.e.: Intensive) the child or young person may require, and the anticipated timeframe for this support (i.e.: 3-6 mths; 6-12 mths; 12 mths to 3 years).

This tool was administered at the point of interview to the carer and clinician to determine how each assessed the care or support needs of the person in care and the length of time this support was needed. It was then used again at a six-month follow up by the clinician only, to validate the anticipated support needs from the initial interview.

3.5 The Behavioural Assessment Report. The Behavioural Assessment Report (See Appendix 6) contained elements consistent within those outlined by the Department of Human Services policy framework (Office of the Senior Practitioner, 2009, pp. 51-69), and draws on current models and tools used within applied behavioural analysis (LaVigna & Donnellan, 1995; Cooper, Heron & Heward, 1987, 2007). In the case of this study’s application of the functional assessment, the clinician reviewed each case six months following the initial assessment being reported. The purpose of this review was to validate observational and interview data collected on these elements and to review the hypothesis of function.

The combination of the information gathered through the direct observation of the child or young person within the range of support contexts, combined with the review of the client profile, including history and carer responses to the CSI assist to formulate the behavioural assessment, which presents an hypothesis for the presence of the behaviours. The findings presented in the behavioural assessment report can be used to develop a behaviour intervention plan or as a basis for a more formal analysis of behavioural function (Cooper, Heron & Heward, 2007).
4. Research Design

The design of research in the field of behavioural and, more broadly, social phenomena, over the last decade have evolved towards greater use of mixed methods models (Tashakkori & Teddie, 2003). Mixed methods research employs both quantitative and qualitative methods (Wilkins K & Woodgate R, et al., 2008). Quantitative methods include the collection, analysis and interpretation of data in numerical forms, while qualitative methods consist of the collection, analysis and interpretation of text or narrative data (Polit, 2010). The mixed methods design contributes value to the researcher’s pursuit of exploratory studies as it allows the study design to be layered and supports the use of a mixture of both qualitative and quantitative measures. For the purposes of this study, a multi-method design was selected, combining two sub-projects, both complete within themselves, into the one core research study. The multi-method design calls for the researcher to develop two or more projects that are interrelated within a broad topic. All projects within the study are required to be designed with the explicit purpose of solving a common and central research problem (Morse, 2003; Tashakkori & Teddie, 2003).

This research model has a core or base project and simultaneous triangulation of two sub-projects. Each was conceived as an independent project to supply an evidence-base to address the research questions. The theoretical drive of the base project is ‘deductive’ (discussed briefly below); as such, the dominant data tools within the study are quantitative. The inclusion of a structured interview as one of the sub-projects has also allowed the inclusion of qualitative elements to enhance descriptions of deductions or causal factors within findings. The sub-projects or independent variables are carer reported primary trauma, resilience and expectations, while the central concern or dependent variable is carer capacity to care.
The two related sub-projects yield a nominally comprehensive picture of the trauma and resilience profiles of participants occupying a variety of roles in the OOHC System. The use of the multi-method design allows for a more substantive and compelling study than either of these sub-projects could afford if completed independently. This research experience of attaining different and expanded perspectives on a topic through the use of the multi-method model is consistent with the notion that the researcher is able to study a complex phenomenon such as carer capacity to care by looking through a different lens (Sandelowski, 1995).
### Table

<table>
<thead>
<tr>
<th>Project</th>
<th>Data Set</th>
<th>Instruments</th>
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</thead>
<tbody>
<tr>
<td><strong>Sub-Project 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma and resilience</td>
<td>Carer Trauma Profiles</td>
<td>Detailed Assessment of Post-Traumatic Stress (DAPS) (Briere, 2001)</td>
</tr>
<tr>
<td>Quantitative</td>
<td></td>
<td>Sensitising Data: Trauma Symptom Inventory (TSI) (Briere, 1995)</td>
</tr>
<tr>
<td></td>
<td>Carer Resilience Profiles</td>
<td>Resilience Scale (RS) (Wagnild &amp; Young, 1993) Short Version</td>
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<tr>
<td><strong>Sub-Project 2</strong></td>
<td></td>
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<tr>
<td>Expectation and attribution</td>
<td>Carer</td>
<td>Carer Structured Interview:</td>
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<tr>
<td>Qualitative</td>
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<td>Carer attribution questions</td>
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<td></td>
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<td>Carer prognostic rating includes Demographic Data</td>
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<td></td>
<td>Clinician</td>
<td>Clinician Assessment:</td>
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<tr>
<td>Quantitative</td>
<td></td>
<td>Behavioural Assessment</td>
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<td></td>
<td></td>
<td>Prognostic scale: Time 1, time 2</td>
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</table>

*Figure 2 - Core Research Project: sub-projects, assessment targets and assessment tools.*

The consideration of audience perspectives (Morse, 2010; Biber-Hesse and Johnson, 2013), along with issues such as research validity, reliability, replicability, and generalisability (Bryman et al., 2008), are noted as consistent generic tests applied to the assessment of quality of any quantitative research. Issues including sustainability of processes, the transparency (Caraceli & Riggin, 1994; Creswell, 2003) of the method, and the degree to which selected methods match the project context are also highlighted as important considerations for study design within the social research literature (Bryman, 2006; Morse, 2010). Three areas have been identified as conceptual points from where the goals for qualitative research questions are drawn: researcher personal goals, practical or practice goals, and intellectual goals (Maxwell, 2005).
4.1 Theoretical drive. Critical to the formulation of a multi-method design is the key commitment to an articulated and consistent theoretical drive. Within this study, a deductive model was selected as the dominant theoretical drive. Within this model, two core projects used quantitative measures and one included a qualitative dimension. A deductive theoretical drive tends to be reflected in research projects that have their major focus on striving to test an hypothesis. Such studies tend to ask questions around ‘How much something applies to a specific group?’ or ‘How many incidents are noted?’ and ‘What the relationship between subjects or conditions may be?’ (Morse, 2003). The current study posed 5 hypotheses, discussed later in this chapter.

The quantitative data derived from normed assessment tools, was supplemented by qualitative information collected at interview with carers around their expectations of the child or young person in their care, their understanding of their charges’ behaviour and predictions of future support. The study utilized descriptive statics, and correlations between variables.

4.2 Research procedure. The overall data set comprised two discrete sets of information: one from the carers of the child or young person, and one from the clinician involved with assessment of the child or young person in that placement. The data set from carers was normally collected in one interview, it comprised: carer demographics, carer scores on trauma and resilience scales, carer assessment of the child or young person’s behaviour inclusive of both reasons for current and expectations of future behaviour (discussed below). The data set from clinicians occurred over two time periods and was concerned with behavioural assessment and expectations of future behaviour. This data was collected at the time of the data collection from carers, and six months post this initial assessment.
The instruments and data collection tools were administered to the carers by accredited, briefed clinicians, who in the normal course of events would have been responsible for behavioural assessments in each case. The use of these clinicians facilitated not only access to required information, but also ensured that there was no requirement for any extension of the information sharing consents, or any extraneous researched-based assessment burden for the child or young person.

5. Procedure

5.1 Initial contact, briefing and consent. Each carer participant who indicated interest in participating in the study was briefed both face-to-face and through a briefing document on the nature and process of the study (See Appendix 2). This briefing included information concerning confidentiality and of the process for withdrawal from the study at any time. Each carer was given the opportunity to formally consent to participation through the use of a consent form (See Appendix 3).

The researcher offered, if appropriate, to inform each child or young person of the research project and their role within it. It was the role of the Department of Human Services (Community Services) as formal Guardian/decision-maker to determine the nature and level of information disclosed to the child or young person in relation to the study. As all of the children and young people for whom behavioural information was accessed through the study were under the care of the Minister, Department of Human Services (Community Services), local representatives were able to manage consent for any child or young person’s material to be included as de-identified information to support carer assessment.

A total of 35 individual carers (28 Aboriginal) approached either decided not to participate following briefing, or withdrew within ten minutes of commencing the
trauma and resilience survey tools. As noted above, it is acknowledged that it is likely that issues related to the re-triggering nature of the content contributed to this result. All materials related to these participants were destroyed at the point of their withdrawal in compliance with the requirements of the ethics approval. There were also a number of carer support and community organisations (4) that withdrew their agency’s engagement in the study at, or within a week, of the briefing. In these cases, all survey information was returned to the researcher and subsequently destroyed. The predominant explanation for withdrawal of support for the research project was the assessment by the organisational leaders that the process of completing the survey information was likely to “re-traumatise” carers. On follow-up, it was noted that none of these services had in fact presented or received any direct feedback from carers, but had rather made the decision to withdraw at the level of the agency. Clearly, this experience raises important questions related to both the most effective processes of engaging participants, and the field or agency culture supporting research related to carers. These issues are discussed in the closing chapters of the study. The final sample (N=125) achieved completed all aspects of the study.

5.2 Carer interview and administration of trauma and resilience assessments. The carer structured interview (CSI) (See Appendix 4), along with the normed psychological assessments were usually conducted by a clinician in a single meeting or session lasting between 45 and 90 minutes. Where literacy or language proficiency issues were identified, assistance was available, and on occasions completion time was extended. The carer interview occurred within the home setting or in a negotiated location. In the case of the paid residential carers, the settings were usually training or meeting rooms within the workplace or agency office.
At interview, all assessment tools (CSI, DAPS, TSI & RS15) were administered. Each carer participant was requested to complete the three standardised psychological tools using an independent completion or self-assessment format. The surveys were presented to participants together in an individual participant envelope numbered with a unique participant identification code. The participant was able to elect in which order they completed the assessment tools. If required, the supporting research officer/clinician would assist the participants to approach and manage access to question and answer booklets, and provide support in the explanation of completion requirements; they were not involved in answering the questions but rather in helping to read or interpret the questions where necessary. On completion of the assessment tools, carers were requested to replace the materials in the envelopes and seal them. To ensure all participant information was maintained as confidential, all consent information was collected and stored separately. Interview information was attached to the sealed envelope and linked to a common participant identification code. The data gathered was coded and de-identified for research purposes.

**5.3 Behavioural assessment and review.** Each child or young person in the care of the research participant carers had a comprehensive behavioural assessment completed by a clinician working with the identified child or young person, clearly showing analysis of the function of the behaviour and recommendations for intervention (See Appendix 6). These reports, along with targeted surveying of clinicians were used to generate a clinician expectation or ‘prognostic score’.

A follow-up review, mirroring aspects of the initial behavioural assessment was undertaken at approximately six months from the initial assessment in order to assist to validate clinician prognostic scores for each identified child or young
person. This review was performed through the engagement of the initial clinician and in consultation with current support providers. Thus research and service provision were aligned.

5.4 Demographic data. The current study collected demographic information on age, gender, role, and ethnicity. Within the research design, the demographic data acts to extend the understanding of the primary research question and core data set to enrich the research findings (Morse, 2003; Wilkins et al., 2008). All data for sub-projects and the demographic data have been combined in a single data set for analysis.

5.5 Sequencing. Within the multi-method design there is also the need to consider the sequencing of the projects and the data collection. For the current research project, the process of simultaneous implementation was selected, i.e., all stages of the study run concurrently. Three of the specific assessment tools are normed psychological assessments, and one is a structured qualitative interview with one embedded quantitative measure, administered in one session. Supplementary data was provided by a follow-up measure six months after the initial collection date, to validate initial assessment information. Although this follow up data collection reflects an element of sequential process within the project, its purpose is sensitising rather than primary data set collection, and there is no aspect of the contingency impacting on the design.

5.6 Sensitising data. Sensitising data sets are notably selected and designed to provide validation and potentially add a dimension of enhanced clues (Morse, 2003; Wilkins et al., 2008) to assist with analysis. Two specific elements of data collection were used to sensitise the material collected for this study. The first is the use of two normed psychological assessments of participant Trauma profiles, rather than a
single tool (for ease of reading only one set of data, the DAPS is presented in the body of this thesis, the results of the second tool used to sensitise the data, the TSI are presented in Appendix 7. The key rationale for inclusion of two measures was to (a) validation of the findings between tools, and (b) to check for, not only the presentation of historic (life-long) primary trauma (DAPS), but also current (last six months) experience of traumatic events and symptoms (TSI). The second was the supplementary data gathered in the six-month follow-up behavioural assessment, used to sensitise the clinician’s prognostic score for each of the children or young people assessed.

The inherent challenge in the inclusion of sensitising data is the risk of over-burdening the study participants with extra survey material or periods of commitment to the targeted research project (Morse, 2003; Tashakkori & Teddie, 2003). This was a central challenge to this project in both the recruitment and retention of participants for the full completion of all elements of the study. To manage this, significant efforts were made to support participants through briefing and, in many cases, provide support to assist with survey completion (for example, staff available to assist participants, staff group briefing following attendance at regular team meetings, and one-to-one clinician facilitation and support). Participants were also free to discontinue at any stage if they felt the research burden too onerous and, as previously discussed, several did this. Further administration challenges involved the requirement for clinicians to contact the sample children and young people after six months, for the follow up behavioural assessment.

5.7 Results recording. The data resulting from the carer psychological profile tools (DAPS, TSI and RS) and carer interviews was processed and analysed in a single database. All individual carer data was linked to the participant code attached
to the envelope within which carers had placed completed assessment tools. The database was designed initially using Microsoft Excel, and then processed through the SPSS system to improve and broaden analysis options.

Data points extracted from Trauma scales (DAPS & TSI) formed the framework of the collated database. Data points extracted from the carer interview and clinician assessment material are presented in the following table.

*Table 8 - Project Analysis*

<table>
<thead>
<tr>
<th>Carer Interview</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Carer</td>
<td>Carer Expectation/Prognosis Rating 1-5</td>
</tr>
<tr>
<td>BEHF</td>
<td>Narrative explanation of behaviours (Function)</td>
</tr>
<tr>
<td>Barrier</td>
<td>Narrative Explanation of Carer understanding of Client</td>
</tr>
<tr>
<td>Clinical Behavioural Assessment</td>
<td></td>
</tr>
<tr>
<td>and Review</td>
<td></td>
</tr>
<tr>
<td>CP Q1</td>
<td>Clinician Expectation/Prognosis Rating – Initial Assessment</td>
</tr>
<tr>
<td>CP Q2</td>
<td>Clinician Expectation/Prognosis Rating – 6 month Review</td>
</tr>
</tbody>
</table>

*Note.* This table outlines the key reported data point variables collated for analysis from the CSI. Program Carer refers to the participant carer, BEHF refers to the carer’s explanation of the function of the child’s behaviour, Barrier refers to the carer’s explanation of their understanding of the child’s behaviour. CP Q1 refers to the resulting Prognosis Rating given by the clinician at initial assessment, and CP Q2 refers to the resulting Prognosis Rating given by the clinician at the 6-month follow-up review.

The full data set was assembled over a 12-month period, with a further five months required to incorporate the 6-month clinician reviews.

5.8 Analysis process. The first phase of analysis focused predominantly on the descriptive statistics related to the participant demographics. This process was able to establish the general representativeness of the sample (assessments for which valid results had been attained), and the scope and limitations for inference of the comparative scores.
The second phase of analysis focused on the scores achieved within the normed psychological scales for trauma and resilience using the standard analysis methods relevant to each tool. Through this phase, the individual and overall carer results were compared and contrasted across carer categories and within groups. The resulting Post-Traumatic Stress (DAPS) profiles were compared with results from the Trauma Symptom Inventory (TSI), to sensitize or validate results.

The third phase of analysis compared carer with clinician’s expectations and prognostic scores. The scores were compared to determine whether carer responses were more or less positive or negative than those of the clinicians assessing the child or young person. The scores were analysed for their consistency between and within carer categories, age, gender and Aboriginality. They were also correlated with the trauma and resilience profiles of each carer. The fourth phase of the analysis undertook to compare and contrast the behavioural review (expectation/prognostic score) findings by the clinician with the original behavioural assessment completed six months earlier. Through this process, the degree of concurrence between clinical assessments was tested, along with expectation/prognostic and treatment recommendations.

The fifth and final phase of analysis reviewed key elements of the carer interviews to identify themes in relation to common beliefs and attributions regarding behavioural function, and identified barriers to development and behavioural change. These themes were grouped in relation to carer categories, and identified the most common reasons carers gave to explain the child or young person’s behaviour (attributions).
6. Research Questions and Hypotheses

The content of the two sub-projects within the multi-method design both have a quantitative dimension.

6.1 Sub-Project 1. As discussed within the opening chapters, there has been limited previous direct study focusing on the psychological profile and expressed capacities of carers (Fraser et.al., 2013). The work that has been undertaken has predominantly described the markers of optimal parenting to meet the assessed needs of children and young people (White, 2005). The clear impact of trauma on carer capacity has been noted as a consistent feature driving theoretical models and parent training (DeGregorio, 2012), along with concerns related to the enhancement of resilience to sustain intervention without any research investigating the primary trauma and resilience levels of carers.

The dominant focus of sub-project 1 was the generation of trauma and resilience profiles of carers occupying a range of positions within the OOHC system. This sub-project was designed to address the research question: What is the trauma and resilience psychological profile of carers of high needs children and young people in Out-of-Home Care in NSW? As outlined in the introduction of this chapter, a number of specific hypotheses were formulated in the process of designing this study, based on previous personal field experience and related research. Each hypothesis and its relative contributing context are explained here.

6.1.1 Hypothesis 1 – Trauma. It is expected that carer primary trauma profile scores, across all carer categories, would be above that that reflected in the general population (under 12% presenting symptoms consistent with a diagnosis of PTSD at sometime in their lifetime). (Briere, 2001).
This hypothesis draws on the weight of research indicating the potential for trauma effected individuals to be drawn to caring work (Pearlman & Saakvitne, 1995). Furthermore, the expressed need for longitudinal support to manage the impact of the caring role, in workers engaged in the welfare fields related to vicarious trauma (McCann and Pearlman, 1990; Hawes et al., 2011; Geiger et al., 2013) implies trauma is a concern for those providing care to high needs children and young people.

6.1.2 Hypothesis 2 – Aboriginal Carer Trauma. It is hypothesised that Aboriginal carers would have higher trauma profile scores than non-Aboriginal carers in view of the history of trauma of Aboriginal Australians (Butler, Hopkins & Nivison-Smith, 2009).

6.1.3 Hypothesis 3 – Resilience. It is hypothesised that carer resilience scores would vary across the carer age clusters, consistent with the spread in general population samples (i.e. sample reflecting the full range of scoring possibilities, and a general increase in reported resilience with age) (Windle, Bennett, & Noyes, 2011).

6.1.4 Hypothesis 4 – The relationship between trauma and resilience. It is hypothesised that there would be a positive and consistent relationship between trauma and resilience profiles of carers (i.e. carers reporting complex histories of significant trauma and associated symptoms will also report resilience levels along a correlated continuum). Consistent with Bonanno & Mancini (2012) it is anticipated that positive resilience scores for individuals reporting the highest and most significant trauma symptoms will be found.

6.2 Sub-Project 2. The second sub-project assessed the individual carer’s expectations of and attributions or understanding of the child or young person in
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their care’s needs and functioning. This project also explored carer’s understanding of and reasons for, the child or young person’s presenting difficult behaviours, and their expectations of behavioural recovery. Carers’ results were then compared to clinician impressions in identifying contrasts in expectations. In testing the ability to accurately project the level of support and the sort of intervention required, it was anticipated that the study would reveal elements of bias, and beliefs. These have been shown to significantly shape carer capacity to manage intervention and sustain functional support (Hawes et al., 2011).

The current research questions targeted through this Sub-Project 2 consist of the following:

What are the expectations, or attributions, carers have about the children and young people they work with?

How do these expectations potentially impact on the carers regarding the support dynamics and their capacity to care?

What expectations or attribution do carers apply in their understanding and explanation of the function or meaning of the child or young person’s behaviour?

How do carers conceptualise their understanding of the barriers to change and development that confront them in caring for children and young people with complex needs?

Even though this data was collected qualitatively and is more consistent with an inductive approach, which seeks to understand how one factor influences or correlates with another, the overarching questions have, for consistency of reporting, been formulated into the following hypothesis:

6.2.1 Hypothesis 5 – Carer expectations. It is anticipated that carers would report both positive and negative expectations in their prognostic scores for the child
or young person they are working with. This hypothesis builds on the current work of researchers such as Hawes (2011) and colleagues who have found the dynamic of relationship between carer and individual child has worked to shape carer behaviours and expectations. From this research, it would be anticipated that the variable personality and presentation of each individual child would inevitably differentially shape carer expectations. Further, the work of Geiger and colleagues (2013) in the research of carers’ expectations of their role and capacity, supported the impact of multifaceted and largely systemic support variables as influencing carer perceptions. In both cases, the research implies expectations are shaped by individual and contextual experiences as directing either positive or negative expectations.

It is predicted that that the range of expectations or attributions used by carers would vary between carer roles. It is anticipated that the nature of the role would hold as a significant variable impacting on the relationship between the carer and the cared for, and potentially the way the carer frames their expectations of the child or young person. This prediction is consistent with Ayalon’s (2011) findings related to the variations in perceptions held between family-based carers and others. This prediction of the impact of carer role variation influencing expectations is also supported by the work of Weiss (2011) and impact variations noted in welfare workers in differing relationships to clients.

7. Thesis Presentation of Project Data and Findings

Chapter 4, ‘Carer Trauma and Resilience Profiles’, focuses on the trauma and resilience profiles emerging in this study, and places this work alongside that of parallel populations. In particular, this chapter explores the relationship between these two concepts, and the profile of psychological symptom measures.
Chapter 5, ‘Expectation and Attribution Impact on Carer Profile’, reviews the analysis of data emerging as a result of the expectation measures. This chapter reports the reasons carers gave for how they understand the behaviour of the child or young person they care for and what support or assistance they believe will be needed to assist this person. It compares this with clinicians’ assessment of the support needs of the child or young person in care and establishes whether carers are more or less optimistic or pessimistic in their assessment of the care needs of the child or young person they care for.

Chapter 6 provides the final analysis, and discusses the study’s findings in relation to current literature. The final, seventh chapter provides a summary of findings and conclusions of the thesis. This chapter revisits the contextual studies that the thesis is based on and reviews the research questions against the results discussed in the analysis chapters. Chapter 7 concludes with a number of recommendations for practice development and areas noted for further research.
Chapter 4: Carer Trauma and Resilience

1. Introduction

This chapter, in presenting the findings of the trauma and resilience scores, will investigate primary trauma and resilience as independent variables in relation to the dependent variable, capacity of carers to care. The central research question driving this first sub-project of the thesis is understanding the nature of carer primary trauma and reported resilience.

Over the last twenty years, meta-analytic research in childhood trauma and deficits in early attachment on child development, has led to theoretical or practitioner led model formulations harnessing critical factors underpinning optimal parenting. Key among these are attachment, resilience and competence (Kazdin & Rotella, 2009, 2010; Blaustein & Kinniburgh, 2010; Sanders, 2008). Although still evolving, evidence of the benefits of the ‘real world’ implementation of intervention and support models for children and young people is showing outcomes (Michelson et al., 2013; Fraser et al., 2013; Meichenbaum, 2012). Essential to ongoing efforts is a need to address the gap between psychological profiles of carers and good enough parenting or care (Möller-Leimkühler & Wieshu, 2012; DeGregorio, 2012). While acknowledging the critical contributions of research into attachment, emotional regulation, secondary and vicarious trauma, the specific focus of this study is primary trauma (DeGregorio, 2012), and resilience (Masten, Hubbard, Gest, Tellegen, Garmezy & Ramirez, 1999). These two areas impact on carer capacity to respond to complex needs, communicate empathic support for healthy attachment, and sustain caring. The results of sub-project 1 are reported in this chapter, along
with details of the nature of the relationship between demographic variables within
the carer sample.

2. Results – Trauma Measurement

The Detailed Assessment of Post-Traumatic Stress (DAPS) (Briere, 2001) was
selected as the key measure of carer participant trauma exposure. The DAPS has
wide industry acceptance as a comprehensive diagnostic tool for Acute Stress
disorder (ASD), Post Traumatic Stress Disorder (PTSD) and profiling purposes, and
also for its calculative production of trauma symptom profiles. The scales of the
DAPS are reliable and demonstrate a variety of types of validity in clinical and
nonclinical contexts (Briere, 2001; Blake et al., 1995; Blake et al., 2000).

2.1 Participant Trauma Profiles (DAPS). Adapted from Briere (2001), the
DAPS is a self-report questionnaire of 104 items. It is designed to assess current and
past exposure to traumatic events (primary trauma) along with their severity and
clinical symptoms (peri and post traumatic symptoms). It generates a profile to
investigate in a clinical interview. Individual scores were then reported through the
use of a database with coded reference to individual participants and their results
across all study measures.

2.1.1 Preliminary analysis – descriptive statistics. One hundred and eighty-
four participants initially agreed to participate in the project but 28 Aboriginal carers,
and 31 non-Aboriginal cares withdrew or submitted incomplete or invalid material.
The sample completing all data collection phases totalled 125 carers (N=125). Prior
to analyses, data was checked for correct entry, missing values and normality
assumptions.

Results on the DAPS indicated a substantial proportion of participants with
indicators of both primary trauma experience and current symptoms; just over half of
the participants reported a symptom indicator in the clinical range, and just over 20% (N= 25) met the diagnostic criteria for PTSD. This result is comparable or above results reported in participants who have experienced significant trauma events (i.e. war veterans, terrorism or natural disaster survivors).

Table 9 - Percentage of participants DAPS (Trauma symptoms/PTSD) based on role category

<table>
<thead>
<tr>
<th>Role</th>
<th>Trauma Symptom</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid Staff</td>
<td>53%</td>
<td>19%</td>
</tr>
<tr>
<td>Foster Carer</td>
<td>55%</td>
<td>27%</td>
</tr>
<tr>
<td>Birth Relative</td>
<td>47%</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>53% (N= 66)</td>
<td>20% (N= 25)</td>
</tr>
</tbody>
</table>

Participants were asked to self-categorise their profile across four demographic divisions: support role (Paid Carer or Staff/Foster Carer/Birth Relative), ethnicity (Aboriginal/Non-Aboriginal), age, and gender. These definitions formed the individual carer identification codes, which were then matched against the returned data for trauma experience and symptoms. The following sections report the survey findings across these profile divisions.

2.1.2 Correlations between variables. Using a One-way Anova the relationship between carer roles, demographics (Aboriginality, gender, age), trauma (DAPS) and Resilience scores where compared (See Table 10 & Table 11). The results indicated that for all correlations none were significant, confirming that role variability was not a factor influencing relationships, and that the carer group, although showing small variations in trends, could be considered as a whole when discussing results. The carer sample reported profile features that are more similar than different, and with no correlations between variables indicative of a relationship
between features, it raises important questions around understanding within sample trends.
Table 10 - Correlation analysis across carer role among demographics, trauma and resilience scores

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid Carer</td>
<td>76.34</td>
<td>17.512</td>
<td>.170</td>
<td>.844</td>
</tr>
<tr>
<td>Foster Carer</td>
<td>76.41</td>
<td>22.159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>73.33</td>
<td>21.299</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>75.99</td>
<td>18.722</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAPS – Criteria met for PTSD</td>
<td></td>
<td></td>
<td>.881</td>
<td>.417</td>
</tr>
<tr>
<td>Paid Carer</td>
<td>1.34</td>
<td>.477</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Carer</td>
<td>1.41</td>
<td>.503</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>1.20</td>
<td>.414</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.34</td>
<td>.474</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>2.820</td>
<td>.064</td>
</tr>
<tr>
<td>Paid Carer</td>
<td>38.14</td>
<td>10.541</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Carer</td>
<td>44.05</td>
<td>8.300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>37.71</td>
<td>11.138</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.08</td>
<td>10.437</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>8.106</td>
<td>.000</td>
</tr>
<tr>
<td>Paid Carer</td>
<td>1.53</td>
<td>.502</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Carer</td>
<td>1.86</td>
<td>.351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>1.93</td>
<td>.258</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.64</td>
<td>.482</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginality</td>
<td></td>
<td></td>
<td>3.608</td>
<td>.030</td>
</tr>
<tr>
<td>Paid Carer</td>
<td>1.80</td>
<td>.406</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Carer</td>
<td>1.59</td>
<td>.503</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Relative</td>
<td>1.53</td>
<td>.516</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.73</td>
<td>.447</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11 - Intercorrelations among demographics, trauma (DAPS) and resilience scores

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Gender</th>
<th>Aboriginality</th>
<th>Resilience</th>
<th>DAPS-PDST</th>
<th>DAPS-PTSD</th>
<th>DAPS-SUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.041</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginality</td>
<td>.136</td>
<td>.178*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>.108</td>
<td>-.024</td>
<td>-.060</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAPS-PTST</td>
<td>-.071</td>
<td>.003</td>
<td>.012</td>
<td>.074</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAPS-PTSD</td>
<td>-.032</td>
<td>-.102</td>
<td>.016</td>
<td>.020</td>
<td>.646**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>DAPS-SUB</td>
<td>-.052</td>
<td>.018</td>
<td>-.079</td>
<td>-.014</td>
<td>.393**</td>
<td>.325**</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: All correlations were not significant at p = 0.05 except * p<.01, **p<.05. DAPS-PDST = Peritraumatic Distress. DAPS-PTSD = Met criteria of diagnosis for PTSD. DAPS-SUB = Substance Abuse. Significant correlations achieved reflect a relationship between carers meeting the criteria for a diagnosis for PTSD and the co-morbidity of target symptoms of reported distress and substance abuse that would be expected.

2.2 Role and Trauma. The role categories were (a) Paid Staff, (b) Foster Carers, and (c) Birth Relatives. Results were consistent across carer categories; approximately half of the carers across all carer types reported results indicating trauma experience and trauma symptoms. The highest percentage scores for trauma symptoms were reported within the (b) Foster carer group. Over half the Foster Carers (55% N= 12) reported symptoms that would notably influence and impact on day-to-day functioning and a high percentage (83% N=18) of carers within the group reported indicators of trauma symptoms. Foster carers were also characterised as less systematically supported, and often in casual roles with limited access to targeted training. The lowest percentage scores for trauma symptom indicators were reported within Birth Relatives. Although slightly lower than the other role clusters, it remains the case that almost half (47% N= 7) of the sample reported symptoms.
Results across groups are substantially greater than results reported in both the general community and within populations with an identified trauma history. The match between the carer results and the criteria for a potential diagnosis of PTSD varied across the groups. Foster Carers reported the highest frequency of participants meeting the DAPS criteria for a diagnosis for PTSD (27% N= 6), and Birth Relatives the lowest frequency (13% N= 2). It is notable that even the lowest group reporting is at a higher rate than that anticipated for normed populations, and more matched to results achieved for populations who have experienced a high trauma exposure.

In summary, work role appeared to vary with trauma symptom frequency, or diagnosis of PTSD. All groups reported a greater frequency of symptoms than those evident within normed or specialist (veteran or explicitly traumatised) populations. In all role categories participants reaching criteria for a diagnosis of PTSD was above these comparison groups’ results. The results support hypothesis 1: that carer trauma profiles, across all carer categories, would be higher compared to that reflected in the general population. Of particular interest was the degree to which variation was noted. The results reflect that the carer group reported higher symptom levels than those reported by test sample participants drawn from specifically traumatised populations (veterans, or survivors of natural disasters). Clearly, these findings have important implications for clinical practice models and resource application.

2.3 Ethnicity. Results showed that Aboriginal carers reported closely matched scores on incidents of trauma experience and trauma symptoms. There was a difference of 12% between the proportions of Aboriginal carers reporting issues in comparison to non-Aboriginal workers. This difference was sustained across carer role types, with a slightly greater result within the Foster care category. The rates of
Aboriginal carers assessed as meeting the criteria for PTSD diagnosis closely matched that for the broader carer group. The breakdown by role category mirrored that achieved for the broader group, with Foster carers being notably the highest rate of carers reaching PTSD criteria.

Table 12 - Trauma Symptom Comparison Aboriginality/Role

<table>
<thead>
<tr>
<th>Measures</th>
<th>Aboriginal</th>
<th>Paid Staff</th>
<th>Birth Relative</th>
<th>Foster Carer</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Symptom</td>
<td>61%</td>
<td>57%</td>
<td>78%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Criteria for PTSD</td>
<td>22%</td>
<td>14%</td>
<td>33%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

This result does not support the study’s second hypothesis, that Aboriginal carers would have trauma profile scores above that of non-Aboriginal carers. In fact, these results indicate that Aboriginal and non-Aboriginal carers share similar rates of primary trauma experience. As discussed above, challenges in achieving participation of Aboriginal carers, saw the withdrawal of almost half of the potential sample of this sub-group of carers by agencies concerned with potential re-traumatisation. This may have influenced results.

2.4 Age. The study sought to investigate trauma profiles relative to age of the participants. The age bands for participants were: 18-25 years, 26-35 years, 36-45 years, 46-65 years. Results demonstrated that there were higher rates of trauma experience and symptoms reported in the younger (18-25 years) (88.8%) and older (56-65 years) (83.8%) participant clusters. This is an important result in terms of symptom indicators. These results build on the understanding of the carer population profile.

2.5 Gender. The study investigated gender in relationship to carer trauma profiles. There were no significant relationships revealed in the results by gender in
the relationship of carer trauma experiences and symptoms or the diagnosis of PTSD.

2.6 DAPS Element Scores. The DAPS (participant trauma profiles) provides a number of specific element measures that are combined to give a trauma profile for each individual respondent. In using the DAP assessment results in practice, it is critical that each profile is examined to understand the individual needs of each person assessed. For the purposes of this study, participant results were aggregated to track trends of the group. The elements from the DAPS assessment were reviewed, indicating the following outcomes and trends.

Table 13 - DAPS Trauma Symptom Indicator Profile Proportion of Sample

<table>
<thead>
<tr>
<th>Symptom</th>
<th>RTE</th>
<th>PDST/PDIS</th>
<th>RE</th>
<th>AV</th>
<th>AR</th>
<th>IMP</th>
<th>T-DIS</th>
<th>SUB</th>
<th>SUI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17%</td>
<td>26%</td>
<td>16%</td>
<td>13%</td>
<td>18%</td>
<td>13%</td>
<td>8%</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>N=</td>
<td>21</td>
<td>33</td>
<td>20</td>
<td>16</td>
<td>23</td>
<td>16</td>
<td>10</td>
<td>15</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note.* The results above reflect the proportion of the sample that reported primary trauma symptoms against each of the DAPS indicators. RTE = Relative Trauma Exposure. PDST = Peritraumatic Distress. PDIS = Peritraumatic Dissociation. RE = Re-experiencing. AV = Avoidance. AR = Hyperarousal. IMP = Post-traumatic Impairment. T-DIS = Trauma-Specific Dissociation. SUB = Substance Abuse. SUI = Suicidality.

2.6.1 Validity Scales. The DAPS Validity Scales assess each respondent’s tendency to deny (positive bias) or over endorse (negative bias) participant reported symptoms. Only those participants who met the criteria for validity within the tool were included in the sample (N= 125). Those who failed validity tests tended to also report clinical scores for positive bias (tendency to deny symptoms) and were withdrawn from the sample.

2.6.2 Trauma Specification Scales. The DAPS specification scales assess the areas associated with the respondent’s experience of trauma (See Table 13). These
experiences are divided into four areas of trauma exposure: the level of cumulative or repeated exposure, the period or duration of exposure, the type and extent of emotional and cognitive change resulting from exposure, and whether the respondent has experienced dissociative experiences during or immediately following the event (Briere, 2001).

Results for Relative Trauma Exposure (RTE) show 17% (N= 21) of all carers scored clinical results for RTE. These results appear to provisionally indicate “that respondents have experienced more types of potentially traumatic events than most other people who have had at least one trauma exposure.” High RTE scores will frequently indicate more complex trauma effects, and often have associated lifestyle issues that potentially correspond with repeated victimisation (Briere 2001, p. 19).

Two scores measure the elements of Distress and Disassociation, the Peritraumatic Distress (PDST) and the Peritraumatic Dissociation (PDIS). In terms of returned results for Peritraumatic Distress (PDST) show 26% (N= 33) of all carers were in the clinical range for Peritraumatic Distress (PDST). These results provisionally indicate “the overall extent to which the respondent was distressed during (or soon after) the traumatic experience relative to other individuals who have trauma histories.” High PDST scores tend to experience greater levels of traumatisation, and more severe symptomatology (Briere, 2001, p. 20).

Results for Peritraumatic Dissociation (PDIS) show 30.4% (N= 38) of all carers scored clinical results for Peritraumatic Dissociation (PDIS). These results provisionally indicate “the tendency (for individuals) to dissociate during traumatic events” and these symptoms usually take the form of “depersonalization” or “de-realization”. People with high PDIS scores are often more likely to develop Post-traumatic Stress Disorder (PTSD), and have greater tendencies to dissociate in
general circumstances rather than only when placed in stressful situations (Briere, 2001, p. 20),

In summary, the results above taken together clearly show that the study sample group have experienced a relatively high level of complexity and repetition in their exposure to trauma. Approximately one third of the sample reported a history of problematic reactive responses and current severe (in the clinical range) symptomatology.

2.6.3 Post-traumatic Stress Scales. The DAPS Post-Traumatic Stress Scales (Briere, 2001) measure a set of four cluster symptoms: Re-experiencing (RE), Avoidance (AV), Hyperarousal (AR), Post-traumatic Impairment (IMP) (See Table 13). These measures are closely associated with symptoms common to diagnosis of PTSD.

Results for Re-experiencing (RE) show 16% (N=20) of all carers scored results in the clinical range for RE. A score in the clinical range on this item measures reported symptoms related to intrusive thoughts, flashbacks, memories and nightmares related to traumatic event(s). Participants with high RE scores are currently experiencing notable post-traumatic stress, and often feel reported loss of control in their lives (Briere, 2001).

Results for Avoidance (AV) show 13% (N=16) of all carers scored results in the clinical range for AV. Respondents with high AV scores report conscious efforts to avoid “people, places and conversations and situations that might trigger flashbacks or other intrusive re-experiencing symptoms.” This group will often be reluctant to discuss their symptoms with others, and often have many associated issues with treatment engagement or adherence (Briere, 2001).
Results for Hyperarousal (AR) show 18% (N= 23) of all carers scored results in the clinical range for AR. A high AR score tends to correspond with a report of emotional distress, and anxiety, along with irritability, somatic symptoms and constantly being ‘on edge’. Additionally, it is often noted that people with high AR scores may use drugs, alcohol or other sedating or soothing devices to down-regulate their emotional state (Briere, 2001).

Results for Post-traumatic Impairment (IMP) show 13% (N= 16) of all carers scored clinical results for IMP. This scale measures psychosocial impairment, the degree to which a person is having difficulties and problems in their life directly attributable to the trauma. Individuals with high scores on this measure are noted to be experiencing impairment on a daily basis during regular activities (Briere, 2001).

2.6.4 Associated Feature Scales. This group of scales reflect measures often co-morbid to post-traumatic stress: Trauma Specific Dissociation (T-DIS), Substance Abuse (SUB), Suicidality (SUI). This group of scales represent a group of specific symptoms that could be expected to interfere with a carer’s ability to parent in an attuned and appropriately focused manner. A carer reporting these symptoms and rating within the high or clinical range would necessarily be challenged in their capacity to care against criteria discussed in the opening chapters.

![DAPS Trauma Specific Dissociation](image)

*Figure 3 - DAPS Trauma Specific Dissociation.*
This pie graph displays the proportions of the carer population that reported symptoms.

Results for Trauma Specific Dissociation (T-DIS) show 8% (N = 10) of all carers scored results in the clinical range for T-DIS. This scale measures derealisation, depersonalization and detachment symptoms following an acute trauma experience. The measure targets reactions to a specific trauma event (Briere, 2001).

Results for Substance Abuse (SUB) for this study: 12% (N= 15) of all carers scored results in the clinical range for SUB. Foster carers and Birth Relatives disclosed the highest rates of substance abuse. Aboriginal Foster Carers results were slightly above that of the rest of the carer categories. This measure scores the participant’s self-reported use of drugs and alcohol. Clinical scores on this scale indicate serious drug and/or alcohol problems. On a normative population sample, this scale is usually endorsed at a very low level and these results should be understood in the context of a trend to under-report experience (Briere, 2001).

![DAPS Substance Abuse](image)

*Figure 4 - DAPS Substance Abuse.*

This pie graph displays the proportions of the carer population that reported symptoms.

Results for Suicidality (SUI) show four percent of all carers (N= 5) scored results in the clinical range for SUI. This measure scores the participant’s self-reported suicidal motives, ideations and behaviours. Clinical scores on this scale are
often associated with individuals who have suffered major losses, depression, or who are suffering extreme psychological pain (Briere, 2001).

![DAPS Suicidality](image)

**Figure 5 - DAPS Suicidality.**

This pie graph displays the proportions of the carer population that reported symptoms.

In summary, 62% (N=40) of those who scored any trauma indicator in the clinical range, scored clinical results on two or more indicators within the whole DAPS tool. The group of foster carers were assessed as showing higher levels of symptoms, and greater impairment of function resulting from their trauma experience and reported difficulties. Of this group of features concerned with dissociation, substance abuse and suicidality, the results for substance abuse are the highest, although the number of individuals with potential for such severe symptoms in all categories is worthy of note.

It should be noted that all of the carers engaged in the study were actively caring for children and young people. Additionally, although there was no element of performance screening included in the profile, all were supported by either an agency or nomination process as suitable to engage in the study.

**2.7 Participant Trauma Profiles (TSI).** As discussed in Chapter 3, the TSI was included as a second trauma assessment scale to provide sensitizing data to check the validity of the results of the DAPS. Adapted from Briere (1995), the TSI
tool is presented as a 100-items questionnaire designed for individual completion with a focus on the individual’s trauma symptom experience of the last six months, in contrast to the DAPS assessment, which seeks to capture lifetime trauma history and symptom experience.

One hundred and seventeen (N= 117) of the study participants completed the TSI tool, meeting all validity requirements, but slightly below (8 less than) the completion rate achieved for the DAPS. This attrition rate may be the result of the TSI component being addressed by the participants after the DAPS component. Participants may have been ‘test weary’, and the TSI being perceived as similar to the DAPS. Analysis of those participants who did not submit a TSI score showed that they were representative of Paid Staff (7), Foster Carers (1). A total of 1 Aboriginal carer made up the group, leaving a total of 33 in the sample. In the context of the reduced number for this qualitative element of the study, the sample remained proportionally representative.

Table 14 - TSI Trauma Significant Symptom Profile Proportion of Sample

<table>
<thead>
<tr>
<th>Symptom</th>
<th>AA</th>
<th>D</th>
<th>AI</th>
<th>IE</th>
<th>DA</th>
<th>DIS</th>
<th>SC</th>
<th>DSB</th>
<th>ISR</th>
</tr>
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Results of the TSI indicate that 18% (N= 21) of the sample group report indicators of trauma experience and symptoms within the clinical range. The TSI results closely mapped the profile of carer symptoms noted in the DAPS. This was true for both general trauma symptoms and those indicators holding potential for a diagnosis of PTSD. The DAPS scores were consistently higher and more likely to
reflect an indicator of trauma experience and/or symptoms than the TSI. The DAPS identified symptom profiles in 23 of the participant carers that met criteria for a diagnosis of PTSD. The proportion of carers identified as meeting criteria for PTSD (DSM-V, 2013) was consistent across carer roles. The TSI identified 23 of the participants carers that met criteria for a diagnosis of PTSD. The TSI (N=32) found a lower frequency of reporting by carers of symptom indicators in the clinical range to that of the DAPS (66). This finding is consistent with the results achieved by a number of researchers (Danieli, 1998; McCann & Pearlman, 1990; Pearlman & Saakvitnes, 1995) who have found high rates of expressed trauma symptoms in those undertaking the caring role.

The TSI results, like the DAPS results, show that Aboriginal carers within the sample have only slightly higher levels of trauma exposure and symptoms than non-Aboriginal peers. Foster Carers consistently reported the highest incidence of symptoms, and, more specifically, Aboriginal Foster carers achieved a high frequency of symptoms results on both the DAPS and TSI tools. Interestingly the TSI, which focuses on trauma experience of the last six months, in contrast to the DAPS lifelong emphasis, showed results indicating a similar carer profile across age, suggesting perhaps that the carer sample showed chronic lifestyle factors consistent with ongoing primary trauma experience. The full report of TSI results and discussion are available in Appendix 7.

3. Results – Participant Resilience Profiles

Of the total participant group (N = 125), only two (2) carers failed to complete valid Resilience Scale (RS) surveys on the selected resilience measure. In both of these cases it appeared that no attempt was made to answer the questions. These participants were both Non-Aboriginal Paid Staff. (N=123)
Resilience Measurement. The Resilience Scale (RS) (Wagnild & Young, 1993) Short version was selected for this study because of its ease of use, as well as its reliability and validity. The RS was selected for a number of reasons: its functional length, its development population of middle-aged women matched predominately to the study sample, and its strong results in meta-analysis review of resilience tools (Windle, Bennett & Noyes, 2011). The short version was preferred over the long version because the study’s central ambition was to measure trend information rather than in-depth, specific information on resilience elements, and to manage the generally lengthy demands of participant engagement. The RS measures what Wagnild (2010) refers to as an individual’s resilience core against five essential characteristics proposed by the model: (a) Meaningful life (purpose), (b) Perseverance, (c) Self Reliance, (d) Equanimity, (e) Coming home to yourself (existential aloneness).

The RS tool comprises 15 questions. Participants were required to rate their responses on a Likert scale from 1 to 7 for each of the questions: 1 being Disagree (the negative), and 7 being Agree (the positive): the minimum total score achievable is 15, the maximum 105. The RS was presented on two pages as part of the package of assessments completed by all participants. Generally, participants required no additional support, or only reassurance of their correct interpretation of the context support (i.e. Does the question relate to only my work experience?) to complete the questions. The procedure required between 5 to 10 minutes to complete and increased the validity and reliability of the results.

For the purposes of analysis, the resilience score results were divided into four groups based on the clustering of results. This grouping of scores was employed to assist in the clear identification of breakdowns in profile trends in order to allow
comparison between carer categories and supplementary data elements. The score cut-offs were made as follows: *Very Low* (7-25), *Low* (26-64), *Moderate* (65-81) and *High* (82-105). The selected cut-offs match to those selected by the tool developers though moved across a four rather than a six point scale. Originally, a simple three point scale was selected, but matched against the hypothesis anticipating variations in resilience at the lower end of the scale, a grouping labelled very low was included to highlight potential clustering in this end of the scale.

Additionally, as part of the completion of the general survey information, the participants were asked to self-categorise their profile across four divisions: their support role, ethnicity, age, and gender. These definitions formed the individual care identification codes, which were then matched against resilience scores. The following sections report the survey findings across these profile divisions. Mean scores were used to reflect overall group trends. It was noted that within the groups there were generally very few ‘outliers’. Outliers, being the most extreme observations, may include the sample maximum or sample minimum, or both, depending on whether they are extremely high or low. In the case of this study all ‘outliers’ occurred at the extremely low scoring end of the sample, and all results were included in the calculations as they met criteria (sample validity across all measures) for inclusion. In statistics, the three-sigma rule, or empirical rule, states that for a normal distribution, nearly all values lie within 3 standard deviations of the mean (Ruan, 2005,). Statistical analyses were completed to assess relationships between variables with Regression tests.

**3.1 Role and Resilience.** The sample was drawn from people who occupied the roles of: Paid Staff, Foster Carers, and Birth Relatives.
These results indicated that across all carer roles the resilience scores were moderate to high. All groups had representatives that delivered scores within the High range. A total of 39.2% of all participants scored in the highest range. Proportionally, the Foster carer group returned the highest number of carers with a resilience score in the High range (55%). The majority of carers (i.e., 56%) scored within the Moderate range. Four percent of all participants achieved results that placed them in the Low range for resilience. All carer role groups held a low number of participants that ranked within the extremely low range. The mean score across all groups was at the top of the Moderate range at 75.99, with Paid staff and Foster carers scoring slightly above, and Birth Relatives slightly below. These scores represent a clear trend for the sample to demonstrate scores in the high moderate or high end of the scale. This is exceptional as the normed tool was designed to capture expressions of the full range of the tool across a population sample (Wagnild & Young, 1993).

### 3.2 Ethnicity

The ethnicity selection options were: Aboriginal or non-Aboriginal.
The results revealed that the Aboriginal carers’ resilience mean score ($M = 78$) was slightly above that of the broader group of carer participants ($M = 75.99$). However, this result was not statistically significant. Exceptionally high resilience scores were recorded for Aboriginal carers engaged in Foster care. This group presented with a mean of 89.2, which was 13 units above the group mean, but failed to meet the test for statistical significance. Across the group of Aboriginal carers, the mean results for Birth Relatives were the lowest. Due to the low carer numbers in this group ($N=7$), the influence of a single case where scores were exceptionally low has been noted. When this particular case is removed from the calculations the mean returns to match that achieved for both Aboriginal carers and the full sample.

In the context of research seeking to explore the link between trauma experience and resilience (Connor, 2006), it is possible that carers ‘self selected’ for the caring role, based on a belief in their ability to offer a positive caring experience and an assumption that they possessed skills to enhance the lives of children and young people in need. The assessment of resilience has predominantly focused on participant reports related to a person’s perception of control, meaningfulness, ability to manage change, engage with others, maintain a sense of humour and self-esteem, and report optimism, patience and/or faith (Connor, 2006). Connor further notes that it integrates complex dimensions of coping mechanisms and personality. Resilience
assessments appear to reflect the participant’s self-belief in relation to their capacity to cope or manage life challenges, and, as such, reflects their understanding of their personal resource available to offer others. In essence, what appears to be measured here is the carers’ perception of their own ‘capacity to care’. This is a relative experience. However, it is a compelling to note that all participants consistently identified themselves as possessing such positive personal resources.

In the context of these findings it is also important to consider the high number of Aboriginal carers that withdrew from the study, largely at the direction of those agencies supporting them in their role. It is possible that in fact those that continued to move through the study to complete all assessments were expressing a greater level of resilience at the outset and in their action to complete, than those who withdrew. As such it maybe that the results achieved for Aboriginal carers are subsequently skewed by the absence of this group.

**3.3 Age.** The participants were grouped accordingly by age (age range: 0-25, 26-35, 36-45, 46-65). The majority of carers are drawn from the age range of 26 to 55 years (\(M_{age} = 37.5\)). The results demonstrated that carers (36-45 years) achieved slightly higher resilience mean scores, although this trend was not statistically significant. Analysis showed that carers over 35 years old scored higher than those 35 and under. The highest individual scores achieved were not in either of the oldest and the youngest age categories. Apart from subtle trends toward increased resilience means as carers aged, resilience scores were noted to be highly individual in relation to age clustering.

The results did not follow a predicted normed population curve against age (Wagnild & Young, 1993); however, results were variable across the sample, with clustering at the higher end of the Resilience scores for all ages. The study results
indicate that older carers are demonstrating slightly higher levels of resilience. This finding possibly reflects the group’s general ‘hardiness’, and, to a lesser degree, carer perceptions of their capacity as developing positively as they age. The noted age variation for the DAPS results are not matched by the generally consistent results achieved across age for resilience. As discussed, there is a slight trend for resilience to increase with age, which provides an interesting contrast to the noted elevation in trauma symptom indicators at the extreme poles of the age clusters within the sample.

3.4 Gender. Across the sample there were a total of 45 males and 80 female participants. The results indicated that generally there were no statistically difference in resilience scores attained when reviewed by gender. However, in the context of the small sample size, the following variations were noted. Overall, male carers achieved a slightly higher mean resilience score than the female carers. The trend for higher score returns by males was consistent across all age groups, except for those carers in the 26-35 age group. In this category, female carers held a slightly higher mean resilience than the male carers. This result is neither directly supported or refuted by current research as there is minimal evidence of gender variation in resilience, and further it appears resilience is essentially related to coping styles, or the presence of specific resilience features noted on scale results (Jordan, 1996).

The general trend towards higher resilience scores for males was also consistent across carer type categories, with both Foster carers and Birth Relative carers showing higher male resilience means. The results for male Paid Staff were noted to be slightly lower than female Paid Staff. The highest gender difference was found in the group of Birth Relative carers, although within this small sample of carers it was noted that individual participants demonstrated some of the most
variable results. Both the highest and lowest individual resilience scores were equally distributed between male and female Birth Relatives.

The gender balance in relation to achieved resilience scores is important in that it greatly assists the provision of evidence of broader carer commonalities related to gender, rather than actual or perceived capacity differences. Certainly, from a screening perspective, female carers are often proactively targeted as most desirable in taking on primary roles in care provision. The study's findings point to the appropriateness of a potentially greater level of focus to be placed on the resilience of the male carer as a possible resource to sustain intervention and care.

4. Carer Resilience and Trauma Profile Comparison Trends.

Data analysis of the relationship between carer resilience and trauma profiles revealed several important observations. Despite the majority of carers overwhelmingly scoring moderate, high or very high resilience scores, where very low resilience scores were achieved, these matched to high trauma indicator scores on both the DAPS and TSI. Carers who achieved very low resilience scores (under 45), also consistently scored in the clinical range for indicators on the DAPS for trauma symptoms, and meeting the criteria for a potential diagnosis of PTSD. The TSI scores also validated this trauma profile of the sample.

This relationship between trauma and resilience scores within this population of carers suggests that where exceptionally low resilience scores are reported it is very likely that the level of reported trauma is also high. Very high resilience scores (82 and over), also had a high rate of trauma symptoms reported on the DAPS. Although this rate of correlation was not as high as those with very low scores, there does appear to be a relationship between the ‘tails of the DAPS curve’.
This pattern was less consistent in the TSI data relationship with resilience scores. At the low levels of resilience scores, TSI data indicated matches with clinical trauma indicators as for DAPS, but as resilience scores elevated, the match to trauma symptoms become less consistent. For those participants with very high resilience scores, the TSI trauma indicator scores appeared to vary across both individuals and carer groups showing no significant correlation.

These results do not support the study’s hypothesis 4: that there would be a positive and consistent relationship between trauma and resilience profiles of carers. The anticipated result that resilience scores would be lower for individuals reporting the highest trauma symptom burden, and higher for those whose trauma experience was moderate or low did not hold. In fact, in the main, the sample showed a large portion of the group as reporting trauma symptoms in the clinical range, and the majority of the sample also reporting very high resilience scores.

5. Implications for Consideration

The resilience scores achieved for the sample appear to reflect the group’s general ‘hardiness’, and, to a lesser degree, carer perceptions of their capacity to care developing positively as they age. There was no difference in the resilience levels of male and female participants, and it was found that Aboriginal carers’ results were essentially matched to the broader sample.

In terms of trauma levels, this sample of carers had high primary trauma, and reported trauma symptom scores of the type associated with the daily experience of impairment during regular activities. They are also consistent with levels associated with people who frequently suffer more complex trauma effects. Briere (2001) observes that people with trauma scales in the region of this sample often have associated lifestyle issues that invite repeated challenges and difficulties in
maintaining relationships and functional coping strategies. The findings achieved in this study link very neatly with research into carers and vicarious traumatisation as a result of the demands of the children with high care needs for whom they are responsible.

In summary, the results above taken together clearly show that the study sample group have experienced a relatively high level of complexity and repetition in their exposure to trauma. However, perhaps more importantly, the group (approximately one third of the sample) is reporting a history of problematic reactive responses and current severe symptomatology. These findings clearly have implications for screening and support functions on an operational level. It is therefore critical that support interventions for debriefing and carer healing are conceptualised as long-term (possibly lifelong), and that support is both attentive to the individual trauma recovery of the individual carer, as well as the support being habilitative (on the ground) assistance to ensure functionality and the consolidation of day-to-day coping skills.

Under the ARC and other models for carer training or implementation, it would be critical that the carer is supported to achieve many of the fundamental ‘building blocks’ that address issues of trauma so as to support the development of positive Attachment. Given the profile described above, it will be important that suitable and sustained support is available to achieve these fundamentals through mechanisms such as accessible casework, modelling and coaching. Individuals with trauma symptom profiles are likely to be specifically challenged to remain engaged in consistent routines, and suitable levels of attunement. This result holds specific relevance in the process of supporting carers to participate in lifestory or therapy with the child or young person. Where the therapy process requires the carer to hear
and empathise with whatever trauma story the child has experienced, there are likely to be many difficulties for carers in terms of re-experiencing symptoms.

The use of a strategy of avoidance, which was evident in all carers reporting trauma indicators (53%), as a result of trauma experience as a carer coping strategy has direct implications for the process of intervention when working to support a child or young person in their care. It will be critical that the clinician or facilitating worker has a central awareness of the high likelihood of this avoidance strategy as being used and modelled by carers to block exposure to experiences that might be distressing. Support to directly manage the desire to avoid specific issues or situations will need to be proactively identified and managed for both the safety of the carer and those they support.

Almost 20% of the sample of carers reported experiencing hyper arousal symptoms regularly. This is an extremely concerning result in that often the experience of Out-of-Home Care environments is often one of high activity and volatility. Such an atmosphere might be associated with the hyper vigilance and variable mood of the children or young people identified with complex care needs; however, these results also direct us to pay specific attention to the presentation and contribution of the adults in the setting. It is clear that these results indicate that a high proportion of our potential carer group are themselves challenged to regulate their anxiety and emotions.

As noted in the description by Briere (2001), where there is an indication on the dissociation, substance abuse and suicidality scales there are usually critical support issues requiring attention. Clearly, the results expressed by carers in this study flag a warning to service providers and clinicians about the seriousness of often-masked psychological challenges within this population.
These results reinforce the comments made above in relation to the imperative for those supporting intervention to children and young people to specifically acknowledge challenges in carer capacity to function predictably in their daily lives. In the context of this statement, it is also interesting to consider the likely challenge of providing sensitive support, corrective feedback or redirection to carers who sustain very high personal perceptions of competence and resilience.

Although it was not within the scope of this study, it would be very interesting to further investigate the functional capacity and actual ‘performance’ of carers matched against trauma and resilience score results on this continuum to better understand the implications of these profiles and psychological and practical support needs.

6. Conclusions

This chapter has examined one of the study’s core research questions; that is, to focus on improved understanding of the central elements of the psychological profile related to Trauma and Resilience in carers of high needs children and young people in Out-of-Home Care. The above findings have both supported and challenged the study’s initial hypotheses, and contribute importantly to filling the research ‘gap’ in relation to those aspects of psychological profile or independent variables, which underpin carers’ capacity.

Analysis of the results delivers a compelling picture of the carer group as both traumatised and, at the same time, reporting exceptional and consistent resilience. It was shown that neither age nor gender are variables influencing psychological profiles, and that there appeared to be no predictive link between trauma and resilience profiles achieved. The results have also demonstrated that, the psychological profile of Aboriginal carers is matched to that of the non-Aboriginal
carers. Although the Aboriginal carers have reported slightly higher rates of trauma symptoms, the trends in the distribution of the sample are very similar.

In the following chapter the results in relation to the second sub-project of the study, regarding carer expectations and beliefs, will be explored.
Chapter 5: Expectations’ and Attributions’ Impact on Carer Profile

1. Introduction

Central to this research study has been the desire to better understand the psychological profile of carers and how this impacts on their capacity to care. This chapter reports on the behavioural assessment and carer interviews; examines the range of carer responses to the expressed needs of children and young people in their care; and discusses the key outcomes and implications of qualitative trends in carer attributions and expectations.

Chapter four reported evidence of the high experience and symptoms of primary trauma and positive carer resilience across carer profiles, and demographic variables. This sub-project 2 investigated carer expectations of the child or young person they care for and attributions they gave to why the child or young person behaved as they did. The investigation of carers’ expectations were concerned to uncover: What underpin carers’ beliefs about the children and young people they work with? How do these attitudes relate to the carer’s expectations in the care relationship?

The importance of understanding beliefs, expectations, attitudes and values or a person’s world-view underpin daily decision-making and behaviour. What carers think is crucial to how they manage themselves and their care for the child or young person and cannot be ignored (Michelson, et al., 2013). Evidence-based research is scarce on the impact carers’ bias and expectations have on the children in their care (Donnelly, Renk, & McKinney, 2013; Hawes, Dadds, Frost, & Hasking, 2011). A number of researchers have investigated the impact of attitudinal perspectives on caring behaviours (Akakpo, 2008; Ayalon, 2011; Rozoni & Dogra, 2012; Wright,
This research has centred on how the carer’s expectations have impacted on outcomes for those being cared for, or the degree to which these beliefs are shared by others in the care team. This study seeks to describe the themes or biases reported in the sample of carers, and investigate the implications these results may have on their capacity to care.

2. Results – Carer Expectation

It was anticipated that carer expectations of the child or young person’s support needs would reflect a range of both positive and negative expectations. This hypothesis is derived from the work of researchers such as Hawes (2011) and colleagues who found that the dynamic relationship between carers and individual children shaped carer behaviours and expectations. Geiger and colleagues (2013) researched the impact of multifaceted and largely systemic support variables in relation to carer capacity. Research found that expectations were shaped by individual and contextual experiences that resulted in both positive or negative expectations.

2.1 Expectation measurement. The measure applied within this study specifically requests the clinician and carer to select the descriptor that “best matches” the anticipated period of intervention or ‘specialist support’ believed to be required to address the child’s or young person’s presenting behavioural issues. The scorer was asked to select from one descriptor from a 5 point scale. In both the interview and survey format of this current study, there was capacity for the participant (clinician or carer) to clarify or make comment on their nominated rating.

2.2 Expectation variation or bias. To generate the score for ‘expectation or prognostic variation’ (or bias), the carer’s score was subtracted from that of the consulting clinician score, as validated through the process of the six-month review.
The resulting score would therefore be either: positive (reflecting that the clinician had awarded a higher score than had been allocated by the carer), zero (reflecting matched scores), or negative (reflecting the clinician had awarded a lower score than that allocated by the carer).

The use of the clinician scores, and validation of the same scores at the six-month review, was designed to achieve a benchmark representing an expert and ‘independent’ measure with medium-term tests of intervention application. It was the revised clinician’s scores resulting from the six-month review that were used for the comparative review against corresponding carer results. Notably, although there was some evidence of small individual variation, the clinician results sampled between the initial assessment and the six-month review returned high levels of significant correlation when compared on a paired sample T-test. A positive correlation of .967 was achieved; clinician reliability over time was significant.

A positive result would show that the carer had predicted that the child or young person would require lower levels of support, via a less intensive model and shorter term, than that assessed by the clinician. This result would be presented as a Positive Capacity Bias by the carer, in that the carer had over-estimated the capacity of the child or young person, in light of their subsequent behaviour and support needs.

A negative result would show that the carer had predicted that the child or young person would require higher levels of support, via a more intensive model and longer term, than that assessed by the clinician, and as assessed six months later. This result would be presented as a Negative Capacity Bias by the carer, in that the carer had under-estimated the capacity of the child or young person.
1. Positive score = Carer Positive Capacity Bias (Over-estimating child or young person’s capacity)

2. Matched score = (0) (Matched perception of child or young person’s capacity)

3. Negative score = Carer Negative Capacity Bias (Under-estimating child or young person’s capacity)

The process of scoring was notably only one element of broader processes of assessment and client needs description. The request for the participant to identify a score occurred within the context of the assessment and interview/survey process, and, as a result, was designed to reflect carer’s and clinician’s progressive and considered formulation of the child’s or young person’s future support needs.

Through asking the participating carers to offer an expectation or prognosis of future needs and support forecasting of the children or young people in their care, in contrast to profiling current or established patterns of needs for an individual child or young person, the study sought to explore more deeply the combination of a range of knowledge and attitudinal features of carers. The process of requesting carers to predict future needs was anticipated to draw more substantially on core beliefs, expectations, and the carer’s own levels of personal optimism (Sharot, 2001), and potentially links to their individual psychological profile (i.e.: primary trauma and resilience).

2.3 Results. Seventy-one of the total 125 carers sampled generated an expectation or prognostic score. The missing data is explained by both challenges in achieving interview attendance (80%), and issues in carer interpretation of scoring task (20%). Analysis of those participants who did not submit an expectation score showed that they were representative of all carer types: Paid Staff (39), Foster Carers
A total of 9 Aboriginal carers made up the group of participants who did not complete the expectation score, leaving a total of 25 in the sample. In the context of the reduced number for this qualitative element of the study, the sample remained proportionally representative.

Of the carers who generated a score, 79.8% (N=56) achieved a result that was either matched or within one ranking variation, either positive or negative, of the corresponding clinician score. Of this sub-group, a total of 38% (N=27) of the total sample of carers had a positive expectation bias, in that they over-estimated the child or young person’s capacity (henceforth referred to as prognostic bias), and therefore under-estimated the time or intensity of intervention required to suitably support them in the future. In contrast, only 17% (N=15) of the total sample of carers demonstrated a negative prognostic bias, in that they under-estimated the child or young person’s capacity, and therefore over-estimated the time or intensity of intervention required to suitably support them in the future.

### 2.4 Expectation bias in relation to carer demographics

The relative Expectation Bias has been broken down in the following sections in order to reflect the relationship this finding has to the range of profile variables available through the study.

#### 2.4.1 Trauma

When the prevalence of positive or negative bias between those carers who had reported significant trauma indicators (consistent to meet the criteria for a diagnosis with PTSD on the DAPS trauma scale) was compared, it was found that there was no significant relationship to bias trends. Not only did the proportion of carers registering a matched or positive expectation bias remain very consistent, it was also noted that the pattern of extreme or ‘outlying’ results mirrored the general pattern of variation (i.e., no correlation between bias and trauma indicators). These
results do not appear to support a hypothesis that there would be a direct relationship between the carer primary trauma profile and conceptualisation of the needs of children and young people in care.

Table 17 - Prognostic Bias in relation to PTSD Diagnosis

| PTSD/Prognostic | Scores | | | | +1 | +2 | +3 | +4 |
|-----------------|--------|---|---|---|---|---|---|---|---|
| PTSD (No)       | 0      | 2 | 2 | 4 | 20 | 11 | 4 | 3 | 0 |
|                 |        |   |   |   |    |    |   |   | 39% Positive Bias |
| PTSD (Yes)      | 1      | 0 | 0 | 3 | 12 | 7  | 0 | 1 | 1 |
|                 |        |   |   |   |    |    |   |   | 36% Positive Bias |

*Note.* This table provides a summary profile of the bias results for the study population against the variable of PTSD indicated by the DAPS. The table displays the frequency of participants indicating the number of individuals within each of the score clusters. It is clear that there is a consistent trend towards positive bias or a matched assessment to that offered by the clinician.

2.4.2 Resilience. When the prevalence of positive or negative expectation bias was compared with the participant resilience scores, it was found that the results maintained variability as they did in the case of trauma indicators. It was noted that those carers who scored very low results on their resilience profiles did not show any marked variation in the pattern of their assessed bias in relation to the child or young person’s capacity. There was also no sustained relationship of positive expectation bias to higher resilience scores.

2.4.3 Role. All participating carers who had a negative expectation for capacity bias (N= 15) were carers undertaking roles defined as Paid Staff. All Foster Carers and Birth Relatives were noted to either match that of the clinician or reflect a positive expectation for capacity bias, with Foster Carers reporting the highest percentage (64.3%) of scores matched to clinician results. The Birth Relatives group had the highest rate of reported positive capacity bias (87.5%). These results point to
a role-related influence on expectation. On reflection, the negative expectation for capacity bias reported by paid staff may in part be attributed to the experience of working with the residential care setting, where children and young people are often congregated in shared placements to assist in the support of challenging behaviour and significant and complex trauma. It may be that the experience of caring for children in this environment, and in the context of a rostered support role may limit carer experience of evidence of positive capacity or child skill acquisition.

2.4.4 Age. When the prevalence of positive or negative capacity bias was compared with the Age, no relationship was found between age and expectation. The lowest results for positive expectation bias were noted in the older carer cohort (56 to 65 years). This result placed this group of carers below the group average. The highest scores for positive expectation bias (57%) were achieved in the 26 to 35 years group. These results do not show any trend relationship between age and expectation bias, but it is potentially important to note the low result in the oldest group of carers, as it perhaps serves as a flag for intervention awareness and further research.

2.4.5 Ethnicity. The results for positive expectation bias when compared between Aboriginal and non-Aboriginal carers demonstrate a statistically significant contrast. Of Aboriginal carers, 56% (N= 14) across all roles indicated a slight positive expectation bias, compared to non-Aboriginal peers 36.9% (N= 17).

For the population of Aboriginal carers, this relationship reached significance. Using the Pearson Chi-squared statistical test for independence, it was noted that there was a significant relationship between positive expectation bias and ethnic origin for Aboriginal carers ($\chi^2 = .064$). This result highlights an impact of ethnicity on the understanding of the skills and capacity of the child or young person in care.
These results suggest that Aboriginal carers within this carer sample tended to over-estimated the abilities of those they care for, and under-estimate the level of support they require to meet their needs.

A possible explanation for this trend maybe linked to the consideration of the high levels of presenting resilience assessed in the Aboriginal carer cohort participating in the study. This group of carers consistently expressed optimism in relation to their own future and the belief that life would continue to improve for them in the future. It is possible that this perspective on the future expressed by the cares translated to a view that the children they care for will require less support and gain skills in a positive manner in the future.

3. Results – Attributions

All of the carers within the sample completed the Carer Structured Interview (N= 125). The Carer Structured Interview (CSI) was the tool used to gather qualitative information from carers. The interview was designed to elicit, through a structured format, the carer’s understanding and beliefs concerning the causes or reasons they held for the child or young person’s behaviour and the meaning or function of the behaviour for the individual. The interview format consisted of a series of standardised questions that were completed by the carer with the support of the clinician; this was generally concurrent with the behavioural assessment procedure (See Appendix 4).

The interview (survey) format was derived from tools commonly used within the practice of behavioural assessment and intervention. The following key elements were included: Carer relationship to the child or young person, Descriptions of behaviours of concern (cycle, impact, frequency', etc.); History of the observed behaviours; Review of the child or young person’s needs; Analysis of the supporting
context and environment; Carer formulation (behavioural function, and barriers); Carer recommendations for support and/or intervention.

3.1 Carer’s attribution – reason for behaviour. To assist participant understanding this question was presented in a number of ways by the assessor within the interview process. Typically, the question was asked in the following manner: “Why do you believe (person) uses these challenging or difficult behaviours?”, “What do these behaviours tell us about (person’s) needs or how they are feeling?”, “What purpose or meaning do these behaviours have or serve for (person)?”

In the short survey format, the question read as follows: “Briefly describe why you believe the person (child or young person) uses their behaviour in a challenging way. What purpose does the behaviour serve for them? How does the behaviour assist them to achieve their needs in their current situation?”

The interview results were initially copied verbatim and logged on the database. Through the analysis process, a number of themes or categories of responses were identified and their frequency collated for trend comparison. There were four key categories of carer responses noted through the analysis process, presented in order from highest to least proportion of respondents:

1. That the behaviour exists and is enduring due to a link to a history of abuse or neglect (and resulting trauma) (38.4% of respondents N= 48).

Quote samples: “These are coping strategies … learnt ways to manage traumatic experiences.” “The behaviour, like clinging and needing to touch someone and have the light on, are all from her bad past. She is really scared.” “Because of being abandoned over and over again … she will not trust anyone to stay” “I think
the way he behaves insulates him from the emotional pain of his past life … I don’t think he can feel properly any more.”

2. That the child or young person uses the behaviour to gain power or control over a situation where they are unable to cope (24% of respondents N= 30).

Quote samples: “This child does not feel good about himself. He does things and then his feelings are confirmed. He is trying to make himself feel better.” “She makes allegations to have power over others. She always needs to have the attention.” “He is just angry and he does not know any other way to manage the situation.” “He is new and confused. He doesn’t understand why he has been placed here and really doesn’t want to stay.”

3. That the behaviour has been learnt (or is the result of poor parenting, or care) as a means to achieving what they want/need (18.4% of respondents N= 23).

Quote samples: “These kids have just learnt that using the behaviour allows them to avoid the hard stuff” “His early life taught him this is the way to behave. He does not know any better” “They just don’t like to be told what to do ... They have seen others get away with it and try to demand things.”

4. That the behaviour exists and is enduring due to organic/syndrome or medical issues at the level of the individual child or young person (17.5% of respondents N= 22).

Quote samples: “She uses her challenging behaviour only due to her disability. This is not a choice. I have an understanding of her disability and I know how to support her consistently, by asking the same question and always repeating myself.” “She can’t communicate, and struggles to understand what is said. She throws things because we can’t meet her needs.”
These results highlight important variations in carer perceptions of the children and young people they care for. It is interesting that only just over one third of the carer sample cited the critical impact of trauma (the child’s experience of abuse or neglect) on behavioural presentation. Further, there were very clear variations in the attribution modelling or weighting of importance when broken down by carer type. These findings will be explored in the following section.

3.1.1 Paid staff. The Paid Staff group responses showed there was a moderate trend to attribute the cause to ‘learnt behaviour’, that being behaviour that has been rewarded or supported by the child’s experience. Specifically, 45% (N= 37) of Paid Staff nominated the primary function or reason for challenging behaviour of high needs children as within the ‘learnt behaviour’ category; that is, as the result of poor parenting or caring. Importantly, this may link to general behavioural intervention/management program models, which focus on ‘behavioural support and training’ in order to ‘re-train’ children with more appropriate responses that form the basis of most agency policy and procedures. Paid Staff agreed with Foster Carers that the child or young person’s history of abuse or neglect was a contributing factor, but with a significantly reduced emphasis. Paid Staff also commonly attributed the function of the child or young person’s behaviour to their desire to exert power and gain control of situations. Behavioural causes and functions related to organic issues had the least influence for this group.

3.1.2 Foster carers. Results suggest that Foster Carers have usually identified the child or young person’s history as the primary cause of the maladaptive behaviour, and trauma response as the function. Seventy-five percent (N= 17) of Foster Carers nominated the behavioural issues to be linked the child or young
person’s history of abuse or neglect. This outcome may be linked to the frame of reference for the Foster Carer’s engagement; that is, the fact of the child or young person’s removal indicates a problematic background. Additionally, their contact with birth families may influence their perspective, and some aspects of their attitudes may also be a function of the training they have experienced as part of their accreditation to become a Foster Carer.

As per the Paid Staff group, Foster Carers did consistently assign attribution to ‘learnt behaviour’ (extending to poor parenting or caring), but at a lower level. Foster Carers considered behavioural causes and functions being related to organic issues at the same relative level of influence as learnt behaviour. Notably, and unlike the other role groups, no Foster Carers attributed significant function of the child or young person’s behaviour to their desire to exert power and gain control of situations.

3.1.3 Birth Relatives. The Birth Relatives generally focused their understanding of the child or young person’s behaviour around their belief that it is driven by a desire to control others and the environment. This group recognise the child as demanding and determined to ‘get their own way’. Predominately, this group tended to describe the child’s profile as ‘individual to them’ and specifically reflective of their personality or choice.

This group returned the highest relative level of attribution to organic difference; however, this was notably below the nominated influence of personal control on behavioural presentation. Birth Relatives agreed with Paid Staff that the child or young person’s history of abuse or neglect was a contributing factor, but with a greatly reduced emphasis in comparison to Foster Carer attribution. Unlike the Paid Staff and Foster Carers, no members of the Birth Relatives group assigned
attribution to ‘learnt behaviour’ (poor parenting or caring). This is important, but perhaps not surprising given their role definition.

3.2 Carers’ attribution – barriers to change. The second element of the interview questions focused on the participant expectations and beliefs about the barriers to change or recovery of the child or young person.

This topic was presented in a range of ways by the clinicians within the interview process in order to assist exploration. Examples of the questions included: “What is getting in the way of (person) being able to move on and change their behaviour?”, “What is stopping (person) using different more adaptive (normal) behaviours?”, “What is stopping (person) becoming more like other children his/her age?”

In the short survey format the question read as follows: “What do you feel are the reasons that limit this person’s ability to manage their behaviour?”

The mediation interview/survey results were initially copied verbatim and logged on the database. Through the analysis process, a number of categories of responses were identified and their frequency collated for trend comparison. There were five key categories of carer responses noted through the analysis process, these are listed in order of most to least common

1. That the child or young person had an organic/syndrome or medical issues that prevented change or healing. (40% of respondents N= 32)

Quote samples: “This kid is just not right. I think it is a medical issue and I believe it will affect them long term”. “She was damaged from an early age. She will always have these problems and we just have to do the best to make her life as good as it can be.”
2. That the child or young person’s age or maturity was the barrier to behavioural change. (25.6% of respondents N= 32)

Quote samples: “It is the age. Things will change as they grow and mature … for some it just takes a while”. “He is not old enough yet to control himself”. “The aggression is very primitive and immature. She seems stuck in toddler behaviour.”

3. That the child or young person’s lack of desire or willingness to engage with supports is the barrier to healing or behavioural development. (16% of respondents N= 20)

Quote samples: “I believe ### soils himself to push us away. He runs because he doesn’t want us involved.”, “I don’t think he has closure on his last few placements, and I know he is not interested in working with us. I am not sure if he will ever want to change …”, “She doesn’t trust that anyone can help … She will not engage. She does not believe it is worth it.”

4. That there existed issues in the availability or suitability of services to meet their needs. (12.8% of respondents N= 16)

Quote samples: “Nobody really knows how hard we try to support these kids. They have no idea what they need … and what we need to keep going”. “At the heart of it we can’t get consistent carers … This just keeps the cycle of failure turning.”

5. That the child or young person’s lack of emotional capacity is the barrier to healing or behavioural development. (7% of respondents N= 9)

Quote samples: “I think she is so anxious that she can’t wait or think sometimes.” “The behaviour is all a way to express emotions. He can’t talk about it and just gets overwhelmed, and then we all have to look out”. “She is scared and confused … I think she sees everyone, even us who care for her, as a threat.” “His
personality is the barrier. He has no self-esteem and can’t stand any criticism or correction. He just can’t handle normal things.”

Further, there were very clear variations in the attribution modelling or weighting of importance when broken down by carer type. These findings will be explored in the following section.

3.2.1 Paid Staff. The Paid Staff cohort were the only group to return responses across all belief categories, indicating a broad spread of views in relation to the range of issues impacting on barriers to progress for children and young people. However, the dominate attribution of barriers was directed to organic and age/immaturity issues.

For Paid Staff a child’s desire or willingness to change was only marginally reported as secondary to the identified primary issues, and this may, potentially, be seen as an extension to the age/immaturity selection. The findings related to Paid Staff mirror attributions reflected in other health care workers (Akakpo, 2008). Importantly, Paid Staff was the only role cohort to return any responses relating to the influence of a child’s desire or willingness to change, with the other roles not mentioning this aspect as having any influence at all on change or engagement.

The representation of multiple opinions in this cohort, as a whole, may be a function of the organisational environments in which they operate, such as having access to professional supports, targeted training and policy guidelines, along with a generally more diversified personnel/qualification pool in comparison to the other role categories.

3.2.2 Birth Relatives. The Birth Relative cohort returned very similar percentages to the attribution categories as Paid Staff, although, unlike Paid Staff, did not return responses across all categories. Like Paid Staff, the Birth Relatives’
primary nominated areas were organic and developmental age/maturity. The key area of contrast between Birth Relatives and Paid Staff returns was in relation to the beliefs around the relative influence of a child’s lack of emotional capacity, with Birth Relatives considering this to be far more important.

It is important to note that all of the trends and attribution beliefs held by the Birth Relative group focused on the deficits of the individual child or young person, however not deficits that the child or young person is necessarily ‘in control’ of. The individual’s desire or willingness to change was considered to have no impact at all on capacity to change.

A further observation of the Birth Relative group’s beliefs was that they believed service availability or suitability to have no bearing at all on blockages to change for the individual, which contrasts with the other role cohorts, and most particularly with the Foster Carers.

**3.2.3 Foster Carers.** By far the most significant barrier for Foster Carers was service availability or suitability (Golding, 2004). Unlike Paid Staff or Birth Relatives, the Foster Carers clearly attributed the barriers around change or development to supports and resources external to the young person and the context in which they were situated. This may potentially be a result of this group of carers having a broader ‘lived’ perspective of the service context, or their inherent focus on “service provision” as the focus of problematic intervention. There is also the possibility that this group have experienced the negative ‘rebound’ from organizational ‘interference’ as a result of feelings of insecurity, inadequacy, pressure, and powerlessness (Golding, 2004).

Although it is not the key barrier for the Foster Carer cohort, they did share a belief in the importance of organic issues with the other role cohorts; overall, this is
the belief category with the most responses. This aspect of attribution clearly reflects a shared belief that the child or young person is ‘damaged’ or impaired in some way that prevents them from following the developmental or recovery path of other young people. The beliefs of Birth Relatives appear slightly higher than the other role groups in this regard. Like the other role cohorts, Foster Carers believe that the individual’s emotional capacity limits change, although Paid Staff considered this a relatively weak influence. Unlike the other role cohorts, Foster Carers did not indicate age or immaturity as a key factor or barrier to change.

The attribution modelling have been important in providing a greater level of context and texture to understanding the beliefs and possible drivers for carer engagement. This information is critical in providing support to a targeted ‘training needs’ analysis, and also to the management of mediation for intervention in general. Clearly, the role delineation between carers is critical, as those working with this group must have an understanding of the variable thinking patterns to assist shaping support strategies (Stone, 2011). The role divergence in views also suggests that the process of providing Parent Management Training (PMT) requires specific consideration of the carer role. As discussed in the opening chapters of this thesis, current models (Triple P or The Kazdin Model or similar therapeutic frameworks) may fail to specifically assess or acknowledge these variations in participant expectations or attributions. These findings around variations (and in some cases starkly differing perspectives) highlights a critical gap in intervention mediation requiring further research and attention.

It is interesting to reflect on the tendency for carers to externalise barriers to healing, to either a deficit or impairment of the child, or service systems surrounding them. There appeared to be only limited acknowledgement of the requirement for
any alteration or variation of the ‘carer’ skill or knowledge set. The carers reported their understanding of the needs and behaviour of the child as being separate from their own experiences or interactions. As discussed in previous chapters, all current models for intervention and recovery have highlighted the importance of the carer in achieving safe attachment and emotional regulation. The results of this study appear to flag a barrier to self-assessment on the part of carers that, in turn, translates to a challenge for intervention mediation. These findings very much echo those results published by researchers and clinicians such as Meadors (2008), Sanders (2008) and Blaustein and Kinniburgh (2010), who have placed emphasis on the critical requirement for the management of carer culture and context to support outcomes for young people.

Further, there were very clear variations in the belief modelling when broken down by carer type. These results will also be explored in depth in the following chapter.

4. Conclusion and Interpretation

This chapter has reported a set of study results from the carer interview process, gathering both qualitative information around expectations, and quantitative data on beliefs around their prognosis of the future needs of children and young people in their care. These outcomes encompass both carer attitudes towards the behavioural functions of those they support, via allocations of ‘attribution’ (why the individual behaves in a certain way) and ‘barriers to change’ (what is preventing the individual to address and change their behaviour), and also expectation bias (relating to the carer’s estimation of the individual’s capacity to positively develop, and the support environment that is required to facilitate this change).
The expectations profile of the carer cohort across a range of demographic variables, were compared with each other, and with those of the professional clinicians working with them. These results are productive in providing valuable insights to support practice approaches that are focused on building sustainable and productive relationships between carers and those they support in practice. They reinforce the importance of customised plans developed in response to individual carer circumstances and expectations.

This conclusion revisits the hypothesis and the relevant results discussed in the following chapters.

4.1 Expectation or Prognostic bias. The study found that, although across the sample of carers there was variation in the expectation or prognosis carers had of the potential child or young person, the results were in the main reflected a positive capacity bias. Carers, across all profile categories (trauma, resilience, role, age, and ethnicity), demonstrated a positive expectation bias in assessing the capacity of the child or young person. That is, they tended to marginally overestimate the child’s or young person’s skills or functional capacity.

It had been initially anticipated that there would be a significant variation between those expectation scores reported by clinicians, and those reported by carers. The carers in fact matched, or were in very close alignment to, clinician assessments in just over one third of the sample. This result stands in somewhat of a contrast to the work by Akakpo (2008), who found differences in the alignment of expectations, beliefs and attitudes between direct carers and clinicians.

One of the important questions initially formulated centred around the relationship between trauma and/or resilience profile of the individual carers and expectation findings. The study outcomes did not support any correlation between
these variables. The findings discussed in the previous chapter, relating to the generally high general resilience scores for the group, is perhaps the more interesting result when combined with the findings around positive expectation bias, impacting on practice, and future research.

One of the strongest findings in relation to carer expectation profiles emerged through analysis of carer roles (with Birth Relatives achieving the highest rates of positive expectation bias), and Aboriginality (with Indigenous carers demonstrating higher rates of positive expectation bias). These features will be further examined in the following chapter. These findings give us better insight into some of the carers’ conceptual strengths and potential vulnerabilities in describing and responding to the needs of children in care.

It is interesting that the carers’ results appeared somewhat matched to that of the clinicians’. It is unclear to what degree the carers’ results have been influenced by clinical input (directly or indirectly) when it comes to assessing the future trajectory of a young person’s needs. Perhaps most importantly, however, they appear to be the proportion of carers who were revealed to be systematically optimistic in relation to the young person’s capacity; in many cases it appears that this is the case despite their own trauma experience, current aversive life events, challenges and frustrations in providing OOHC and experiences of the child or young person’s challenging behaviour. In reference to the broader study, it is a strong possibility that the impact of the population being highly resilient overall, matched with other aspects of psychological profile, has also influenced the level of optimism, despite resilience not being a noted relational correlation within this sample. This is clearly an area for further investigation and research across a larger sample.
4.2 Attribution. Analysis of carer responses revealed a clustering of attribution responses. Carers’ beliefs about the function or meaning of the child or young persons’ behaviour could be clustered into four core themes. Importantly, just over 60% of carers did not attribute behavioural difficulties of the child to a history of trauma or abuse. These results suggest that the carer cohort may not be integrating the profile information related to the child or young person they support, or in some cases service policy or procedures where references to trauma history have been highlighted. These results are very informative when understood in concert with the linked results in relation to expectation above. Although not explicitly articulated as a hypothesis, it was anticipated that carers would express much greater weighting in their awareness towards this aspect of their knowledge of the impact of the child’s experience of abuse or neglect in the context of care. Provisionally, this suggests the critical need for carer education, and, in a practice context, around a greater emphasis on linking the lifestory of the child to discussions around the impact of trauma, capacity building and behaviour support.

The study found a diversity of carer opinion on the barriers and issues impeding change or healing for the child or young person that they support. The thematic analysis of the interview material identified five core conceptual themes; however, across carers, responses varied. The largest percentage of responses (39.5%) identified the primary barriers as related to ‘organic’ issues, followed by the further clusters of: ‘age/maturity’, ‘willingness to engage’, ‘the level of services/resources’, and ‘emotional situation’, which, while not equivalent, were substantially lower than ‘organic’.

This outcome suggests a diversified carer cohort in relation to their understanding of what prevents the child or young person from learning and
developing. An outstanding insight provided by this set of data is obtained when carer perceptions in relation to attribution for ‘cause or function’ of behaviour (above) are compared with those relating to ‘barriers’. The carer group attributed ‘organic’ issues as the least significant cause of difficult behaviour, but saw ‘organic’ issues as the most significant barrier to overcoming these behavioural challenges. This pair of findings raises some interesting questions in relation to the psychological models at play in both conscious and unconscious rationale building on the part of carers.

One potential explanation would be that carers have linked the perceived damage the child or young person has suffered to an organic impairment that blocks trauma recovery and development. A second perspective to explain the shift links to the potential for carers to be seeking a defensive position in understanding the limited impact of their role in achieving timely change in their clients. It may be that attributing a caveat to development to a perceived organic impairment, somewhat ‘protects’ the carer from the responsibility of their interaction directly influencing healing or the future achievement of normed developmental milestones. This is a particularly interesting aspect for further investigation, and practice consideration, emergent from the data.

The above findings have interesting implications when viewed through the lens of the application of the ARC or similarly focused child and family intervention models. For example, when focusing on the development of attachment through honing carer responses, and developing their capacity for predictable routine management, it would be critical that carer expectations and beliefs be identified and addressed. Education around the impact of trauma and neglect on a child’s development may provide carers with a broader range of understandings when it
comes to how they understand and respond to challenging behaviours. It may also influence and guide the process of goal setting and assessment of ‘change’ or trauma recovery.

It is also important that in planning intervention there is an overt consideration of the challenge of sustaining support to a carer over time. Supporting carers when working with children and young people with complex needs clearly requires specific consideration of both the management of their understanding and expectations of those they care for, along with a balanced insight into what they are required to deliver and sustain to target and support recovery. Moreover, what appears critical in analysis of these findings is that the psychological profile and expectations of carers are likely to play a significant role in shaping how carers interpret and respond to the challenges they face. They contribute to carer capacity.

This suggests the critical need for carer education, and a potentially greater emphasis on linking the lifestory of the child to discussions around capacity building and behaviour support. This finding was notably supported in current peer research (Akakpo, 2008; Weiss, 2011; Wright, 2011), where specific and targeted training were seen as core recommendations to remediate challenged attitudes towards those they cared for.

The goal of a direct support (OOHC) program, from an interactive clinical perspective, is to facilitate the progressive development of an individual’s life and lifestyle towards increased personal capacity, trauma recovery, reduced anxiety and negative mental health characteristics. That is, the primary aim is to enhance the individual’s resilience and adaptability in the face of their personal challenges. This is a developmental relation goal, and an individual’s carer is, arguably, the most important agent of change. A greater understanding of the perspectives, expectations,
beliefs and, therefore, applied support approaches of individual carers is invaluable; indeed, not taking into account these personal perspectives of the care relationship is very likely to lead to approaches that are, in fact, either counterproductive to the primary goal or simply unrealistic in application.

As discussed in the opening chapters, there has been significant research on the needs of children and young people in OOHC, but only very limited attention on the profile of the carers in the key support role (Michelson et al., 2013; Barlow et al., 2013; Fraser et al., 2013; Geiger et al., 2013). Providing working insights, such as those brought forward in this study, means that an attending clinician, case worker or support team can be alerted to the need to question the assumptions and expectations of carers.

This chapter has explored the study’s findings in relation to carer expectations and some of the implications for carer capacity. The following chapter will discuss each of the findings of the hypothesis in the context of the current literature.
Chapter 6: Discussion

1. Introduction

This chapter provides an overview of the study’s findings in the context of the current literature, and highlights areas of emerging new knowledge. The focus of this study is the psychological profile and relationship between primary trauma, resilience and expectations of carers engaged in caring for young people with complex needs in OOHC settings in NSW, and how these factors impact on their capacity to care. This project—although built on the work of practitioners and researchers exploring the profile of support required to facilitate trauma recovery, impact of vicarious trauma, the nature of resilience and aspects of carer capacity—stands as unique in its particular focus on the psychological profile of direct carers, and their expectations. The study used a mixed methods model as the basis of its structure, and was divided into two major sub-projects. The key findings of the study have been the discovery of a profile of the OOHC carer population as one that reflects a significant experience of primary trauma, while also reporting resilience. The study also discovered that the carer sample as a whole tended to hold expectations that tend to under-estimate the support needs of the children and young people they cared for, and that variations in carer attributions or beliefs about those they care for are related to specific carer role.

2. Review of Research Questions and Key Findings

Collaboratively therapeutic and PMT models addressing trauma recovery and habitation of children, identify the capacity of the carer as foundational to the successful outcomes of children being cared for in a home other than their own (Kazdin & Weisz, 2003; Sanders, 2008; Redshaw, 2009; Kinniburgh et al., 2005).
Common to these models is the recognition of the importance of the carer to present themselves as attuned, emotionally intelligent, stable, and predictable (Cleaver, et al., 2011; Fuller, 2012) to the child or young person in order to support their critical attachment and development (Kinniburgh et al., 2005). As discussed in previous chapters, studies examining the profile of the carer population have largely focused on aspects of the population demographics, and features that may promote retention (Geiger et al., 2013). There is a gap in the literature in relation to the psychological profile of the carer population, and how this profile potentially impacts on carer capacity, engagement in the carer role, and treatment interventions (Fraser et al., 2013).

Two aspects of the psychological profile were explored in this study: the experience of primary trauma, and the expression of resilience; specifically, what are the core trauma and resilience elements in the psychological profile of carers of high needs children and young people in OOHC, and what is the relationship between them? The study’s ambition was to gain information on both the degree to which these elements are present, and how they may correlate. The second area of investigation is the challenge to better understand the expectations, perceptions, or bias, that underpin carer relationships with the children and young people they work with. Emerging research is alerting us to the importance of carer expectation and beliefs of the child or young person in care to the health and achievements of that person (Akakpo, 2008; Hawes et al., 2011). Of particular interest is the expressed beliefs or attributions carers apply in their understanding of how the function or meaning of the child or young person’s behaviour or presentation relate to the support dynamics and their capacity to care. Throughout this project, I have also sought a better understanding of the relationship of a range of demographic variables
on carer trauma and resilience profiles and expectations. The study has targeted information from participants around their particular category of carer type, Aboriginality, age, and gender.

2.1 Sub-Project 1. Trauma and Resilience. The dominant focus of sub-project 1 was the generation of Trauma and Resilience psychological profiles for Carers from a range of work roles. This first sub-project was designed to generate participant scores for future review and analysis. This sub-project was designed to address the research question: ‘What is the trauma and resilience psychological profile of carers of high needs children and young people in OOHC?’ Four specific hypotheses were generated in the process of formulating this question.

2.1.1 Hypotheses 1. Trauma. It was anticipated that carer trauma profile scores, across all carer categories, would be above that reflected in the general population (under 12% presenting symptoms consistent with a diagnosis of PTSD at some time in their lifetime. Briere, 2001). This hypothesis draws on the weight of research indicating the potential for trauma affected individuals to be drawn to caring work (Pearlman & Saakvitne, 1995), the intergenerational transmission of abuse symptoms (DeGregorio, 2012), along with the clear evidence of vicarious traumatization in workers engaged in the welfare fields (McCann & Pearlman, 1990).

This hypothesis was tangentially supported by research related to vicarious trauma (Meadors, 2008; Garrett, 2009; Stone, 2011, Weiss 2011, Ali, 2012), and the acknowledged impact of caring for high needs individuals (Kurtz, 2005; Collins & Long, 2003). The results confirmed this hypothesis to be true. Findings demonstrated that over half of the participants reported signs or symptoms of trauma that were noted to be clearly above results achieved within the general population, and further
that the rate of participants meeting criteria for a diagnosis of Post Traumatic Stress Disorder (PTSD) was above that anticipated within the general population, and also generally above those results achieved in studies of servicemen and women returning from military action, or individuals who have experienced natural disasters or catastrophic events. This finding is clinically significant, and stands as a study demonstrating the exceptional rate of primary trauma and which flags the vulnerability of carers and the limits to their capacity to care.

This is consistent with the research into the profiles of those who enter the caring professions (Pearlman & Saakvitne, 1995), and as such, alerts us to the parallel need for the consideration of suitable supports and protection from psychological risk factors.

2.1.2 Hypotheses 2. Aboriginal Carer Trauma. It was hypothesised that Aboriginal carers would have trauma profile scores that rated above that of non-Aboriginal carers, in view of the history of trauma of Indigenous Australians (Butler, Hopkins & Nivison-Smith, 2009; Redshaw, 2009).

Study outcomes, in fact, indicated that this hypothesis was not accurate. Aboriginal carers reported only slightly higher rates of trauma signs and symptoms than their non-Aboriginal peers. This trend was noted to be consistent across all carer categories. Again, this finding is important in that, combined with the finding above related to generalized carer trauma, it presents a picture of shared psychological experience of those providing care rather than specialist variable impact based on Aboriginality. Again, the current study stands alone in the literature in presenting this finding, and stands in some contrast to the demographic or case research targeting Aboriginal communities, which focus on the unique aspects of the Indigenous experience and its particular impact on individuals, family and

This finding was unexpected based on the review of the literature articulating the specific trauma history and the recorded impact of generational trauma of Indigenous Australians, and must be understood in the context of the acknowledged withdrawal of a number of the sample group by representative support agencies, or in the very initial stages of the study. However, to see similar levels of trauma mirrored in the non-Indigenous population raises significant questions around the background and needs of those involved in caring for children and young people in OOHC. The review of the literature has found that the challenges related to attracting and sustaining carers, and most particularly Aboriginal carers, is a significant task (Geiger et al., 2013), against a background of increasing numbers of children in need of OOHC (AIHW, 2011). It is important in this context to then acknowledge that those attracted to this work/role are themselves vulnerable, carrying a substantial primary trauma burden. Importantly, against these findings, it appears the carer group, including both Aboriginal and non-Aboriginal carers, have more aspects in their trauma profile that appear shared than divergent.

2.1.3 Hypothesis 3. Resilience. It was predicted that carer resilience scores would vary across the carer age clusters and that, consistent with general population samples, results would be spread through the sample (i.e. sample reflecting the full range of scoring possibilities).

This hypothesis was not confirmed by the study results. In fact, the results show consistent and strong evidence of positive resilience scores across the whole sample. Resilience scores appeared to be unrelated to age or gender, matching current research by Garrett (2009), which found also that gender is not a significant
variable impacting on reported resilience. However, there were noted consistently high levels of resilience and trauma scores achieved in Foster Carers as a group. It was also noted that the group of Aboriginal carers, on average, achieved a slightly higher mean resilience score than that of the non-Aboriginal carers. Of particular note was that the Aboriginal Foster Carers achieved the highest mean resilience score of any carer group in the study. Although this was not able to be demonstrated at any significance level given the small sample size, it does potentially flag an interesting trend for further investigation.

As for all of the study’s findings related to the psychological profile of carers, these findings related to positive resilience within the OOHC carer population stand as unique in the literature. In similar ways to the gaps identified in the study of primary trauma, the study of resilience has been largely limited to identifying key criteria for identifying and supporting the development of resilience in children and young people within the context of OOHC or in similar ways in school settings (Fuller, 2012). Clearly, resilient carers are essential, but measures targeting these associated criteria tend to form only a very limited aspect of the existing fragmented screening process, and despite a recognition of the need for these qualities to sustain placements, support ‘optimal’ parenting models (Redshaw, 2008; Michelson et al., 2013) and family structures, there is often gaps in supports to assist in its development (Geiger et al., 2013).

The issue of what resilience is, and how people come to develop or demonstrate resilience is still under discussion within the literature. As discussed in chapter 2, resilience has been seen as an important feature in emerging theoretical and practice models of care and trauma recovery (Michelson, Davenport, Dretzke, Barlow & Day, 2013). However, what these findings bring up is the degree to which
resilience is an indicator or surrogate of the attributes known to be important, such as the capacity for emotional regulation or awareness (Fuller, 2012); the degree to which an individual has had supportive access to social networks (Garmezy, 1991); the continuously evolving interaction between the person and their environment (familial, communal, and social) (Luthar & Cicchetti, 2000); the opportunities experienced in childhood to learn and be reinforced for using adaptive behaviours across contexts (Bernard, 2004); the family systems and process experienced by the individual that support the development of resilient qualities (Walsh, 2003); and the participation in strengths and relationship-based psychotherapies focusing on enhancing personal control (Seligman & Peterson, 2003). The findings within this study flag an important positive feature in the carer participants that potentially contributes positively to carer capacity. Acknowledging this strength against the backdrop of both the chronic pressures of the carer role, and the findings related to the vulnerabilities of discovered trauma profile, may be helpful in shaping both carer assessment and intervention models for the future.

2.1.4 Hypothesis 4. The relationship between Trauma and Resilience. It was hypothesised that there would be a positive and consistent relationship between trauma and resilience profiles of carers (i.e., carers reporting complex histories of significant trauma and associated symptoms will also report resilience levels along a correlated continuum). Consistent with Bonanno (2012), it was anticipated that resilience scores for individuals reporting the highest trauma symptoms would be high, as testament to their continued care role, and belief in their capacity.

The study outcomes did not support this hypothesis. There was no significant correlation between trauma and resilience, and, additionally, the small sample size and individual outliers further reduced the capacity for valid trends to be identified.
It was, however, noted that there was a large proportion of carers with significant trauma profiles (reported indicators to where significantly impacting on their daily functioning, along with meeting symptom criteria for PTSD), that also reported very high resilience scores. Although within this study the results are inconclusive, this does appear to be an area for further investigation.

Other findings for consideration included that many of the trauma indicators or symptoms reported by participants were of a significant and overtly behaviourally recognisable nature, but had clearly either not been identified in current screening, or had not met criteria or been noticed in the process of casework review, which would have resulted in excluding the carer from the caring role. The current study did not collect information on participants in relation to their reported performance within the caring role, but the interplay between individual reported psychological profile (functioning challenges) and actual capacity should be noted.

It was also noted that the participant carers reported high rates of trauma symptom issues reflecting both historic and current lifestyle trauma experience, independent of their carer role. Although not directly addressed in the literature in relation to psychological profile (White, 2005), evidence of carer vicarious trauma (Figley, 2002), compassion fatigue (Weiss, 2011), reduced caring resources and support (financial, social, expert support, autonomy) (McHugh, 2003; Geiger et al., 2013), intergenerational transmission (DeGregorio, 2012), and general stress to the carer and their family has been related to the OOH carer role. This compounded profile appeared to indicate that many of the carers were dealing with chronic and persistent issues of historic trauma symptoms, while maintaining their high demand carer role. This finding clearly raised the overlay between primary and secondary or
vicarious trauma, and builds on the research of Hernandez et al., (2007) in the discussion of the layering or interaction between trauma and resilience.

These findings are reflective of contemporary research, but also challenge established norms in relation to core practice expectations. As noted above, the anticipated high level of prevalence in trauma profiles in carers has been chorused by a number of researchers (Danieli, 1998; McCann & Pearlmann, 1990; Pearlmann & Saakvitne, 1995; Stone, 2011). The characterisation of carer trauma as secondary or vicarious, and in a sense caused by the undertaking of the carer role, appears challenged by these results. From these results, it would appear that there exists a high level of primary trauma history, and exposure to chaotic events in the participant’s life that would reflect a level of distress with causal indicators beyond those attributed to the care role alone. Borrowing again from the ARC and other PMT models, it would appear that on fine analysis of the group’s trauma profile and features there is evidence of significant issues with personal regulation, self-management and functional management impacting on expressed competence on a daily basis (i.e. substance abuse, dissociation, and hyper-arousal). Given this symptom profile, it is interesting that the achieved resilience scores were so positive for the overwhelming majority of the group, and that all participant carers were currently functioning in care roles.

In particular, these findings mirror those achieved in recent work by Wu (2008), Ali (2012), and Geiger et al. (2013) who have noted the impact of various issues including self-care and support as contributing to resilience. Wu (2008) conducted a study to explore the formulation of coping resources used by workers within women’s shelters. A number of common themes emerged, with the interviewed workers reporting very similar motivations for maintaining their roles,
common personal experiences and like coping strategies to deal with work related trauma or stress. Wu’s (2008) work points to a number of concrete features and practices that appear to enhance worker resilience in the face of STSD. Central to this paper is the highlighted requirement of workers to develop personal protective practices to avoid symptoms of STSD, and the great importance of worker beliefs and perceptions of their role and value. Wu’s (2008) study further identifies a number of reported resilience enhancing experiences or psychological aids identified by interviewees. Of particular interest, these included staged exposure to aspects of the work, worker symptom tracking, integration/addressing of spiritual practices or needs in the work role, varying tasks and responsibilities, and practical coping strategies being implemented.

The high level of noted resilience in the carer population within this study also suggests the presence of practices and beliefs that are both sustaining and successful in balancing otherwise significant symptom vulnerabilities. Findings related to the performance of Aboriginal carers are also very interesting to reflect on, given both the high proportion of Aboriginal young people in care and the significant mediation challenges in providing services or support to the carer group and general community population (Paxman, 2006). In essence, the results flag more similarities than differences between the Aboriginal and non-Aboriginal groups in relation to psychological profile. This finding presents a picture of the noted support challenges as potentially both shared and layered for these carers. As a group, they clearly share many of the features of the broader carer population, but there are also cultural and societal mediation barriers to account for in any intervention. Of specific interest in this area are the very high trauma and resilience scores attained by those Aboriginal carers working in foster care. As noted through the introductory chapters, the
mission of attaining culturally competent carers in the OOHC sector within NSW is fraught. However, it does appear that the barriers to entry and retention of carers, based on the results of this study, are multi-dimensional.

As discussed in chapter four, this finding holds many implications for the practice approach and the nature of clinical support and intervention demand on carers by clinicians, agencies and more broadly the community at large. In the context of these findings, it is not adequate or helpful to focus on the needs of the child or young person to the exclusion of consideration of the needs of carers. In fact, research around the needs of the traumatised child highlights the requirement for emotionally regulated and attuned carers to be available to support healthy child attachment (Kazdin & Weisz, 2003; Sanders, 2008; Redshaw, 2009; Kinniburgh et al., 2005).

Field experience and research neglectful of the needs of carers in the context of significant primary, and the acknowledged potential vicarious trauma, appears to be failing to nurture the key mediation variable of carer capacity, which in effect holds the potential or otherwise to deliver sustainable outcomes in the OOHC context, no matter which intervention or theoretical model selected.

2.2 Sub-Project 2. Carer Expectation and Attribution. The second sub-project investigated the individual carer’s expectations and understanding of a child or young person’s needs and functioning. It also explored the carer’s understanding of the child or young person’s presenting difficult behaviours, and their understanding of the child or young person’s future support needs. Carers’ results were then compared to clinician impressions to identify contrasts in expectations. Central to this research study has been the desire to better understand the diversity of carer expectations and beliefs, in relation to the needs and experiences of the
individuals they support, and the impact these conceptualisations have on the carer’s capacity to support children and young people with complex needs. There is currently only scarce research directed to the impact of carer perceptions and beliefs on support outcomes (Donnelly, Renk, & McKinney, 2013; Hawes, Dadds, Frost, & Hasking, 2011; Geiger, et al., 2013; Fraser et al., 2013). Two major areas of investigation were undertaken through the study in order to explore this issue: prognostic bias (the forecast of the supported individual’s presentation and future needs), and attribution (the perception of the factors that cause and maintain the supported individual’s presentation).

The importance of research in the area of understanding of the beliefs and expectations of individuals in caring roles, and how this may impact on capacity to care or the nature of interactions in that care relationship, has received some recent attention in the literature (McElroy, 2009; Wright, 2011 & Ayalon, 2011). Researchers have highlighted the impact of role (Akakpo, 2008; Ayalon, 2011), carer mental state (Möller-Leimkühler, A.M., & Wiesheu,A. 2012), carer support and resources (Geiger, et al., 2013), carer experience (Hawes, et al., 2011), carer beliefs about parenting (Akakpo, 2008), and the manner in which carers make meaning of their experience (McElroy, 2009) as influential in the capacity or nature of the care relationship and if it can be sustained.

The research questions targeted through this sub-project consist of the following:

1. What are the trends in expectation, or bias, that underpin carer beliefs and attitudes about the children and young people they work with?
2. How do these attitudes and attributions potentially impact on the carer’s expectations regarding the support dynamics and their capacity to care?
From these questions, the following hypothesis was formulated.

2.2.1 Hypothesis 5. Carer Expectation. It was anticipated that carers would reflect both positive and negative expectations in their scores for the child or young person they are working with. This hypothesis was building on the current work of researchers such as Hawes (2011) and colleagues who have found the dynamic of relationship between carer and individual child has worked to shape carer behaviours and expectations. From this research, it would be anticipated that the variable personality and presentation of each individual child would inevitably differentially shape carer expectations through their experience. Further, the work of Geiger and colleagues (2013) in the research of carers’ capacity, supported the impact of multifaceted and largely systemic support variables as influencing carer capacity. In both cases the research implies expectations are shaped by individual and contextual experiences as directing either positive or negative expectations.

The current study found that, overwhelmingly, carers across all categories demonstrated a slight positive expectation bias in assessing the capacity of the child or young person; that is, that they tended to overestimate the child’s or young person’s skills or functional potential. These findings hint at the linkage discovered by peer researchers in the optimistic thought tendencies noted in resilient individuals (Resnick, Harris & Blum, 1993; Fuller, Wilkins & Wilson, 1998). The findings in relation to positive expectations bias for carers in the OOHC sector bring a new layer to the understanding of carer perceptions that direct possibilities for both further research and practice considerations.

The study also investigated the trauma and/or resilience profile of the individual carers and how they would correlate with the discovered positive expectation bias findings. There was no clear correlation discovered between either
trauma or resilience profiles score outcomes. The greatest trends towards identified relationships appeared through analysis of carer roles (with Foster Carers achieving the highest rates of positive expectation bias), and Aboriginality (with Indigenous carers demonstrating higher rates of positive expectation bias). Clearly the link between findings related to the generally high reported resilience of the group, along with discovery that those groups (Foster Carers and Aboriginal carers) who consistently scored highest in resilience were most drawn towards this positive bias, opens up an interesting avenue for further understanding of both the strengths and vulnerabilities related to carers’ investment in the nature of support needs of those they choose to care for. This idea is further explored in the following chapter.

2.2.2 Carer Attribution. The study investigated the range of attribution profiles used by carers through the analysis of qualitative data achieved through interviews. Through analysis of carer responses it was clear that there appeared to be a strong theme trend in the clustering of attribution responses within carer role groups. In overview, Paid Staff tended to focus on the role of behavioural conditioning (or learnt behaviour), Foster Carers reported their views that the specific trauma history of the child was pivotal, and Birth Relatives stated consistently that they believed the child or young person’s desire for personal control was the core explanation of the behavioural issues.

Through interview, carers reported their belief that the function or meaning of the young persons’ behaviour to be only clustered across to a narrow group (4) of core themes. These results highlight important variations in carer perceptions of the children and young people they care for. It is interesting that only just over one third of the carer sample cited the critical impact of trauma (the child’s experience of abuse or neglect) on behavioural presentation; this is particularly interesting given
the discoveries of this study in relation to carer primary trauma experience, and
perhaps indicates points of inference related to the nature of the individual carer
‘trauma narrative’ (Meichenbaum, 2006a).

It was found that carers have various understandings of the barriers and issues
impeding change or recovery for the child or young person that they support. Carers
remained variable in their beliefs and understandings of the barriers to change.
Thematic analysis of the interview material identified five core conceptual themes
emerging.

Although these attributions were generally represented in each carer group at
some level, it was again clear that carer role heavily influenced the way individual
carers understood challenges to future capacity and development of the child in their
care. It is interesting to reflect on the tendency for carers to externalise the
acknowledged barriers to recovery to either a noted deficit or impairment of the
child, or those service systems surrounding them. There appeared to be only very
limited acknowledgement of the requirement for any alteration or variation of the
‘carer’ skill or knowledge set. The carers reported their understanding of the needs
and behaviour of the child as being separate from their own experiences or
interactions. As discussed in previous chapters, all current models for intervention
and recovery have highlighted the importance of the carer in achieving safe
attachment and emotional regulation. The results of this study appear to flag a barrier
to self-assessment on the part of carers that, in turn, potentially translates to a
challenge for intervention mediation. These findings very much echo those results
published by researchers and clinicians such as Meadors (2008), Sanders (2008) and
Blaustein and Kinniburgh (2010), who have placed emphasis on the critical
requirement for the management of carer culture and context to support outcomes for children and young people.

The study’s findings in relation to expectations build on research (Michelson, et al., 2013) around the impact of beliefs and values on relationship and caring. However, these specific findings related to the impact of role in OOHC carers, on beliefs and attributions related to those they care for offer new insights to the research literature. Further, this study has found the impact of role is potentially shaping the process of carer attribution in a way that has great potential to influence reception to particular intervention assumptions.

3. Implications for Consideration

Interestingly, there is a clear, normative and embedded expectation in the industry that participants of should display: appropriate ‘professionalism’; the capacity for the healthy maintenance of ‘personal distance’ (Crehan, 2002); high levels of emotional intelligence (Payne, 1985); and expectations of individuals taking responsibility for ‘self care’ and managing a mature ‘work life balance’. Furthermore, these ‘requirements’ are, in many circumstances, often presented anecdotally, or are poorly defined and deficiently supported in practice, insofar as they exist in a definable way.

Where there has been some acknowledgment around carer needs and support, the focus of both research investment and support has seen the needs identified as resulting from ‘vicarious’ trauma’ or STSD (Meadors, 2008). There has been a growing and significant emergence of recognition of the impact of exposure to the tragic and distressing life events of others when in the role of carer or support worker (Ali, 2012; Figle, 1995; Meadors, 2008; Stone, 2011). In part, by both definition and inference, these terms tend to characterize the individual carer as a ‘blank canvas’
initially coming to the situation of exposure as fully functioning and without the symptoms associated with trauma exposure or challenging life events. It is then thought that through undertaking the role of supporting or caring that they are seen as being ‘exposed’ to traumatizing experiences indirectly at the hands of their client group. This model of carer injury imposed by the ‘damaged’ child or young person obviously impacts on the notions of capacity for placement sustainability, and by default feeds the conceptualization of carer burn-out or ‘work-place injury’ through undertaking the role. Studies such as those undertaken by Hawes and colleagues (2011) on the detrimental impact of the experience of caring for the most emotionally challenging child or young person, in essence perpetuates this narrative.

The primary recommendations emerging from previous studies that target trauma in the form of vicarious trauma or STSD, tend to focus in the main on training, systems support to the caring role, and giving individuals agency to support the development of positive self-care practices (Stone, 2011; Geiger et al., 2013). It is often from this perspective that discussion emerges in relation to model development or re-development to address these needs.

In contrast, the findings from this study highlight a number of fundamental and concerning signs of primary trauma experience and symptoms expressed by a significant proportion of the carer population. The high number of carers reporting significant trauma symptoms, and reaching criteria for possible diagnosis of PTSD, clearly flags many risks related to carer capacity to demonstrate desired attunement, emotional regulation or attachment. Combined with the accepted phenomenon of vicarious trauma or STSD, it is apparent that the risks to carers in this field are multi-faceted, and in response, the matched recommendations for intervention are necessarily more complex, and necessarily required to be targeted at the level of the
individual within their specific role. It is highly likely that, by simply maintaining their work role, carers are also sustaining a significant exposure to trauma-inducing experiences. This was particularly true for foster carers and Aboriginal carers. Many of the emerging recommendations closely match those proposed in relation to the enhancement of culture, the targeted monitoring of personal impact on emotional life, and the development of individual coping styles (Sexton, 1999; Hernandez et al., 2007; Geiger et al., 2013). By systematically addressing ‘recovery’ needs in the carer population through attention to the primary trauma of those carers, some aspects of secondary trauma impacts for the primary clients (children and young people) may also be addressed. This type of systematic integration of intervention would also pro-actively speak to the interactive impact of distressed and challenging children and young people’s behaviour on the caring style adopted by individual or groups of carers (Hawes, Dadds, Frost & Hasking, 2011).

Within the psychological profile of carer population revealed by the study, the findings related to resilience add another significant layer to our understanding. The consistently high levels of reported resilience across the carer group combine with the generally high rates of trauma symptoms to present a compelling outline of the carer psychological profile. Despite the reported experience of historic and current traumatic life events, this group reported a strong sense of self-belief, hope and personal capacity or competence in their resilience results. Resilience notably underpins the ability of an individual to face adversity and manage a recovery. This capacity for recovery is one of the most critical qualities in the ability to sustain the care role with consistency, so critical in rebuilding ‘attachment’ and ‘self-regulation’ for children and young people with high and complex needs (Blaustein & Kinniburgh, 2007; Cleaver et al., 2011).
In combination, the carer psychological profile emerging from the study’s findings in relation to trauma and resilience leaves a picture of both carer vulnerability and the presence of a critical ‘hardiness’ essential to the role. Overall, the study found that the carer group reported very positive rates of personal resilience. These positive scores perhaps provide an explanation of the carers’ tendency to feel they have suitable capacities and ‘something to offer’ in support of high needs youth and people in crisis. These findings build on the work of Pearlmann and Saakvitne (1995a) where they suggested that therapists with a history of personal trauma can in fact be drawn to work in areas where they encounter similar ‘trauma survivors’.

The carers’ bias towards overestimating the skills and capacity of the child or young person could be directly linked to the very coping or survival scheme that has supported the carer to develop their own high personal resilience through their own experience and the overcoming of relative life challenges and aversive experiences. Psychologically, the carers appear to be expressing an optimistic conceptualization of both their own situation and that of those in their care, where the focus on inherited impairment or disability inhibiting progress is limited. Within this frame of reference there is a potential risk that adequate clinically assessed and configured supports will not be sustained by carers, and that performance and recovery expectations will exceed the actual trajectory of trauma recovery or rehabilitation. The degree to which this is important and impacts on capacity to care is perhaps one of the key emerging questions trigged by these findings for further research.

From the findings of this study, it could be postulated that carer belief in the possibility of an investment in the child’s success is at least partially matched to the desire for an experience of mirrored ‘resilience building’, where the carer gains
reassurance and relief from their own symptoms through engagement with the child or young person’s milestones or the cathartic experience of ‘success’. This concept is perhaps most closely linked to the interactive notions of vicarious traumatisation (VT) and vicarious resilience (VR) explored by Hernandez, Gangsei, and Engstrom (2007).

The study’s findings through the qualitative interviews have also provided some important insights into the expectations and attributions held by carers in relation to those they care for. Firstly, the most significant outcome appears to be the variation in attribution across carer role groups. This role-divided analysis of the carer attribution results appears as one of the few findings that separates an otherwise very homogeneous group of subjects. Despite the very similar experience and coping skills profiles, it is interesting to reflect on the very specific impact of carer category on the issue of assigning behavioural function and barrier attribution to the children they care for. Membership of a particular carer role group is clearly pivotal in the framing of beliefs around both causal and sustaining factors. This sort of qualitative information points to the need for specifically crafted training and support models across the various roles, along with the acknowledgement of the common aspects of shared needs. It appears that the specific role that defines the relationship between the carer and the child is fundamental in shaping understanding of needs and intervention. In some cases, the ‘mask’ of the identified role category appears to generate a ‘blind spot’ in awareness that potentially requires specific attention to sustain positive insightful support.

Secondly, overall there was a generally low level of direct recognition of the impact of trauma history on the individual child or young person’s behaviour or capacity, with the exception being those carers in the role of foster carer. Allied to
this was the carers’ tendency to attribute barriers to trauma recovery or development to generally organic issues or personality aspects of the child or young person. Again, as for the findings related to carer overestimation of client skills and capacities, it appears likely that this form of attribution is matched to the individual carer’s own coping and resilience-building strategies, which focus on personal capacity and adaptive functioning to overcome impairment. From an intervention perspective, these trends provide a number of direct clues to better targeting support and training.

These opportunities to participate in the life and experience of the child or young person, with the support and explanation of a skilled facilitator, offers the carer a rich and guided insight into the child or young person’s needs and their own role in facilitating the meeting of these needs. It is the researcher’s view that the traditionally separated process of clinical or therapy-based intervention from the role of the carer is counterproductive and a barrier to intervention mediation on many levels (Pearlmann & Saakvitne, 1995). Case studies to track longitudinal outcomes, impressions and changes would be very desirable to support the continued development of industry practice (Coalition for Children in Care, 2010). Some of this information may also be achieved through the examination of lifestory information (Taplin, 2005), and the use of ‘trauma narratives’ (Meichenbaum, 2006a) integrating carers with OOHC experience. This process of ensuring the articulation of practical goals, which are accessible and contributed to by carers, assists to focus expectations, and hopefully bring into greater congruence the views of the care team (Butler, 2009).

In closing, it is important to pick-up on the chronic challenges recognised as endemic in the approach and methodology of research in this area of carer capacity
(Fraser, et al., 2013). As raised in the methodology discussion in chapter three, there were a number of significant barriers to accessing carers from both a logistics and agency culture perspective. The issues of logistic management to achieve a representative sample of carers willing and able to sustain engagement in the study relied heavily on the researcher's pro-active use of her established professional network and reputation. Challenges related to the engagement of Aboriginal carers were also overlayed by a concern by agencies that carers would be re-traumatised by participation, and in a number of cases decisions were taken at the agency level not to allow carers the opportunity to consider an invitation for engagement in the study. While acknowledging the complexity of this area of research, the experience of the barriers and difficulties in approaching this population for the purposes of this study, has highlighted both legitimate and possibly culturally constructed hurdles that will require active consideration to enable future progress.

The following chapter will build on the findings and discussion, presenting the study’s conclusions and recommendations for further research and practice development.
Chapter 7: Thesis Conclusions

1. Introduction

This thesis has had as its focus the achievement of a better understanding of features of carer capacity through the examination of carer psychological profiles. The findings of this study present a confronting profile of the carers’ population in the New South Wales OOHC sector. As summarized and discussed in the previous three chapters, a number of critical features were discovered in relation to high reports of carer primary trauma, positive resilience scores and optimistic trends in carer expectations of those they care for. The study results revealed that Aboriginal carers reported very similar profile features to their non-Aboriginal peers, and that demographic variables held only limited impact on reported results. In this final chapter, a summation of the conclusions of the thesis will be provided, reflecting on the dynamic and complex nature of the study, and also revisiting the driving issues that compelled this research in the context of research and practice recommendations.

As discussed in the opening chapters, NSW presents with a unique profile of statistics related to the large numbers of both Aboriginal and non-Aboriginal children in care, and with a challenging history of OOHC reform. The present study was conducted across both rural and urban locations within NSW. The OOHC service provision environment within New South Wales is currently extremely pressured in relation to financial, political and continued population growth challenges (Bromfield & Higgins, 2005; Bromfield & Holzer, 2008). To date, much academic and policy attention has been concerned with the growing cost of providing care and the development of models that might be able to respond to the
diversity of the individual and demographic needs of children in care (McHugh, 2002; Schmied & Tully, 2009), but with only patchy evidence of studied outcomes, particularly in relation to investment in longitudinal tracking of intervention model impact (Cashmore, Higgins, Bromfield, & Scott, 2006; Michelson et al., 2013). Research has focused on the needs of traumatised children and young people, and described the optimal profile of placements that might assist their recovery and positive development (Redshaw, 2010; Kazdin, 2008; Tarren-Sweeney & Hazell, 2006; Blaustein & Kinniburgh, 2010). These needs reflect a demand for carers that are able to provide predictable, attuned and nurturing relationships to support relational attachment that will allow trauma recovery over time. However, to date, very little attention has been focused on the capacity of those charged with the responsibility of caring and taking up the significant responsibility of raising these children in our community (Fraser, et al., 2013).

There appear to be many factors influencing the capacity of a carer to be sustained in the caring role, and clearly there is significant advantage achieved where carers are supported (Geiger, et al., 2013) for the young person or child, the agency, community and the carer. My practice experience, and the scarce literature in the field (Schmied & Tully, 2009; Fraser, et al., 2013), highlight that the current investment in this aspect of the work reflects a predominantly practical, systemic and ‘reasonable’ approach to carer case management and support linked predominately to the targeted ‘model’ of intervention ascribed in agency or government policy. Issues of understanding carer capacity remain one of the key areas of practice research (Cleaver, et al., 2011).

The critical ‘tool’ required within the delivery of each and every clinical theory, service system or model proposed for intervention is the ‘carer’.
Collaboratively therapeutic and PMT models identify the capacity and skills of the carer as foundational to the successful outcomes of children being cared for in a home other than their own (Michelson et al., 2013; Redshaw, 2010; Kazdin, 2008; Tarren-Sweeney & Hazell, 2006; Blaustein & Kinniburgh, 2010). The aim of this thesis has been to examine the profile and relationship between the specific psychological features of primary trauma, resilience and expectations of people providing care to children and young people with high and complex needs in OOHC settings. The findings build on a number of fields of research work in relation to literature dealing with carer capacity, trauma and resilience profiling, and the nature of carer expectation.

This study has also sought to include exploration of the psychological profile of Aboriginal carers. Literature reviews suggest that existing models and understandings of this population of carers has been largely superficial and limited to a focus on case studies, cultural norms, the examination of demographic information, and community based profiles, while tending to neglect individual psychological dimensions of presentation or experience (Butler, Hopkins, & Nivison-Smith, 2009). The findings of this study identify a number of unifying experiences and profile features between Aboriginal and non-Aboriginal carers.

The carer trauma symptom profiles discovered through the study should give cause for concern to service providers, clinicians, peak bodies, funders and the broader community. In essence, the study results point to a scenario where the service system charged with the support and protection of our community’s most complex and vulnerable children is relying on the efforts of some of our most distressed and chronically trauma effected community members and families. These findings move towards providing some understanding of the process of sustaining
and enabling the complex work of carers, and requires focused efforts not only at the systemic or community level, but also directly at the level of the individual carer.

The study has presented both the commonalities and subtle differences between the profiles of the various carer groups (Paid carers, Foster carers and Birth Relative carers). The results show many more variables that unify these groups than define their differences in relation to trauma, resilience and expectation profiles. Those carers that take this work on as a paid career share many features of foster carers and birth relatives. The findings achieved challenge us to consider the common psychological drivers derived from a lived experience of trauma and the expression of resilience. Such insight offers direction for intervention and support across models or theoretical frameworks. As suggested in earlier chapters, acknowledgment of the primary trauma experience and profile of psychological resilience in individual carers, begs our consideration of the role of ongoing counselling, debriefing and trauma recovery work with carers to address their experience, and ongoing psychological needs.

The study’s findings also flag further questions around the management, rationale and implications of the pairing of what we have discovered to be traumatised individual carers with potentially similarly traumatised children and young people with complex care needs. The co-morbidity of high resilience with significant trauma exposure opens the way for many new questions to be investigated around how such a pairing impacts on both aspects of carer capacity, and the experience of those being cared for. In the findings it was discovered that this pairing of psychological features (high trauma and positive resilience) was linked to a tendency to a more positive or optimistic set of expectation of what the child or young person could achieve. Often, it’s the failure of a child or young
person to sustain their pace of recovery or achieve milestone skills acquisition that carers find most testing over time. Chronic perceived failure by a child or young person in their care, whether it be in terms of behavioural issues or the lack of development of life-skill milestones, is often extremely difficult for carers to manage, and inevitably results in distress and a focus on blaming the child or young person, loss of confidence or commitment from the carer, or review of the case plan by the attending agency or system. From this study, it is clear that attitudes of low demand or low expectations were not reflected in the majority of carer reported expectations. In fact, it is likely from these results, that carers would require direction and coaching to ‘slow’ or ‘pace’ the level of demand expectations matched against the child’s developmental capacity.

The study found that the carer group, our ‘frontline’ in the management of trauma recovery and providers of healing support, are themselves in a process of ‘trauma recovery’, with many individuals actively battling the impact of constant trauma symptoms. Better understanding of these needs must assist the service sector and individual clinician to focus more sharply on appropriately supporting this group if we as a community aspire to respond to the ballooning numbers of children and young people increasingly occupying the OOHC sector, or in fact impact on the sustainability of generally challenged distressed families.

As mentioned in the introductory chapters, the availability of carer resources within the industry is limited, and the OOHC caring workforce both difficult to build and sustain. It is likely that those individuals drawn to these roles, both now and in the future, largely come to it because of both their first-hand knowledge of the need, and a belief in their capacity to ‘make a difference’ as a result of ‘life experience won’, and a belief in their competence and personal resilience. Despite innovative
and continuous care recruitment strategies, there is no indicator of another population cohort ‘putting their hand up’, or stepping forward to provide an alternative carer population. As an industry and as a community there is a need to continue to work to understand the needs of the carer population, and to shape suitable supports and models to both assure nurturing, focused care of children and young people unable to live with their families, and also further enhance the lives and wellbeing of carers and assist them along sustainable paths to their own psychological health. The following sections provide both practice and research recommendations building on the context of this thesis.

2. Practice Recommendations

2.1 Carer recruitment and screening. It is critical that the current processes of carer recruitment and screening are further examined to incorporate the finding related to psychological profiling, along with attitudinal perspectives or bias. Critical for carer participation in testing of this nature will be the degree of support and consideration of the nature of the presentation and management of such assessments and subsequent feedback.

It is clear that the existing tools and processes require ongoing development with, potentially, a greater focus on clarifying the impact of previous trauma experience, current symptoms and related coping strategies. It was also clear from this study’s findings that the linkage between trauma results and resilience scores is critical in describing the combined functional presentation of the individual. Future profiling tools would be assisted by the inclusion of both of these elements.

Enhanced standardization in profiling would greatly assist in building understandings of carer needs at an industry level, and to support ongoing research around carer trends and needs. The standardization of expectations for a level of
Disclosure of both history and current symptom challenges, in a developmental manner, would potentially substantially enhance the ability to develop more targeted models and possibly an enhanced culture of carer support. Standardization of tools and reporting would also allow the generation of benchmarks and frameworks for the formulation of risk identification, and the better management of evidence-based support practice through supporting research in this area.

Consideration should be given to the notion of ongoing or periodic ‘fitness’ or ‘wellbeing’ assessment of carers, rather than only an initial ‘suitability’ or ‘matching’ screening assessment. It is clear that carers who offer themselves as competent willing carers are not likely to be assisted or feel supported by any process that draws information flagging overt deficit or vulnerability. Any assessment or measures need to be framed as supportive of carers needs, assisting to enhancing acknowledged competence and commitment to the caring role.

Repeated assessment or profiling in some form appears critical given the level of trauma and the high proportion of carers that expressed symptoms matched to a diagnosis for PTSD. It appears appropriate that regular mental health ‘snapshot’ screening is integrated into the structure of carer supervision and support. This type of pro-active review would be most effective if placed within a revised model of service that focused on the importance of carer ‘wellbeing’ as a core goal to ensure intervention mediation, and that variations or changes in capacity were responded to in a supportive and habilitation-based model. This re-framing of the carer assessment process linked to enhanced, more sustained support and engagement by case managers, is also likely to promote resilience in the carer.

The process of tracking carer profiles over time would give significant capacity to the industry, agencies, professionals, and the individuals themselves in
identifying risks and relevant support needs. Current carer assessment practice assumes a standard of professional competence or clinical judgement, which appears to currently mitigate the need for more continued psychological supports other than the singular focus on crisis support or emergency debriefing. This study’s results challenge this assumption and prompt reconsideration of the way longitudinal assessment and support of carers is integrated into casework and clinical practice.

2.2 Carer support and case management. Carer capacity is something that is not static, nor can be understood in one snapshot assessment or measurement, and will inevitably fluctuate as the individual carer’s psychological state evolves through experience and time. The results in this study have highlighted the significant needs reflected in the whole sample of carers related to issues of trauma experience and significant symptoms, and the strengths related to positive resilience scores. Further work needs to be undertaken to shape the impact of these findings on intervention, but it is clear that, along with the focus on policy and procedures, carers require targeted support to ensure key aspects of their psychological profile and mental health are understood, and that they have access to suitable longitudinal assistance.

One of the clear and possibly most critical implications of the study is that it provides evidence of the need for carers to access regular psychological support along with debriefing. Given the high symptom levels reported, it is critical that mechanisms for psychological support are robust and readily available. Unlike existing systems, which seek to separate that which is “work related” from that which is “personal”, this group are likely to require a model of support that tolerates, and perhaps actively supports, the integration of those issues to be explored through incidents in their carer role and those emerging through their home life and general lifestyle. The systemic inclusion of aspects of trauma therapy or trauma recovery in
the system of supervision and support provided to all carers is a clear recommendation emerging from this study.

The study also provides some information related to carers’ various expectations and investments in explanations for the function and barriers to change in children and young people in the OOHC context. This insight allows for case workers, clinicians, and trainers to more specifically shape information provided to carers in their different roles to support them to broaden, or refine, their understanding of the needs of those they care for. This information also greatly assists professionals in targeting their mediation process to build, where possible, on existing trends in bias or expectations to strengthen intervention engagement and sustainability. In response to the findings around ‘positive expectation bias’ and some aspects of the attribution carers held for those they cared for, it is recommended that there are efforts to imbue the case planning process with realistic and ongoing goal setting, both on a broad-scale longer-term life direction and also on a focused, short-term basis.

2.3 Carer education, training and participation. The general training need for carers to receive support to understand the impact of the trauma and recovery process in the children and young people they care for is a key practice recommendation. To achieve this, clinicians would be required to invest in a process of assessment and ‘forecasting’ to support the carer understanding of not only the impairments but also the likely trajectory of recovery and corresponding support resources for the child in care. To be effective this information would need to be very focused on the carer as the primary audience and, as such, the information needs to be practical and applied. Given the high turnover of carer team members in some OOHC settings, this information needs to be regularly refreshed to
accommodate new information and change, but also to be regularly repeated to ensure support for retention and application in implementation. It may be that this sort of ‘case formulation’ information should be included as part of each case review or during regular care team meetings to ensure accessibility, understanding and meaning for carers (Wright, 2011).

The findings of this study clearly support the need for content related to the impact of trauma on child behaviour and development to be brought to the forefront of carer curriculum, or youth-work certificate training. Personal practice experience and the literature suggest that the delivery of this content is variable in both quality and accessibility (Pithouse, Hill-Tout, & Lowe, 2002). It would be of great industry benefit for there to be investment in standardized course material, and flexible options for delivery to allow carers from all contexts and support settings to receive information.

Furthermore, the process of carer education and support needs to be a combination of both theoretical and practical engagement (Golding & Picken, 2004). Carer participation in facilitated aspects of therapy or intervention for the child or young person can be very valuable in directing and enhancing understanding of needs and capacities (Blaustein & Kinniburgh, 2010). In this regard, it is proposed that carer engagement in activities, such as counselling, lifestory work for the child or young person, along with practical therapy-directed activities, should be targeted where possible (Golding & Picken, 2004; Pithouse et al., 2002).

3. Recommendations for Further Research

This study represents a new insight into the capacity of carers through investigation of the psychological profile of carers of children and young people in
The study findings offer a springboard for further investigation of a number of themes related to carer trauma, resilience and expectations.

1. Replication of this study, with the ambition of capturing a broader representation of carers from other regions beyond NSW, would be both informative of the discussed dynamics in a broader context, and also provide valuable validation of the themes discovered here. It would also be of interest, to further investigate the profiles of Aboriginal carers and develop understanding of this carer group within the context of the broader Aboriginal community. Clearly the challenges of ethically mediating the process for studying a population acknowledged as suffering significant trauma requires very careful consideration (Cochran et al., 2008; Hill, Lau, & Sue, 2010; Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011). As discussed previously, considerations around modifying the complexity and length of the carer assessment and interview process would be recommended.

2. Continued investigation of the nature of primary trauma experience, and carer resilience, and the relationship to vicarious trauma experience resulting from the carer role is suggested. The findings from the current study suggest that in practice participants experienced a ‘layering’ in their experience. Greater insight into the impact of this combination of experience on carer functioning, performance and capacity would appear very relevant to developing practice.

3. Further research into effects of carer psychological profiles on the sustainability of placements; capacity to engage or implement intervention recommendations; trends in the care provided; and potential shared characteristics between both the carers and those they care for. Case studies to track longitudinal outcomes, impressions and changes would be very desirable to support the continued development of industry and clinical practice (Coalition for Children in Care, 2010).
Some of this information may also be achieved through the examination of lifestory information provided by carers with OOHC experience (Taplin, 2005). This information would contribute to support the refinement of the screening, intervention and casework support process, and possibly assist in identifying the critical psychological capacities needed for specific development to enhance outcomes.

4. Picking up on the range of practice implications recommended through the previous section, there are a number of practical impact studies that would support the process of trialling new tools and/or training, support or intervention processes.

5. Study into the match, or otherwise, between carer attribution models and that of children and young people in care, would potentially provide interesting insights into the impact of carer expectations and experience, along with potentially adding greater weight to the imperative to prioritize intervention and support attention to carer expectations and beliefs.

4. Conclusions

This thesis articulates an ambitious study to achieve a greater understanding of the relationship between psychological trauma, resilience, and expectations profiles of those caring for children and young people with complex care needs in OOHC within NSW. The findings revealed carers exhibiting significant primary trauma symptoms, and consistently positive resilience scores. Furthermore these carers tended to over-estimate the capacity and under-estimate the support needs of those they were caring for, and variously attribute rationale and meaning to the cause of these behaviours, and the barriers they identified to behavioural change differed depending on the role they occupied as either foster carers, paid carers, or birth parent.
This study presents those engaged in the field of care and protection of children and young people with complex care needs, with a confronting message. It is evident that many of our most vulnerable and emotionally, psychologically, and physically challenged children and youth are being cared for by some of the most similarly traumatized members of our community. These results call on the community and welfare service system to urgently reform, and, indeed, transform. This thesis and its findings clearly direct us as a community, and as practitioners, to work in a more ‘carer focused’ manner to care for those who care.
Appendices

Appendix 1: Participant Information Sheet

Lisa Fahey
UWS School of Psychology
PO Box 620 Richmond NSW 2753
02 45790122
lfahey@quovus.com.au

Information Statement for the Research Project:

“Managing the Cost of Caring”
Document Version 1: dated 20/11/08

You are invited to participate in the research project identified above which is being conducted by Lisa Fahey from the school of Psychology at the University of Western Sydney.

The research is part of Lisa Fahey’s PhD studies at the University of Western Sydney, supervised by Dr Jo Milne-Home (Principal Supervisor) and Prof Nigel Bond (Co-Supervisor) of the School of Psychology.

Why is the research being done?
The purpose of the research is to investigate the impact of Carer trauma and resilience has on the children and young people they care for. This study is particularly targeting Carers who provide Out-of-Home Care.

**Who can participate in the research?**

We are seeking Carers who are providing support to children and young people in Out-of-Home Care to participate in this research. Your name was selected in consultation with DoCS / NGO.

**What choice do you have?**

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate, you may withdraw from the project at any time without giving a reason.

**What would you be asked to do?**

If you agree to participate, you will be asked to participate in an interview and complete a series of surveys. A trained researcher will contact you and book a time and place to meet at your convenience. This interview and survey is likely occur in conjunction with a process of behavioural assessment of a child or young person in your care.

**How much time will it take?**
The questionnaires and interviews should take about one hour to complete and can be completed on one or two meetings.

**What are the risks and benefits of participating?**

We do not anticipate any risks or promise direct benefits to you in participating in this research.

**How will your privacy be protected?**

Any information collected by the researchers which might identify you will be stored securely and only accessed by the researchers unless you consent otherwise, except as required by law. The questionnaire is anonymous and it will not be possible to identify you from your answers.

Data will be retained for at least 5 years at the University of Western Sydney.

**How will the information collected be used?**

This information will be used in a thesis to be submitted for Ms Lisa Fahey’s PhD. Individual participants will not be identified in any reports arising from the project. Participants will be offered at least a summary of the results written in lay language.

**What do you need to do to participate?**

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher.

If you would like to participate, please complete the attached Consent Form and return it in the reply paid envelope provided, or fax to (02) 45790144.

I will then contact you to arrange a time convenient to you for the interview.
Parent / Guardian consent.

If you are consenting on behalf of a child or young person under 18 years of age, and they can understand what is being asked of them, please discuss the project with them before making a decision. Where a parent/guardian consents to their child or young person participating, the final decision will rest with the child / young person.

Further information

If you would like further information please contact Lisa Fahey 0417257053.

Thank you for considering this invitation.
Appendix 2a: Participant Consent Form 1

Consent Form for the Research Project:

“Managing the cost of caring”

The Impact of Carer Trauma and Resilience Profiles on Capacity to Support Young People with Complex Support Needs

Lisa Fahey

Document Version 1: dated 20/11/09

I agree that my child/ young person in my care is able to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
I understand I can withdraw my child/ young person in my care from the project at any time and do not have to give any reason for withdrawing.

I consent to

- The researchers access to file information (including relevant reports) related to the generation of a behavioural assessment
- Observation of my child/ young person in my care on one occasion

I understand that my child/ young person in my care personal information will remain confidential to the researchers and that all information gathered will be returned, along with any generated reports or assessments.

I have had the opportunity to have questions answered to my satisfaction.

Print Name:

Contact Details:

Phone number:

Signature: Date: _________________________

Consent of child / young person < 18 years: (if appropriate)

Print Name:

Signature: -

____________________________ Date: ______________________
Appendix 2b: Participant Consent Form 2

Lisa Fahey
UWS School of Psychology
PO Box 620 Richmond NSW 2753
02 45790122
lfahey@quovus.com.au

Consent Form for the Research Project:

“Managing the cost of caring”

The Impact of Carer Trauma and Resilience Profiles on Capacity to Support Young People with Complex Support Needs

Lisa Fahey

Document Version 1: dated 20/11/09

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to

- completing presented questionnaires and assessments;
- participating in an interview and having it recorded;
I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.

Print Name:

Contact Details: Phone number:

Signature: Date:
Appendix 3: Client Review Survey

This document should be completed by the Assessor as part of the interview with Carer.

Please complete the following sections to assist the Review facilitator to achieve a clear and informed profile of the issues in relation to current support challenges for the identified client and those around them.

<table>
<thead>
<tr>
<th>Client identified for Review</th>
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</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Date of birth</th>
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<table>
<thead>
<tr>
<th>Person completing survey</th>
<th>Contact details</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date completed</th>
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Please indicate your relationship to the Client:
<table>
<thead>
<tr>
<th>Role</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Carer/ respite</td>
<td></td>
</tr>
<tr>
<td>Professional service provider</td>
<td>Please specify:</td>
</tr>
<tr>
<td>Relative</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
</tr>
<tr>
<td>Guardian</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Please specify:</td>
</tr>
</tbody>
</table>

**How long have you known the Client?**

<table>
<thead>
<tr>
<th>months</th>
<th>years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
# BEHAVIOURAL CHALLENGES

<table>
<thead>
<tr>
<th>Behaviour(s) of concern</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe the behaviour(s) you have experienced or are aware of. Start with those you consider the most severe.</td>
<td>Rate the impact of the behaviour on the identified Client and others.</td>
</tr>
</tbody>
</table>

1 = No impact  
2 = Low: client social isolation; routine management  
3 = Moderate: minor injury to self and/or others and/or property damage  
4 = High: serious injury to self and/or others and/or property damage  
5 = Very High: extreme risk to self and/or others and/or property damage

*Bold/ Circle chosen rating*

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Impact Summary RATING</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td>This rating should be the highest score across all behaviours identified above.</td>
<td>Bold/ Circle chosen rating</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident Severity Summary RATING</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No incidence: Few incidents: Regular incidents:</td>
<td>Low intensity and severity Moderate intensity Significant intensity and severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please provide any further comment as required:
## BEHAVIOURAL FORMULATION

### Assessed behavioural function

Briefly describe why you believe the person uses their behaviour in a challenging way.

What purpose does the behaviour serve for them?

How does the behaviour assist them to achieve their needs in their current situation?

### Treatment prognosis and behaviour persistence

Select the descriptor below that best matches the recommended intervention model/time frame required across the range of behaviours noted.

**Note:** ‘Intensive’ refers to a model of clinical support that involves assessment, intervention design or re-design, and/or an allocated clinical resource equivalent to b—weekly or weekly contact.

*Bold/ Circle chosen rating*

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<thead>
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<tbody>
<tr>
<td>1 – Short term intensive (3mths)</td>
<td>2 – Medium term (6-12mths)</td>
<td>3 – Medium term intensive (6-12mths)</td>
</tr>
<tr>
<td>4 – Long-term (12mths-3yrs)</td>
<td></td>
<td></td>
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<tr>
<td>5 – long term intensive (12mths-3yrs)</td>
<td></td>
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<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
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<tr>
<td><strong>Bold/ Circle chosen rating</strong></td>
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</table>

Please provide any further comment as required:
BEHAVIOUR INTERVENTION AND SUPPORT

Use the following table to describe the intervention and support currently offered to the client and those who support them:

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>Brief description</th>
<th>Impact or results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ecological</strong></td>
<td>Managing the person’s environment</td>
<td></td>
</tr>
<tr>
<td><strong>Positive programming</strong></td>
<td>Programs designed to teach and support skills and competency</td>
<td></td>
</tr>
<tr>
<td><strong>Direct treatment/ therapeutic</strong></td>
<td>Programs designed to modify or ‘treat’ the presenting behaviour(s) of concern</td>
<td></td>
</tr>
<tr>
<td><strong>Reactive strategies</strong></td>
<td>Programs or protocols to support the management of identified behavioural issues</td>
<td></td>
</tr>
<tr>
<td><strong>Case Worker</strong></td>
<td></td>
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<tr>
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</tr>
<tr>
<td>Is there an allocated Case Worker?</td>
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<tr>
<td>How often does this person have contact with the Client?</td>
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<table>
<thead>
<tr>
<th><strong>Clinical consultation</strong></th>
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<tbody>
<tr>
<td>Is there an allocated clinician?</td>
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<tr>
<td>How many hours of service per month are available for support?</td>
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<tr>
<td>How often does the clinician have contact with the Client?</td>
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<table>
<thead>
<tr>
<th><strong>Behavioural Intervention Summary RATING</strong></th>
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<th>5</th>
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<tbody>
<tr>
<td>Working well.</td>
<td>Moderate success:</td>
<td>Not assisting</td>
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<td></td>
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<tr>
<td>Low intensity and severity</td>
<td>Identifiable change</td>
<td>To manage behaviour</td>
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</table>

*Bold/ Circle chosen rating*
## USE OF RESTRICTIVE PRACTICES

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Target behaviour</th>
<th>Frequency (daily, weekly, monthly)</th>
<th>Duration (5,10,15 minutes)</th>
<th>Review date</th>
<th>Outcome of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seclusion</td>
<td></td>
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<td>Exclusionary time out</td>
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<tr>
<td>Restricted access/</td>
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<td></td>
<td>&amp;/or increased supervision</td>
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<tr>
<td>Physical Restraint</td>
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<tr>
<td>Mechanical Restraint</td>
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<tr>
<td>Chemical restraint</td>
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<tr>
<td>Response Cost</td>
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<td>Detention</td>
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<td>Other</td>
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Please provide any further comment as required:
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</table>
**COMPLEX DIAGNOSIS**

<table>
<thead>
<tr>
<th>Mental Health / Health / Psychological / Syndrome</th>
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<tbody>
<tr>
<td>Are there any diagnostic issues you are aware of that impact on the complexity of the Client’s support?</td>
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<table>
<thead>
<tr>
<th>Unknown</th>
<th>Not Applicable</th>
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**Multiple-diagnosis management RATING**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>No resource issue:</td>
</tr>
<tr>
<td>2</td>
<td>Moderate resource issues:</td>
</tr>
<tr>
<td>3</td>
<td>High resource issues:</td>
</tr>
<tr>
<td>4</td>
<td>Well managed.</td>
</tr>
<tr>
<td>5</td>
<td>Generally managed.</td>
</tr>
<tr>
<td></td>
<td>Intensive</td>
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</tbody>
</table>
Describe support requirements and any associated challenges you have experienced:
Are there any issues related to offending behaviour or risks of such behaviour you are aware of that impact on the complexity of the client’s support?

<table>
<thead>
<tr>
<th>Offending behaviour management RATING</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No resource issue:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate resource issues:</td>
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<tr>
<td>High resource issues:</td>
<td></td>
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</tbody>
</table>
Describe support requirements and any associated challenges you have experienced:

<table>
<thead>
<tr>
<th>Well managed</th>
<th>Generally managed</th>
<th>Intensive management</th>
</tr>
</thead>
</table>

*Bold*/ Circle chosen rating
**HISTORY OF SUBSTANCE USE AND ABUSE**

Are there any issues related to drug use or substance abuse you are aware of that impact on the complexity of the client’s support?

<table>
<thead>
<tr>
<th>Substance use and abuse management RATING</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No resource issue:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate resource issues:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High resource issues:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well managed.</td>
<td>Generally managed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensivemanagement</td>
<td>requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bold/ Circle chosen rating**

Describe support requirements and any associated challenges you have experienced:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Communication Skills

<table>
<thead>
<tr>
<th></th>
<th>Auditory comprehension</th>
<th>Unknown</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive skills</td>
<td>Simple commands</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td></td>
<td>Multipart commands</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td></td>
<td>Abstract and Complex</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td></td>
<td>Information (feelings)</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td></td>
<td>Written instructions</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td>Expressive skills</td>
<td>Effective spoken communication skills (speech)</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td></td>
<td>Non-verbal (uses a range of non-speaking skills to communicate)</td>
<td>Yes ( )</td>
<td>No ( )</td>
</tr>
<tr>
<td>Combination of spoken and non-verbal methods</td>
<td>Yes ( )  No ( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses VOCA (voice output device)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses AAC – <em>Describe:</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td>Yes ( )  No ( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate recall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Insight and inferential thinking</strong></td>
<td>Planning</td>
<td>Concentration</td>
<td>Attention span</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Interpreter required</strong></td>
<td>Yes ( )</td>
<td>No ( )</td>
<td></td>
</tr>
<tr>
<td><strong>Over all communication profile</strong></td>
<td>Strengths</td>
<td>Weaknesses</td>
<td>Please comment:</td>
</tr>
<tr>
<td><strong>Communication Impact RATING</strong></td>
<td>1 2 3 4 5</td>
<td>No resource issue:</td>
<td>Moderate resource issues:</td>
</tr>
</tbody>
</table>

*Bold/ Circle chosen rating*
Describe support requirements and any associated challenges you have experienced:

Please provide information in relation to communication breakdown. Note repair strategies and desired areas for communication improvement.
SPECIALIST SUPPORT

Please list those specialists currently involved in providing support to the identified Client:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Practitioner if applicable</th>
<th>Approximate start of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical – GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical – Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical – Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Generally describe the specialist support requirements and associated progress for the Client that you are aware of:
Describe any deficits in specialist services and associated challenges that you have experienced:
History of complaints or contentious issues raised on-behalf of or in relation to the identified client.

Are you aware of any issues or complaints raised in relation to the identified client?

| Unknown | Not Applicable |

Describe

SUPPORT SETTING – Accommodation

| Unknown | Not Applicable |
From your knowledge and experience of the Client’s accommodation environment please identify any issues or challenges associated with the provision of support in this context:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental match to identified Client needs RATING</td>
<td>1</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Well matched to needs.</td>
<td></td>
</tr>
<tr>
<td>Environmental and Client needs require intervention</td>
<td></td>
</tr>
<tr>
<td>redesign and resources</td>
<td></td>
</tr>
<tr>
<td>Poor match:</td>
<td></td>
</tr>
<tr>
<td>Review required.</td>
<td></td>
</tr>
</tbody>
</table>

*Bold/ Circle chosen rating*
SUPPORT SETTING – Co-resident support issues

From your knowledge of the people the Client currently resides with, describe the shared needs and challenges using the table below:

<table>
<thead>
<tr>
<th>Common support requirements</th>
<th>Support issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe features of the support model that are shared by co-residents,</td>
<td>Describe any practice issues related to this support feature which impact</td>
</tr>
<tr>
<td>e.g. access to 24-hr support; wheelchair access; 1 to 1 community assistance;</td>
<td>on the Client’s well being.</td>
</tr>
<tr>
<td>restricted access to kitchen.</td>
<td></td>
</tr>
</tbody>
</table>

Unknown | Not Applicable
Shared support challenges RATING

Nominate a single rating across all issues noted.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No safety or support issues</td>
<td>Moderate safety and support issues</td>
<td>Significant safety and support issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Bold/ Circle chosen rating*

Please provide any further comment as required:
**DAY SERVICES/ VOCATIONAL/ EDUCATION SETTINGS**

From your knowledge of the Client’s day service or vocational environment please identify any issues or challenges associated with support in this context:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Unknown | Not Applicable
### Day Service Access RATING

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No coordination</td>
<td>Moderate coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant coordination</td>
<td></td>
<td>or support issues:</td>
<td>or support issues:</td>
<td>and support issues:</td>
<td></td>
</tr>
<tr>
<td>or support issues:</td>
<td></td>
<td>Generally manageable.</td>
<td>Manageable within</td>
<td>No day program</td>
<td></td>
</tr>
<tr>
<td>or</td>
<td></td>
<td>or</td>
<td>Unit program.</td>
<td>Client fully supported.</td>
<td></td>
</tr>
</tbody>
</table>

*Bold/ Circle chosen rating*
STAFFING/ CARER PROFILE – Accommodation

Please provide a staffing breakdown of the support format experienced by the Client:

<table>
<thead>
<tr>
<th>Staffing Type</th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Full-time</td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td></td>
</tr>
<tr>
<td>Agency/ casual</td>
<td></td>
</tr>
<tr>
<td>Vacant positions</td>
<td></td>
</tr>
</tbody>
</table>

From your knowledge of the staffing configuration please identify any issues or challenges associated with support in this context:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff skills and experience RATING</td>
<td>1</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Specific and advanced skills and experience in providing support to clients with complex needs.</td>
<td></td>
</tr>
<tr>
<td>General minimal training.</td>
<td></td>
</tr>
<tr>
<td>Limited skills and experience in supporting clients</td>
<td></td>
</tr>
</tbody>
</table>

**Bold*/ Circle chosen rating
Please provide any further comment as required:
Prognostic Scoring Tool

<table>
<thead>
<tr>
<th>Client identified for Review</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person completing survey</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date completed</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4a: Confirmation of Candidature

To Associate Dean Research, Prof Michael Atherton

Re: Confirmation of Candidature Lisa Fahey (Psychology)

Date: 6th November 2008
Time: 10:30 to 11:45
Location: Building 24 - 03 - Research Room
Student: Lisa Fahey
Student ID:

Chair: Prof Michael Atherton (Assoc Dean Research, COA)
Supervisors: Dr Josephine Milne-Home and Prof Nigel Bond (Psychology)
CoC Panel: Assoc Prof Meg Smith (Social Sciences); Dr Gawaian Bodkin-Andrews (Centre for Educational Research)

Thesis Title: Managing the Cost of Caring: the impact of carer trauma and resilience profiles on capacity to support young people with complex support needs.

Documents: (attached)

1. Overview introducing the topic area and key concerns; design and method; proposed chapter outlines; and timeline
2. Brief Bibliography
3. Questionnaire - Carers

4: Questionnaire - Behavioural Assessment

**Cover Sheet:**
Signed cover sheet submitted to the Chair

**Format:**
Chair Prof Michael Atherton gave a brief outline of the procedure from 20 minute presentation to questions, followed by panel discussion / decision (student absent from the room) and feedback plus further questions, including questions of the panel from the student.

**Presentation:**
The student contextualized the research agenda with her history of work in the field and close working relationship with the Department of Community Services in assessment, training and interventions with the "target" populations in the study. Credibility in the field is key to the success of the project and Lisa was able to demonstrate this prior to introducing the proposed research program. The statistics available speak volumes on the timeliness of the research into assessing trauma along with the capacity to care. The current situation that emphasises assessment rather than the success or otherwise of training and interventions means a shift in focus from problems to solutions and education and training for carers and children in the various categories of out of home care. The over representation of Indigenous children and youth indicates the need for cultural awareness and competence, as well as modifications to interview and assessment protocols to respect different care
arrangements and support models. This is already a system in place in DOCS to address these concerns, but the point presented was that this population would definitely be included in the research projected.

**Outcome:**

The Panel recommended that Lisa Fahey be awarded an A.

**Feedback was extraordinarily positive**

- The student was focused and well prepared, the depth of her knowledge in the area was apparent to all. The sample size suggested was noted as ambitious. Lisa was commended on the Bibliography as it was current and fine-tuned to her research agenda.

**Minor concerns**

- That the student be absolutely confident about the APA style for referencing.

- That a standard be set for the use of abbreviations common in government services and when working with Indigenous people. It could not be stressed strongly enough that this area had to be thoroughly correct at the standard expected of international publication. The NEAF application process would definitely be a place where the queries on respect and integrity in working with Indigenous populations would be apparent.

- Concern was genuinely expressed as to the effects of anxiety and pressure. Supervisors were asked to build in strategies to ensure student health and safety (regular meetings, queries about welfare of the student, and other things that psychologists need to be aware of in ensuring student success). Lisa reported that the
areas that were pressure points were not in the data-gathering phase, but in the analysis and write up phase.

- Timeline is detailed and a guide to the project roll out, but that it should be expected that things can and do take longer than projected. There is room for some flexibility here but the structure is set out and it would be expected that it would feature in progress reporting.

**Suggested support for this Candidate**

*Computer and Software*

A dedicated laptop with the usual Professional Windows software and internet requirements - plus:

- Leximancer (preferred qualitative research package)
- SPSS (quantitative research package)
- EndNote (bibliographic/referencing, research tools and template support)

*Transcription*

Payment for transcription services for the qualitative data entry would be helpful given the sample size and the amount of material that would come from the interviews. (Ethics: that the transcription service provider be bound by the same confidentiality protection as the researcher).

*Training*

Research methods refresher for qualitative an quantitative research,

Leximancer software and training,

EndNote refresher,

Advanced e-document/resources research skills from the Library
Writing for Publication - including journal destinations and protocols

(expectations re publication process)

Conference Attendance and Presentation

As part of the academic process, the student would present at conferences and be included in the academic community exploring issues of this complexity and importance. That Lisa be made aware of support (rights and obligations) available in the COA / UWS.

Travel

It is clear that there will be travel involved in the research. That Lisa be made aware of any support available for collecting her data.

Summation

Lisa Fahey was confirmed as a candidate.

She will now move to the Ethics (NEAF) Application and confirm with DOCS on the success of that application before gathering her data.

Dr Jo Milne-Home (Principal Supervisor)
Prof Nigel Bond (Co-Supervisor)
Associate Prof Meg Smith
Dr Gawaian Bodkin-Andrews
Dr Jo Milne-Home MAPS

j.milnehome@uws.edu.au

Executive APS College of Educational and Developmental Psychology

UWS School of Psychology BA-24-2-09

Locked Bag 1797

Penrith South DC NSW 1797

Australia

Ph: +61 2 9772 6715 or +61 2 4736 0185

Mobile: 0417 627 599

Fax: +61 2 9772 6736
Appendix 4b: Ethics Approval Notice

Notification of Approval

Email on behalf of the UWS Human Research Ethics Committee

Dear Jo and Lisa

I'm writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

TITLE: The impact of carer trauma and resilience profiles on capacity to support young people with complex support needs.

H6893 Student: Lisa Fahey (Supervisor: Dr Josephine Milne-home)

The Protocol Number for this project is H6983. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:

1) The approval will expire on **31 December 2010**. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer (humanethics@uws.edu.au) prior to this date.

2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.
3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/ors/ethics/human_ethics

4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/ors/ethics/human_ethics

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

Dr Janette Perz,

Chair, Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC  NSW 1797
Tel: 02 47 360 883

Appendix 5: Behavioural Assessment

**Behavioural Assessment – Client**

**Date**

Client:

DOB: Age:

Date of Referral:

Date of Report:

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**Referral Information**

**Data Source**

- Observations of behaviour at interview
Interviews with carers, Case Worker, Specialist support workers and Medical Professionals, Parents and Client

A review of current programs, incident reports, professional reports and other historical records

Background Information

Behaviour Intervention History

Interaction guidelines

Routine and Scheduling

Behavioural support

Reactive Strategies

Positive, clear communication

Structured Routine

Supervision & Instruction

Reassurance and clarification

Teaching appropriate behaviours

Functional Analysis of Target Behaviours

Social skills

Functional skills

Description of Target Behaviour (Topography):

Operational Definition
Cycle, Course and Impact

Antecedent Events

Consequent Events

Analysis of Function

Motivational Analysis

Mediator Analysis

Recommended Intervention Plan Directions

Recommended Intervention Elements

Incident Response Plans

Interaction/communication Guidelines

Routine/Schedule

Functional Skills Training

Direct Treatment (Focused Supports)

Social Skills Program

Access (family) preparation and debriefing

Data Collection

Mediation Recommendations

Additional Comments and Recommendations

Completed By:

Date:
# Appendix 6: Prognostic Scoring Tool

<table>
<thead>
<tr>
<th>Assessed behavioural function</th>
<th>Treatment prognosis and behaviour persistence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe <em>why</em> you believe the person uses their behaviour in a challenging way. What purpose does the behaviour serve for them? How does the behaviour assist them to achieve their needs in their current situation?</td>
<td>Select the descriptor below that best matches the recommended intervention model/time frame required across the range of behaviours noted.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> ‘Intensive’ refers to a model of clinical support that involves assessment, intervention design or re-design, and/or an allocated clinical resource equivalent to b—weekly or weekly contact.</td>
</tr>
</tbody>
</table>

*Bold/ Circle chosen rating*

- **1** – Short term intensive (3mths)
- **2** – Medium term (6-12mths)
- **3** – Medium term intensive (6-12mths)
- **4** – Long-term (12mths-3yrs)
5 – long term intensive (12mths-3yrs)

Bold/ Circle chosen rating

Please provide any further comment as required:

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Appendix 7: TSI Results Summary

4.1 Role

As for the DAPS analysis, the role selection options were: Paid Staff, Foster Carers and Birth Relatives.

Results indicated that there was substantial variation in the level of significant symptom indicators across carer categories. Additionally, the highest percentage score was reported within the Foster Carer group (41%). However, the Birth Relatives group demonstrated the lowest percentage score (13%). These results appear to correlate with the DAPS assessment results. It was noted, conversely, that the variation between the role groups was greater. Notably, despite this slight variation in the degree of convergence, the order of frequency of presenting trauma symptoms across groups consistently placed Foster Carers at the top.

4.2 Ethnicity

Again repeating the process of testing the impact of the ethnicity of carers, participants were asked to make a selection on their profile for Aboriginal or Non-Aboriginal.

The results indicated that Aboriginal carers were consistently assessed as reporting higher incidents of significant trauma experience and symptoms. Secondly, there was a difference of between 14% and 15% between the ratios of Aboriginal carers reporting significant issues in comparison to non-Aboriginal workers. This difference appeared sustained across Paid staff and Foster carer types. It was noted
that on the TSI Birth relatives scored a consistent (13% and 14% respectively) percentage for both Aboriginal and Non-Aboriginal carers.

The TSI results closely mapped to the profile of carer symptoms noted in the DAPS. This was both true for general trauma symptoms and those indicators holding potential for a diagnosis of PTSD. However, the DAPS results consistently noted higher levels of symptoms overall across all samples.

4.3 Age

As for the Resilience and DAPS tools, the age selection options were: 0-25 years, 26-35 years, 36-45 years, 46-65 years.

Current findings suggest that there were high rates of trauma experience and symptoms reported evenly across the age groups. Interestingly, the TSI showed a slight comparative elevation in the younger age group cluster 26-35 years. Although not significant, this trend was a variation in that noted for the DAPS. Importantly, there was not specific correlation or relationship identified between age and trauma profile, which supports the findings generated by the DAPS.

4.4 Gender

The gender selection options were: male or female. Analysis demonstrated that there were approximately two thirds of the numbers of men than women that were assessed as reporting significant scores related to trauma experience and symptoms. This proportion is above the comparative ratio of male to female carers within the sample, indicating that the incidence of trauma experience and symptoms to be slightly higher for male carers.

Again, these results were not significant; as a result, the TSI tool yielded results that were consistent with those achieved on the DAPS.
4.4.1 TSI Element Scores. The breakdown of the TSI results yielded a number of measures that are then combined to formulate a profile of the individual respondent. It is critical that each profile is examined holistically to understand the individual needs of each person assessed. For the purposes of this study, each of the carer’s results have been combined in a broad analysis to track the various trends of the group and sub-categories of carers.

The range of elements drawn from the TSI assessment has been discretely reviewed and the following trends and analysis indicates the following outcomes. The TSI scores reflect the extent to which the respondent endorses 10 different types of trauma-related symptoms (Zhou).

4.4.2 Validity Scales. The TSI Validity Scales assess each participant’s responses in three areas: tendency to deny symptoms that others commonly endorse, tendency to over-endorse unusual symptoms, and inconsistent or random completion of the tool. Those respondents who were required to be withdrawn from analysis due to not meeting the validity criteria totalled 13 of the 125. The profile of the validity failure tended to reflect significant scores from representative of each of the validity scales (symptom denial, over-endorse and random endorse).

4.4.3 TSI Clinical Scales. In terms of returned results for Anxious Arousal (AA) for this study: 5% of all carers returned significant results for AA. Also, 7.7% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for AA. According to Briere, this measure indicates the extent to which the respondent is experiencing symptoms of anxiety and autonomic hyper arousal. Reports of generalised anxiety and panic attacks are not uncommon among people with very high AA scores.
When compared to similar symptom measure for the DAPS, this result indicates a marked reduction in reported significant scores. The score achieved for the TSI places the group as only slightly above population norms, whereas the DAPS results are more consistent with highly distressed, traumatised populations.

In terms of returned results for Depression (D) for this study: 4% of all carers scored significant results for D. Additionally, 6.4% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for D. According to Briere, high scorers on this indicator often report frequent feelings of sadness and unhappiness, and a general sense of being depressed. Individuals with a significant indicator are also often a high risk of suicidality. When compared to the similar symptom measure for the DAPS (suicidality), this result shows a match in reported significant scores. As discussed in the analysis of the DAPS results, high results in these areas of functioning have specific implications for the management of daily functioning, and clearly inhibit the carers capacity to sustain a therapeutic relationship with the child or young person they are charged with caring for. Again, this clearly highlights the very serious psychological challenges inherent in supporting highly traumatised individuals. Service providers and clinicians clearly need to develop awareness and suitable support strategies to address these needs in order to sustain any level of meaningful intervention.

In terms of returned results for Anger/Irritability (AI) for this study: 10% of all carers scored significant results for AI. Also, 16% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for AI. Briere suggests that, high scores on this indicator reflect irritability often
associated with PTSD, or a more chronic angry state. Brier also stresses that respondents who score on these items often have difficulty managing aggression towards others. There was no measure within the DAPS that offered a direct comparison, but perhaps links to discussion around general arousal levels.

In terms of returned results for Intrusive Experiences (IE) for this study: 3% of all carers scored significant results for IE. 4% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for IE. According to Briere, high scores on this indicator reflect that the respondent is experiencing flashbacks, memories and/or repetitive thoughts that are unpleasant and related to a traumatic event. When compared against a similar measure within the DAPS (Re-experiencing), the proportion of the study population assessed as having significant indicators is much less within the TSI. The score achieved for the TSI places the group as only slightly above population norms, whereas the DAPS results are more consistent with highly distressed traumatised populations.

In terms of returned results for Defensive Avoidance (DA) for this study: 6% of all carers scored significant results for DA. 9% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for DA. According to Briere, high scores on this indicator reflect that the respondent describes a history of aversive internal experiences that they repeatedly seek to avoid. This active attempt to consciously avoid thoughts is notably different from dissociation or other unconscious psychological defences. When compared against a similar measure within the DAPS (Avoidance), the proportion of the study population assessed as having significant indicators is much less within the TSI. The score achieved for the TSI places the group as only slightly above population norms,
whereas the DAPS results are more consistent with highly distressed traumatised populations.

In terms of returned results for Dissociation (DIS) for this study: 6% of all carers scored significant results for DIS. 10.3% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for DIS. Briere suggests that significant scores on this indicator measure a variety of dissociative symptoms, including cognitive disengagement, depersonalisation and derealisation, out-of-body experiences, and/or emotional numbing. When compared against a similar measure within the DAPS (PDST and T-DIS), the proportion of the study population assessed as having significant indicators is approximately matched or slightly below that within the TSI. The score achieved for the TSI places the group as above population norms, and the DAPS results are consistent with highly distressed traumatised populations.

In terms of returned results for Sexual Concerns (SC) and Dysfunctional Sexual Behaviour (DSB) for this study: The TSI measures were 6% of the carer sample, which is slightly above population norms. The DAPS tool does not have a measure for direct comparison, although this result is under half of the results achieved for general Impairment (PTS-I).

In terms of returned results for Impaired Self-Reference (ISR) for this study: 9% of all carers scored significant results for ISR. Also, 14.2% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for ISR. Briere found that significant scores on this measure tend to reflect an individual’s inability to separate their needs from that of others, a general lack of identity and life goals or ability to resist the demands of others. This
score does reflect a result above that of the normal population, and is more consistent with highly distressed, traumatised populations.

This is an interesting result given the mediation of a number of the other symptom areas. Clearly the capacity to separate the needs of yourself (carer) and those you care for (child or young person) is critical to both the functional ability to manage intervention, and more fundamentally to sustain care. As with the analysis of the DAPS elements, the implications of this deficit are significant when related to the management of education and support to therapeutic intervention and responses. In response to knowledge of this challenge, clinicians would clearly need to specifically address the process of goal setting and the management of ‘carer vs. child’ identity to ensure a supportive understanding of separate needs and change.

In terms of returned results for Tension Reduction Behaviour (TRB) for this study: 7% of all carers scored significant results for TRB. 11.6% of those carers who were assessed as reporting a significant trauma indicator in their profile scored significant results for TRB.

Briere describes this symptom as external acts performed by an individual as a method to avoid, moderate, interject, or reduce negative internal states. The respondents in this group report tend to be less functional under stress and often use anti-social or high-risk activities to relieve distress. This score does reflect a result above that of the normal population, and is more consistent with highly distressed, traumatised populations. It appears that there is a general match for DAPS measures for substance abuse, and perhaps avoidance symptoms.
Table 18 - TSI Trauma Significant Symptom Profile

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In conclusion to this section, the carer sample scored significant results on measures for Anger/Irritability (AI), Impaired Self-Reference (ISR) and Tension Reduction Behaviour (TRB). Of the carer categories, the Foster Carers scored the highest proportion of symptoms and reported the most significant level of trauma experience. This finding is consistent with the DAPS tool results, and clearly analysis of these scores call service providers and clinicians to more proactively focus on the critical nature of the psychological profiles of the carer group. Clearly the study has highlighted many results that place the carer group at risk, and, in order to address the achievement of therapeutic outcomes and sustainable supports to children and young people, there is no solution other than to directly shape our interventions to accommodate the complex and long-term practical management of trauma healing and recovery indicated by the carer population.
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