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CIAO

Care-system Impacts on Academic Outcomes

Research Report
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Executive summary

Background

Education is a basic right of all children and young people, and is fundamental to living a full life. Being happy at school, engaging in learning and experiencing success is a big part of one's quality of life in childhood. Success at school is also an essential ingredient for long-term positive outcomes into adulthood.

Despite the importance of a quality education, children and youth who live away from the families of their birth parents are known to experience poor education outcomes compared to children and young people in the community generally. Although Australian research is somewhat limited, the findings are unequivocal; children in out-of-home care perform academically below what is normal for their age, are at risk of 'disengaging' or are disengaged from school and often don't achieve any academic qualification.

Deficiencies in educational functioning places out-of-home care children and youth at risk for continued difficulties in adulthood, including low income, incarceration and chronic problems with employment and housing.

Research into the impact of out-of-home care placement on education outcomes has highlighted several care-system factors that may operate to diminish children's chances of success at school. These include; lack of participation in school-based opportunities and extra-curricula activities, disruption to educational continuity and school stability (caused by factors such as court appearances, placement changes and parental visitation), lack of co-ordination and planning between significant stakeholders responsible for children's care, and inadequate commitment, encouragement and support for education among carers and caseworkers.

Yet, while the risks that operate within the care system are manifest, it is recognised that children may have accumulated considerable risks for education failure as a result of trauma and deprivation experienced prior to entering care. The quality and suitability of the school environment to manage, support and effectively engage children in out-of-home care in learning is another significant factor that appears to impact on education pathways and success at school.

The Care-system Impacts on Academic Outcomes project

Although positive steps have been taken at both a system and an agency level, still more needs to be done to increase education opportunity and outcomes among the out-of-home care population. The Care-system Impacts on Academic Outcomes (CIAO) project was conducted by Anglicare Victoria and Wesley Mission Victoria to improve understanding of the education needs and outcomes of children and youth receiving non-relative foster care and residential care services and, through a process of identifying risk factors and risk processes, to identify where and how policy and practice interventions may be best targeted. The research included a detailed survey of 199 carers and 21 teachers and in-depth case studies focussing on six young people.

Research findings

Survey research

The survey research uncovered an elevated rate (36.7%) of functional limitations among children and young people in the sample due to a long-term health, medical or behavioural condition. Scores on the teacher-rated Strengths and Difficulties Questionnaire (SDQ) also showed a heightened risk among the CIAO sample for emotional and behavioural adjustment problems compared to Australian 7-17 year olds generally.

In terms of education outcomes, a high proportion of children had repeated a grade at school (23.7%), had experienced a change of school (60.2%), were not attending school on any days (18.1%), had wagged school in the past year (30.8%), or had been suspended in the past 12 months (14.7%). However, the data suggested that children's participation in extra-curricula activities, exposure to electronic media and in-home education support was comparable to children in the community generally.

A more in-depth analysis of the sample on education processes and outcomes showed that negative outcomes and adverse individual circumstances were concentrated in two of three groups; a 'damaged' younger group of children who were characterised by high rates of cognitive, emotional and physical disorders and extremely poor school achievement, and a 'disengaging' group that was less compromised but older and showing the least engagement and attachment to school. A third group of children, labelled 'doing well', appeared to be functioning on par with children and young people in the community generally.

Multivariate statistical analysis reinforced the strong relationship between developmental functioning and repeating a grade (intellectual disability), overall achievement (learning disability), temporary suspension (ADD/HD), working hard at school (intellectual disability) and behaviour at school (learning disability/ disorder). There was also an indication that physical disabilities were related to repeating a grade at school. High expectations for education among carers were related to overall achievement and not having been suspended from school, working hard at school and positive behaviour at school. Carer capacity to support education was positively related to overall achievement and carer help with homework was also positively linked to working hard at school.

Case study research

The case study research shed light on a number of factors which, in interaction with each other, appeared to affect educational achievement. Childhood trauma and its ongoing impact on young people's minds, feelings and behaviour was a core negative influence on academic achievement. A concern with the situation of birth families also appeared to intrude on young people's capacity to concentrate and engage in learning. There was also indication of insufficient resources within the out-of-home care and school systems to respond to trauma and young people's specific learning needs, including a lack of appropriate and/or therapeutic placements, flexible learning options and alternative education settings. There also appeared to be limits on the models of practice required to meet the needs of young people and support education outcomes.

There were also factors that appeared to contribute to positive change, growth and achievement in the cases examined, despite less than optimal outcomes for some young people. These factors included a commitment to the young people among staff in both educational and care settings, skilful practice and intensive intervention, often in the face of inadequately resourced care, as well as education staff working co-operatively to increase support to young people and maximise their ability to grow, develop and achieve. Finally, the young people themselves displayed a responsiveness to intervention and support and resilience against overwhelming odds.

What should be done to improve education outcomes among children and youth in OOHC?

The report concludes with eleven recommendations designed to:

- Promote placements that are likely to make a positive future impact on educational outcomes
- Extend the provision of placement and support until young people in out-of-home care complete Year 12 or an equivalent accredited qualification
- Improve support for children who exhibit or are at risk of developing severe emotional and behavioural disturbance
- Increase the capacity of mainstream schools to respond to trauma-related behaviour
- Improve the scale and reach of evidence-based alternative education programs and settings
- Introduce co-ordinated education assessment and planning across the out-of-home care and education systems, and
- Introduce a co-ordinated system, owned by out-of-home care and education, to monitor the education progress of children and young people in out-of-home care.

Chapter 1 - Background

Educational outcomes among children in OOHC

Education is a basic right of all children and young people and is fundamental to living a full life ("children" will be used as a shorthand for children and young people throughout). Being happy at school, engaging in learning and experiencing success is a big part of one's quality of life in childhood.

For children living in out-of-home care (referred to from this point as OOHC), education can provide a pathway to social inclusion and opportunity and can assist children to develop resilience. Positive school experiences can also provide vulnerable children with social connections and friendship, as well as a sanctuary from chaos and trauma in their lives (Bonny, Britto, Klostermann, Hornung, & Slap, 2000; Mansour, Kotagel, Rosenfeld et al., 2003). Educational achievement also seems to go hand-in-hand with stability in placement as well as successful transition out of the care system.

Sadly, for most children living away from the homes of their birth families, the education process reinforces social exclusion and disadvantage. Research consistently shows children and young people in care are at a greater risk of experiencing poor education outcomes compared to children in the community more generally.

Studies that looked into learning outcomes show that children in OOHC perform academically below what is normal for their age. A recent analysis of national numeracy and literacy test records conducted by the Australian Institute of Health and Welfare, for example, found that children in Government schools on guardianship and custody orders were considerably less likely to reach national benchmarks for numeracy and literacy, compared with all children who participated in the tests (N = 895) (AIHW, 2007b).

The education deficits of children in OOHC are also shown by higher rates of being held back a year, as well as higher absenteeism and truancy than their peers (Lips, 2007; Zeltin, Weinberg & Kimm, 2003; Christian, 2003). The latest CREATE Report Card on Education (CREATE Foundation, 2006), which involved 297 children and young people across Australia aged 10-17 years, showed that approximately one-third of those surveyed missed more than 10% of total attendance days.

It is also clear that children in care complete fewer years of schooling and are much less likely to continue within mainstream education beyond the period of compulsory school attendance, which is 16 years. In Cashmore and Paxman's seminal study of wards leaving care (1996), only 6% of the study sample had completed secondary school. The CREATE Report Card on Education showed that less than half (44%) of 17-year-olds attended school. In Queensland, the recent Views of Young People in Residential Care survey highlighted that almost half of the 221 young people who participated in the survey did not attend school and of these two-thirds were not involved in any other training or education (Commission for Children and Young People and Child Guardian, 2009).

Impact of education failure

The failure of the mainstream school system to retain children in OOHC often leads to the entrenching of wide-ranging social issues and self-harming behaviour. This makes it extremely difficult for some of them to step back into education or training and, as a result, into mainstream society.

The impact of early school leaving on earnings and adults' chances of employment is also obvious. Changes in labor markets have meant that qualifications are increasingly necessary for gaining employment. The 2009 Foundation for Young Australians National Report on the learning and work situation of young Australians (Lamb & Mason, 2009), for example, highlights the fact that early school leavers who do not continue in education are less likely to be in full time work and more likely to be unemployed or not in the labour market and less able to support themselves in the future. The How Young People are Faring '09 report showed that 40% of young people who left school before Year 10 in 2007 had no job at all 12 months later.

Current understanding of the cause of education failure

There is a large body of literature that highlights factors operating in the birth family, the OOHC system and the education system that heighten children's vulnerability to education failure.

A risk perspective

Research has highlighted a solid link between education achievement and social and economic background in Australia (eg. OECD, 2009). However, recent research conducted on Australian students participating in the Longitudinal Study of Australian Children (LSAC) has revealed that it is likely that the relatively high number of risk factors operating for disadvantaged children is at the root of poor outcomes (Smart, Sanson, Baxter, Edwards & Hayes, 2008).

The risk factors and risk processes for poor education outcomes are the same for all children, and include such things as emotional and behavioural problems, maternal factors, family educational climate, parenting style and preschool experience. Simply, disadvantaged children tend to experience more risk factors than children generally. The high proportion of children in care who experience difficulties prior to or immediately following placement gives weight to the suggestion that they are likely to have suffered significant deprivation in the homes of their birth parents.

Risks operating in the birth family

It is well accepted that the problems faced by children before they come into care have become more extreme, and these negative life experiences do carry consequences. Research suggests that children often have low educational performance when entering child protection services (Queensland Government, 2003; Evans, Scott & Schulz, 2004).

There is increasing awareness that a large part of the cause of problems among children and young people in OOHC may lie with the circumstances of the children before they are admitted to care, particularly abuse and neglect (Veltman & Brown, 2001; Social Exclusion Unit, 2003).

In Victoria in 2001–02, an audit of roughly 1,600 children in home-based care conducted by the Victorian Department of Human Services (DHS) showed that 95% of all children entering foster care had a history of protective involvement, which means that the vast majority would have experienced some form of abuse and/or neglect (DHS, 2003).

Abuse and neglect is thought to impact on academic performance in a number of ways. Child maltreatment can cause cognitive impairments that manifest in speech and language delay, memory difficulties, distorted and disorganised thinking patterns and information processing, as well as attention/concentration disorders (OCSC, 2007). Children who are abused and neglected to the extent that they need the care system also often suffer emotional disorders, affect emotional dysregulation (eg. disassociation and hyperarousal) and attachment disorders, which may affect educational attainment through damage to their self-esteem and personality, and problem behaviours that impact negatively on their social relationships with teachers and peers and their attachment to school (Pecora et al., 2005).

Abused and traumatised children also frequently have injuries, conditions and physical disabilities and a heightened susceptibility to frequent illness, which can impact on academic performance as a direct result of the condition and/or the school absences that result. Traumatised children may also lack the capacity to regulate their own sleeping and eating behaviour, which may affect their education through sleep disturbance and subsequent lack of rest. Children in care may also miss the opportunities to develop the important foundational skills that serve as the basis for later educational achievement.

Risks operating in the OOHC system

Research has highlighted children in OOHC experience high rates of absenteeism, relating to court appearances, visitation, and duration of travel in order to maintain the child in the same school (CREATE Foundation, 2004), changes in schools as the result of moves to new placements (Jackson, 1994; Kurtz, Gaudin, Wodarski & Howing, 1993; Wulczyn, Kogan & Harden, 2003), lack of participation in school-based opportunities and extra-curricula activities as the result of difficulties obtaining parental consent and because of the cost involved (CREATE Foundation, 2004), lack of co-ordination and communication between significant stakeholders responsible for children's care (Conger & Finkelstein, 2003), and inadequate support (Harker, Dobel-Ober, Lawrence, Berridge & Sinclair, 2003).

Lack of engagement and involvement among social workers and carers in children's education experiences, such as contact with schools and a lack of commitment to education by carers has also been linked to low achievement at school (Sawyer & Dubowitz, 1994; Jackson, 1994; Social Exclusion Unit, 2003).

Quality and suitability of the school environment

The quality and suitability of the school environment is clearly critical in regard to educational engagement and outcomes among children in OOHC. Children's complex behaviours pose a significant challenge for teachers and they may not have the skills and understanding to effectively manage the disruption and chaos children with complex needs can create in the classroom. Schools may also not have specialised programs and supports matched to children's complex learning needs and learning styles.

Current responses to education failure among OOHC children

There are some positive steps being undertaken to improve education opportunity and outcomes among disadvantaged children across all tiers of government and within the community sector as well. This is evidenced through the large number and diversity of initiatives, programs and alternative settings designed to improve education outcomes and prevent disengagement among children and youth at risk of education failure.

The Department of Human Services shares responsibility for education outcomes among children in OOHC with the Department of Education and Early Childhood Development. Under "The Partnering Agreement" (Victorian Department of Education and Training and the Department of Human Services, 2003), the two departments have established protocols to build a sense of shared responsibility for providing support and educational opportunities to children across education and care systems and to ensure the educational needs of children in care do not go unmet.

Under the Partnering Agreement, the principal, in partnership with the caseworker, is expected to establish a student support group (SSG) for all children in OOHC. The SSG is then to develop an Individual Education Plan (IEP) within the first month of ongoing attendance at the school. The two departments have also established an initiative providing free kindergarten to children involved with child protection.

Within the OOHC system, the Looking After Children (LAC) assessment and planning process is being implemented to strengthen communication and collaboration between care team members responsible for OOHC children. The Victorian Department of Education and Early Childhood Development is also undertaking the development of policy relating to the education of the most at risk children, including those in OOHC. Their recent publication "Re-engaging our kids" (KPMG, 2010) and the associated discussion paper, "Pathways to re-engagement through flexible learning options: A policy direction for consultation" (DEECD, 2010) are further indications of their commitment in this area.

Despite this commitment, focus and investment, little progress appears to have been made in alleviating significant problems of school disengagement and education failure among children in OOHC. Whether this is because programs are too narrow, disproportionately focussed towards crisis-end treatment, not grounded in firm evidence, inadequate in scale or with inadequate sustainability and reach, or whether there is a lack of a shared strategic vision and effective co-ordination, is unclear.

Chapter 2 - The Care-system Impacts on Academic Outcomes project

Background

OOHC provides a range of alternative accommodation to children and adolescents who, for whatever reason, are unable to live at home with their birth parents. At any one point in time in Victoria, approximately 5,283 children aged 0–17 years live in OOHC (Australian Institute of Health and Welfare, 2010). This research is concerned with children living in non-relative foster care (as distinct from relative/kinship foster care) in the state of Victoria, Australia. Throughout this report "foster care" is referred to as meaning non-relative foster care.

Despite a growing recognition that children entering OOHC need a clear commitment to ensure their education needs do not go unmet, poor education outcomes and limited opportunities for this special group of children and young people remains an intractable problem.

Anglicare Victoria and Wesley Mission Victoria are two of the largest providers of OOHC in Victoria. Together, they provide OOHC to approximately 710 children and young people aged under 18 years of age who are unable to live at home with their families.

The organisations provide accommodation through:

- Foster care to 380 children and young people
- Kinship care in 321 families
- Residential care in 12 residential houses
- A leaving care residential unit with a therapeutic focus and seven lead tenant properties which assist young people make the transition to independent adulthood, and
- Case management to 96 young people.

These services are provided across metropolitan Melbourne and throughout regional Victoria.

Both agencies currently provide a range of outside school education supports such as one-to-one tutoring, coaching and mentoring, as well as specialist support services for young people in residential care who are unable to participate in the formal education and training system. A current strategic priority for both agencies is to expand the educational options and opportunities for children and young people living in OOHC in order to improve their educational outcomes.

Aims and objectives of the Care-system Impacts on Academic Outcomes project

The Care-system Impacts on Academic Outcomes (CIAO) project was explicitly designed to provide an evidence base for the development of new initiatives that would support education outcomes among children and young people receiving foster care and residential care services. Specifically, the CIAO project aimed to:

- Produce data on key education indicators and outcomes for different groups of children and young people in OOHC
- Identify relevant, modifiable risk factors and processes for education failure among children in OOHC, and
- Identify where and how policy and practice interventions may be best targeted.

A further aim of the CIAO project was to ensure that knowledge of risk factors, risk processes and effective interventions were informed by the experience of practitioners in the OOHC field, caregivers and education providers, as well as children and young people receiving OOHC services.

Study method

The CIAO project covered both quantitative and qualitative methods of research. Use of mixed methods of data collection means that the research benefited from the strengths of each method and was able to minimise its corresponding limitations.

The quantitative research was conducted through a survey of carers and teachers. The surveys were intended to provide a valid assessment of education outcomes among children in OOHC and to identify risk factors and processes underlying education outcomes. Six case studies focussing on young people were undertaken to complement the survey research. A detailed, contextual analysis of the education pathways of a these cases was designed to generate a deeper understanding of why certain outcomes eventuate for certain individuals.

Details on the method, sample, recruitment and findings from the survey and case study research are presented in chapter 3 and 4 respectively.

Chapter 3 - Survey research

Survey method

Sampling strategy

The survey research focussed on children aged 4-17 years who had received Anglicare Victoria and Wesley Mission Victoria's OOHC services for at least three months. The sample did not include children/youth on permanent care orders or in kith/kin placements. The total number of OOHC children who were within scope for the research was 228. The survey sample included foster carers, key staff working in children's residential services as well as a small number of lead tenants. Carers of all 228 children were approached to take part in the carer survey. In all, 222 carers agreed to take part in the research. At the close of fieldwork, 199 carer surveys had been completed; that is an 87.3% response rate.

Teachers of children who were on a guardianship order[1] were approached to complete a survey. Of the 199 children and young people for whom a carer survey was completed, 158 (79.4%) were enrolled at a school or early childhood program and 53 of these were on a guardianship order. Of this number, 21 completed teacher surveys were received; this represents a response rate of 39.6%.

Recruitment procedure

Agency placement workers from Anglicare Victoria and Wesley Mission Victoria were actively involved in the recruitment of carers to the research. Initially, team leaders and caseworkers across home-based care and residential care programs distributed a plain language statement to all carers within scope for the study. The letter conveyed to carers that if they wished to be part of the research they initially need do nothing; their contact details would be transferred to a social research agency who would contact them to take part in a telephone survey. Carers were also informed that they were able to opt out of the study by contacting the relevant caseworker/team leader within five working days of receiving the letter. Six of the 228 carers who were sent a plain language statement opted out of the study and their private details were not released.

Case managers/team leaders forwarded to the researchers essential case details about carers who did not opt out of the study and the children in their care. This information included carer name and telephone number, the names of children, child client reference number, whether children/young people were in care under a statutory order or voluntarily, the type of order children/young people were under and the Anglicare Victoria/ Wesley service location. This information was consolidated and transferred to the fieldwork agency, I-view. I-view made telephone contact with carers and conducted the carer survey over a two week period. Carer interviews took approximately 20-30 minutes.

At the end of the survey carers were asked for permission to contact children's teachers for the purpose of research. At this stage the child's main teacher and school name was recorded. Although case managers have a duty to ensure that schools have information about the child's history and care arrangements, a decision was made to only involve cases where children were looked after under a guardianship order. This was to prevent disclosure of a child's care status in the event that essential information had not been passed on to schools.

Approval to involve teachers in Government schools in the research was subject to approval from the Department of Education and Early Childhood Development (DEECD) as well as individual school principals. Authority to approach school principals for permission to conduct the research in Government schools was obtained from the central office of the DEECD. School principals were sent a letter about the research and this was followed up by a telephone conversation to obtain their verbal consent to approach relevant teachers about the research.

1 Finalised guardianship orders grant legal custody and guardianship to an authorised department, with the head of the state or territory community service department usually becoming the guardian of the child. Guardianship orders convey to the guardian responsibility for the long-term welfare of the child.

Teachers in scope for this part of the research were then mailed a short questionnaire focussing on children's educational attainment and behaviour at school. A teacher information form was included with the teacher survey. School characteristics such as school size were identified from the name of school provided on the survey.

Measures

The carer survey covered seven domains of interest:

- School enrolment
- Educational outcomes/outcome indicators
- Care-system factors
- Special education needs
- Specialised education support
- Individual child factors, and
- Individual carer factors.

The teacher survey was brief and focussed on children's educational attainment and behaviour at school. The decision was made to attempt to involve teachers in the research to provide a first-hand account of children's education progress and in-school behaviour.

Measures included in the carer survey and teacher survey were chosen because they possessed known properties of validity/reliability and/or because they have been used in general population surveys and thus provide a benchmark for comparison purposes.

Sample characteristics

At 30 June 2009, just five months prior to the fieldwork for the CIAO project, 2,868 children and young people were living in non-relative foster care and residential care in Victoria (AIHW, 2010). The current sample of 199 therefore represents approximately 7% of the total population of children and young people in OOHC.

As described in Table 1 on the following page, the mean age of the CIAO sample was approximately 12 years. The vast majority of children were born in Australia or another English-speaking country. Approximately three-quarters of the sample were accommodated in a foster care program (74.9%) and 18.6% were living in residential care. These proportions are approximately similar to the State average (83.3% and 16.7% respectively).[2]

2 Excludes kinship care placements.

Table 1

Sample characteristics	Percentage	*M*	*SD*
Child Characteristics			
Age (years)		12.0	4.2
Child sex (female)	48.2		
Aboriginal and Torres Strait Islander	3.6		
Born in non-English speaking country	4.1		
Placement characteristics			
Foster care placement	74.9		
Residential care placement	18.6		
Lead tenant arrangement	6.5		
Age when placed in OOHC for first time (months)		78.0	32.9
Time in current placement (months)		27.3	32.9
No. adults who have acted as child's main carer since birth		6.0	8.0
Carer characteristics			
Carer age (years)		46.9	11.9
Carer sex (female)	78.9		

Survey findings

Descriptive techniques, cluster analysis and regression analysis were used in tandem to profile the study sample and understand risk factors and risk processes linked to education outcomes.

Descriptive statistics

Descriptive techniques were used to profile education inputs, children's difficulties and outcomes for the sample as a whole. The results of the descriptive analysis are included in Table 2 on the following page. As discussed in the measures section on page 15, many of the measures could be benchmarked to larger populations of children and youth. Where applicable, these are included for comparison purposes.

Table 2

Key education outcomes and outcome indicators for the survey sample	
CIAO survey sample	Comparative data
Functional limitations	
Proportion of children with a long-term condition or health problem which prevents or limits his/her participation in school, at play, or in any other activity typical for a child of his/her age = 36.7%	Victorian children with functional limitations[3] due to a long-term health, medical or behavioural condition (birth to < 13 years) = 4.1% (DHS, 2007)
Proportion of children with ADD/HD = 8.5%	Proportion of Victorians aged 12 to 17 years with ADD/HD = 8% (AIHW, 2007a)
School enrolment	
Proportion of children attending school part-time = 6.3%	Proportion of part time students in Australia = 0.4% (ABS, 2009a)
Kindergarten participation rate of 4-year-olds = 100%	Kindergarten participation rate of Victorian 4-year-olds = 92.4% (DEECD, 2009)
Proportion of children enrolled in: Government school = 89.9% Catholic independent school = 5.1%, and Other independent school = 5.1%	Proportion of Victorian students enrolled in: Government school = 69% Catholic independent school = 21%, and Other independent school = 10% (ABS, 2009a)
Home learning environment	
Proportion of children who have access to a computer with internet access at home = 71.6%	Proportion of children aged 5–14 years who accessed the internet at home during the 12 months prior to April 2009 = 75% (ABS, 2009b)
Proportion of children who always have a suitable (e.g. quiet, with adequate space and light) place to do their homework or quiet study = 92.4%	
Proportion of carers who always helped child with homework in the current school year = 47.1%	Proportion of parents who always helped 8-9 year olds with their homework every day Mothers = 28% Fathers = 7% (FAHCSIA, 2009)
Proportion of carers who feel good grades are important or very important = 79.4%	
Education support	
Proportion of children who receive specialised education services within the school = 31.8%	Proportion of Victorian children who need or use special services, therapy or counselling for a long-term health, medical or behavioural condition (birth to <13 years) = 9.5% (DHS, 2007)
Proportion of children with a SSG established = 47.9%	
Proportion of children who receive any help or tutoring outside of school hours = 15.9%	
Education outcomes/outcomes indicators	
Proportion of children who read or look at things like books, magazines, newspapers, material on-line for fun every day or a few times a week = 74.7%	Proportion of Victorian children (aged 5-14) who participated in reading for pleasure = 71.7% (ABS, 2009a)
Proportion of children who have ever repeated a grade at school (including kindergarten) = 23.7%	

3 Child with a functional limitation is defined as a child who is limited in his/her ability to do things that most children of the same age can do, due to a long-term health, medical or behavioural condition.

Key education outcomes and outcome indicators for the survey sample (cont.)	
CIAO survey sample	Comparative data
Proportion of children who have changed schools (other than natural progression through school system) = 60.2%	
Proportion of children aged 15 years and above not attending school = 45.1% (*N* = 71)	Proportion of Australian students in 2009 aged 15 to 19 years who left school before having completed Year 12 = 32% (DEECD, 2009)
Mean number of days in past four weeks of school that children have been absent = 1.5[4]	Average absence days in each school year for children who attend Government schools in Victoria Prep = 13.2 Year 1 = 12.5 Year 2 = 12.1 (DEECD, 2008)
Proportion of children aged 12 years or more who look forward to going to school most days = 42.3%	Proportion of Australian Year 9 students who agreed or strongly agreed with the statement "My school is a place where I really like to go each day" = 35.3% (Marks, 1998)
Proportion of children and young people who use electronic media (computer games, internet, TV) for more than two hours per day = 27.9%	Proportion of children who use electronic media (computer games, internet, TV) for more than two hours per day 5-8 years = 14.3% 9–12 years = 23.3% (DEECD, 2009)
Proportion of carers who talk about child's school/ kindergarten activities or events of particular interest to child on a daily basis = 78.3%	Proportion of mothers who talked about how school was going with their child every day 4-5 year-olds = 69% 8-9 year-olds = 88% (FAHCSIA, 2009)
Peer contact	
Proportion of children with no close friends at school = 10.5%	
Proportion of children who rarely or never see friends outside school = 33.9%	
Behaviour at school	
Mean and standard deviation scores on SDQ sub-scales and total difficulties scale Conduct problems = 3.4(1.9) Emotional difficulties = 2.3(2.2) Hyperactivity/inattention = 6.2(3.0) Peer problems = 2.7(2.0) Pro-social behaviour = 5.3(2.7) Total difficulties = 14.6(4.9)	Normative SDQ data from Australia (7-17 years) (*N* = 910) Conduct problems = 1.0(1.5) Emotional difficulties = 1.4(1.7) Hyperactivity/inattentio*N* = 2.5(2.6) Peer problems = 1.6(1.8) Pro-social behaviour = 7.8(2.1) Total difficulties = 6.5(6.0) (Mellor, 2005)
Proportion of children who have wagged school or played truant in past 12 months = 30.8%	
Proportion of children suspended in past 12 months = 14.7%	Proportion of Victorian children ever suspended in Year 7 (5.3%), Year 9 (13.3%) and Year 11 (14.5%) (DHS, 2000)
Proportion of children ever expelled from school = 5.5%	
Proportion of children who participate in an organised recreational activity outside school hours = 59.7%	Proportion of Victorian children (aged 5-14) who took part in organised arts, cultural and recreational activities outside of school hours in the past 12 months Organised cultural activity = 32.4% At least one cultural venue/event = 71.4% At least one organised sport = 68.5% (ABS, 2010)
Proportion of children who participate in extra-curricula activities at school = 37.5%	

4 Note: Government schools operate for approximately 40 weeks per year.

Cluster analysis

Cluster analysis, which is an exploratory statistical technique used for analysing similarities and differences in a target population (Everitt, Landau & Leese, 2001) was used to investigate whether there were statistically discernable groupings of children in the sample. This analysis involved children who were attending school or TAFE (*N* = 141). Children and youth who were school age and not attending school and pre-school aged children were not included in the cluster analysis due to missing data on school-related variables.

A two-step approach was used to define the relevant characteristics of the in-school sample. Two-step cluster analysis was chosen over Hierarchical and K-Means analyses because it is able to manage categorical and continuous variables.

Three highly internally homogeneous and highly externally heterogenous groups emerged from the analysis. As well as meeting the cluster solution evaluation criteria to a high degree, the coherence of the cluster solution points to its underlying validity. The three groups that emerged through the cluster analysis were labelled 'damaged', 'disengaging' and 'doing well'.

Significant differences were identified between 'damaged', 'disengaging' and 'doing well' groups on the following variables; child age, ethnic origin, long-term health condition, intellectual disability only, ADD/HD without intellectual disability, physical disability only, intellectual disability and physical disability, emotional problem, intellectual disability and emotional problem and school type.

The 'damaged' group is marked by its high rate of cognitive, emotional and physical conditions, poor grades and low school achievement and problem behaviour and relatively long careers in OOHC. The 'disengaging' group is characterised by its older mean age, low school engagement and relatively recent entry into OOHC. What is most evident among the 'doing well' group is its relatively good education outcomes and general functioning.

Individual characteristics

The 'disengaging' group is significantly older than 'damaged' and 'doing well' groups (*M* = 15.0 years compared to 11.7 and 9.9 years respectively). Compared to 'disengaging' and 'doing well' groups, the 'damaged' group has significantly more long-term health conditions, intellectual disorders and physical conditions. The 'damaged' group has significantly more learning condition/disorders (55.8%) than the 'disengaging' (15.4%) and 'doing well' groups (4.0%).

School characteristics

Significantly more children in the 'damaged' group (40.4%) attend an alternative/special development school compared to 'disengaging' (18.0%) and 'doing well' (0.0%) groups. However, more children in the 'doing well' group (10.0%) attend a Catholic school compared to 'damaged' (3.8%) and 'disengaging' groups (0.0%). The 'damaged' group is receiving significantly more specialised in-school support services (67.3%) than 'disengaging' (12.8%) or 'doing well' groups (8.0%).

Education outcomes/outcomes indicators

School achievement

Significantly more children in the 'damaged' group has repeated a grade (36.5%) compared to 'disengaging' (17.9%) and 'doing well' groups (8.0%) and are working significantly less hard at school and are performing less well as measured by school grades and carer-rated achievement levels and motivation to learn. Carers of 'damaged' children have significantly lower expectations for education achievement than carers of 'disengaging' and 'doing well' groups.

School engagement

In the previous four weeks of school, the 'disengaging' group was absent from school for more days (3.5) than the 'damaged' (1.9) and 'doing well' groups (1.1). The 'damaged' and 'disengaging' groups were also significantly more likely than the 'doing well' group to have been suspended from school (25.0% and 17.9% compared to 2.0%).

The 'doing well' group also looked forward to going to school significantly more than the 'damaged' and 'disengaging' groups. The 'disengaging' group looked forward to school the least. Further, the 'disengaging' group watched more hours of TV each day compared to the 'damaged' and 'doing well' groups. They read the least often, watch more TV and socialise out of school more.

Emotional and behavioural problems

Children in the 'damaged' group have significantly more emotional problems, are behaving significantly less appropriately at school and have been suspended from school on significantly more occasions than the 'disengaging' and 'doing well' groups.

Placement characteristics

The 'disengaging' group was significantly older when first placed in OOHC (8.9 years) compared to the 'damaged' (4.7 years) and 'doing well' groups (5.3 years) and the 'damaged' group has had significantly more carers (8.3) than the 'disengaging' (5.1) or 'doing well' (4.8) groups since birth. However, the 'damaged' group had spent significantly longer (44.8 months) with the current carer than the 'disengaging' (21.7 months) or 'doing well' (26.3 months) groups. Finally, the 'doing well' group was more likely to be living with siblings and more likely to be in homes with other children than the 'damaged' and 'disengaging' groups.

These findings are summarised in Table 3.

Table 3

Characteristics of 'damaged', 'disengaging' and 'doing well' groups of school-enrolled children		
Group one (*n* = 52) 'damaged'	Group two (*n* = 39) 'disengaging'	Group three (*n* = 50) 'doing well'
Individual factors		
Mean age = 12, with 6% of ethnic origin	Mean age = 15, with 15% of ethnic origin	Mean age = 10, none of ethnic origin
High incidence of long term-health conditions (87%)	Moderate incidence of long-term health condition (18%)	Low incidence of long-term health condition (8%)
High incidence of learning difficulties (56%)	Moderate incidence of learning difficulty (15%)	Low incidence of learning difficulty (4%)
Placement factors		
Carers have the lowest expectations for educational achievement	Main carers are younger (*M* = 45), more likely to be male (21%) and less likely to agree that they can help with homework and help child do well at school Carers have the least contact with schools	Carers have the highest expectations for educational achievement Carers place high importance on achieving good school grades
Been with the same carer longer (*M* = 45 months) More carers overall (*M* = 8.3)	Considerably older when first placed in care (*M* = 8.9 years)	More likely to be living with siblings and more likely to be in homes with other children
School factors		
High use of specialised education support (67%), mostly for behavioural and emotional problems	Moderately low incidence of specialised education support (13%) Use of specialised support for behavioural and emotional problems	Low use of specialised educational support (8%)
Attends primary or special school Mostly in Government schools	More likely to be attending TAFE More likely to be enrolled in school part-time	Attends primary school More likely to be enrolled in a Catholic school (10%)
Education outcomes/outcomes indicators		
Poor performance at school – they have the lowest grades and overall achievement More likely to have repeated a grade (37%)	Variation in education achievement Like school the least and are absent from school more They read the least often, watch more TV and socialise out of school more	'Doing well' at school – they are working hard and achieving the highest grades overall
High rate of school suspension (24%)	High rates of school suspension (18%) Less likely to have homework, to have a suitable place to do it, and don't get a lot of help from carers with it	Low rates of school suspension (only one suspension). They like school and are likely to have homework

Characteristics of the sample of children who were school age and not attending school

As the children and young people who were school aged and not attending school (*N* = 41) were not included in the cluster analysis due to missing data on school-related variables, chi-square analysis and F-tests were undertaken on a range of individual and education factors to determine whether differences between school attending and non-attending groups within the sample reached conventional levels of statistical significance; that is $p < .05$.

Non-attending children and youth were compared to the school-enrolled group on several aspects. Compared to the group of children and young people who were attending school, the non-attending group were significantly older (*M* = 15.4 compared to *M* = 12.2), were less likely to have a long-term health condition (22.0% compared to 40.3%), and less likely to have a physical and emotional disability or a physical disability only (2.1% and 0.0% compared to 15.8% and 17.3%).

The non-attending group also differed from the school-enrolled group on several aspects relating to their experience with the OOHC system. First, they had been in their current placement for a significantly shorter period of time (*M* = 8.8 months compared to *M* = 33.0 months), had significantly younger carers (*M* = 41.0 years compared to *M* = 48.4 years) and had significantly more educated carers. The survey respondent for the non-attending sample was also more likely to be male (41.5% compared to 16.5%). The non-attending sample were also living with significantly more other children and young people (3.3 compared to 2.7), but were significantly less likely to be living with birth siblings.

Some of the items in the carer survey were included for non-school enrolled children only. The analysis of these items shows that the majority of the non-attending sample were enrolled in school in the year the survey was conducted (53.7%), but that 36.6% of carers were unable to report the year the child/young person was last enrolled in school. The survey findings also suggested that the main reason for non-attendence was school refusal (51.2%). The remainder of children/youth were not attending school for a wide variety of reasons, including expulsion (4.9%), pregnancy (4.9%), employment (7.3%), drug and alcohol problems (4.9%) and peer problems (4.9%). A small number of children/youth were waiting to commence at another school or were searching for an appropriate school (4.9%).

Regression analysis

Regression analysis is a statistical method for describing and evaluating relationships between an 'outcome' or criterion variable and one or more 'predictor' variables. The current regression analysis examined the prediction of five separate education outcomes/outcome indicators (criterion variables). The education outcomes analysed through regression analysis were; repeating a grade, school achievement, suspension, working hard at school and behaviour at school (see Table 4).

Table 4

Criterion variables used in regression analyses	
Has the child ever repeated a grade at school (including kindergarten)?	0 = No 1 = Yes
How would you describe the child's overall achievement at school?	1= Excellent 2 = Above average 3 = Average 4 = Below average 5 = Well below average
During the past 12 months has the child been temporarily suspended from school?	0 = No 1 = Yes
Compared to typical students of the same age, how hard is the child working at school?	1 = Much less 2 = Somewhat less 3 = Slightly less 4 = About average 5 = Slightly more 6 = Somewhat more 7 = Much more
Compared to typical students of the same age, how appropriately is the child behaving at school?	1 = Much less 2 = Somewhat less 3 = Slightly less 4 = About average 5 = Slightly more 6 = Somewhat more 7 = Much more

Initially, five multiple regression models were fitted involving conceptually distinct subsets of the predictor variables:

- Placement variables (model 1)
- Carer variables (model 2)
- Carer support for education variables (model 3)
- School support for education (model 4), and
- Child variables (model 5).

The particular variables that were included in each of the five models are presented in Table 5.

Table 5

Predictor variables included in the initial regression models	
Variable	Measure
Control variables	
Child age	Months
Female	0 = Male (reference category) 1 = Female
Placement variables (model 1)	
Age on first placement	Months
Number of caregivers	Numeric
Time with current caregiver	Months
Carer variables (model 2)	
Carer age	Years
Carer education	1 = Less than year 10 2 = Year 10 3 = Year 11 4 = VCE or equivalent 5 = Trade or vocational training 6 = Bachelor degree 7 = Postgraduate degree
Carer sex	0 = Male (reference category) 1 = Female
Carer support for education variables (model 3)	
Carer expectations for education	1 = Leave school before finishing secondary school 2 = Complete secondary school 3 = Complete a trade or vocational training course 4 = Go to university and complete a degree 5 = Obtain post-graduate qualifications at a university (eg. Master degree or Doctoral degree)
Carer-school contact	Ten items measuring carer-school contact were included in the carer survey. A carer-school contact score was computed as the mean of the ratings on the 10 items. The internal consistency reliability of the scale was moderate to strong (a = .79)
I know how to help the child do well at school	1 = Strongly agree 4 = Strongly disagree
I think I can make a difference in the child's success at school	1 = Strongly agree 4 = Strongly disagree
I am able to help the child at home with school work that is difficult	1 = Strongly agree 4 = Strongly disagree
How often do you and the child talk about his/her school/kindergarten activities or events of particular interest to the child? Would you say you do this…	1 = Daily 4 = Rarely or never
During this school year, did someone in this household help the child with his/her homework?	1 = Never or rarely 4 = Always
School support for education variables (model 4)	
SSG established	0 = No (reference category) 1 = Yes
Receives specialised in-school services	0 = No (reference category) 1 = Yes

Predictor variables included in the initial regression models (cont.)	
Variable	Measure
Child functioning variables (model 5)	
Physical and emotional disability/disorder	0 = No (reference category) 1 = Yes
Intellectual disability only	0 = No (reference category) 1 = Yes
ADD/HD	0 = No (reference category) 1 = Yes
Physical disability only	0 = No (reference category) 1 = Yes
Intellectual and physical disability	0 = No (reference category) 1 = Yes
Emotional disability/disorder only	0 = No (reference category) 1 = Yes
Intellectual and emotional disability/disorder	0 = No (reference category) 1 = Yes
Learning difficulty/disorder	1 = Yes (reference category) 0 = No

Variables within each set were entered into the regression equation simultaneously. A variable selection process was then carried out, where independent variables were manually removed one at a time if they did not contribute significantly to the regression model ($p < .05$) and/or increase R^2 when considered together with other variables. The critical p and R^2 criteria was balanced with the parsimony principle that states a model with fewer variables is preferred to one with many variables. This process produced the best subset of predictor variables of education outcomes within each set (the best regression model, in other words).

The resulting subsets of variables were then entered into a single regression equation and subjected to the same variable selection process until a final model was arrived at. These final sets of predictors are presented as the results of the final analyses below. Child age and gender were included in all regression models as controls prior to the selection process, but were removed if they did not contribute to the regression model.

In the results of the final regression analyses the coefficient of multiple determination (R^2) and Adjusted R-Square (Adj R^2) showed the percentage of variance in the outcome explained by the predictors in the model. Adjusted R-Square is an adjustment for the fact that a large number of independent variables can artificially inflate R^2 because of chance variations. The β coefficients (standardised estimates) estimate the strength of the effect of each predictor variable on the dependent variable, controlling for the other predictors.

Repeated a grade

Table 6 below presents the variables identified in the initial regression analysis on repeated a grade.

Table 6

Subset of variables identified in the initial regression analysis on repeated a grade
Placement variables (model 1)
Gender
Carer characteristics (model 2)
Gender
Carer support for education variables (model 3)
Gender
Expectations for education
School support for education variables (model 4)
Gender
SSG established
Child functioning variables (model 5)
Intellectual disability only
Physical disability only
ADD/HD

The final regression model presented in Table 7 below indicates that having an intellectual disability only and physical disability only is significantly related to repeating a grade at school. There is also a trend for a relationship between being male and repeating a grade at school. This model explains 14% of the variation in repeating a grade at school as indicated by *Adj* R^2.

Table 7

Final regression analysis predicting repeated a grade (*N* = 93)					
Predictor	**B**	***SE***	***β***	***R²***	***Adj R²***
(Constant)	1.72	.15		.18	.14
Male child	-.17	.09	-.19†		
Intellectual disability only	-.29	.12	-.24*		
Physical disability only	-.21	.11	-.19†		
SSG established	.12	.09	.13ns		

†$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$.

Overall achievement at school

Table 8 below presents the variables identified in the initial regression analysis on overall achievement at school.

Table 8

Subset of variables identified in the initial regression analysis
Placement variables (model 1)
Number of caregivers
Carer characteristics (model 2)
nil
Carer support for education variables (model 3)
Expectations for education
I know how to help [child] do well at school
School support for education variables (model 4)
Specialised services
Child functioning variables (model 5)
Child age
Physical and emotional disability/disorder
Learning disability/disorder

The final regression model presented in Table 9 below indicates that as the number of carers increases the level of achievement decreases and as carers expectations for achievement increase so does achievement. Children of carers who report they are able to help the child do well at school also have children who achieve better at school. This model explains 34% of the variation in overall achievement as indicated by *Adj* R^2.

Table 9

Final regression analysis predicting overall achievement (*N* = 123)					
Predictor	**B**	***SE***	***β***	***R²***	***Adj R²***
(Constant)	3.99	.46		.36	.34
Number of carers	.03	.01	.18*		
Learning disability/disorder	-.29	.21	-.11*ns*		
Expectations for education	-.50	.08	-.50***		
I know how to help the child do well at school	.34	.11	.22**		

†$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$.

Temporary suspension

Table 10 below presents the variables identified in the initial regression analysis on temporary suspension.

Table 10

Subset of variables identified in the initial regression analysis
Placement variables (model 1)
Child age
Carer characteristics (model 2)
Child age
Carer support for education variables (model 3)
Child age
Expectations for education
School support for education variables (model 4)
Child age
Specialised services
Child functioning variables (model 5)
ADD/HD

The final regression model presented in Table 11 below indicates that having ever being suspended from school increases as children get older and with the presence of ADD/HD. There is also indication that having ever been suspended decreases with increasing expectations for achievement among carers. This model explains 34% of the variation in temporary suspensions as indicated by Adj R2.

Table 11

Final regression analysis predicting temporary suspension (*N* = 141)					
Predictor	**B**	***SE***	***β***	***R²***	***Adj R²***
(Constant)	.06	.13		.11	.10
Child Age	.02	.01	.17*		
ADD/HD	.19	.10	.16*		
Expectations for education	-.06	.03	-.19*		

†$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$.

Working hard at school

Table 12 below presents the variables identified in the initial regression analysis on working hard at school.

Table 12

Subset of variables identified in the initial regression analysis
Placement variables (model 1)
Child age
Carer characteristics (model 2)
Child age
Carer support for education variables (model 3)
Expectations for education
Help with homework
School support for education variables (model 4)
Child age
Specialised services
Child functioning variables (model 5)
Child age
Intellectual disability only
Learning disorder/disability

The final regression model presented in Table 13 below indicates that children with an intellectual disability only work less hard at school than children who do not have an intellectual disability only. There is also indication that children work harder at school with higher expectations for achievement and the frequency with which carers help children with their homework. This model explains 26% of the variation in working hard at school as indicated by *Adj* R^2.

Table 13

Final regression analysis predicting working hard at school (*N* = 92)					
Predictor	**B**	***SE***	***β***	***R*²**	***Adj R*²**
(Constant)	1.37	.60		.29	.26
Intellectual disability only	-1.42	.42	-.31***		
Expectations for education	.56	.13	.40***		
Help with homework	.37	.14	.24*		

†$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$.

Behaviour at school

Table 14 below presents the variables identified in the initial regression analysis on behaviour at school.

Table 14

Subset of variables identified in the initial regression analysis
Placement variables (model 1)
Nil
Carer characteristics (model 2)
Carer sex
Carer support for education variables (model 3)
Expectations for education
School support for education variables (model 4)
Specialised services
Child functioning variables (model 5)
Learning disability/disorder

The final regression model presented in Table 15 below indicates that male respondents (carers) rated children's behaviour at school more positively than female respondents (carers) and that children with learning disabilities behave less appropriately at school than children without learning disabilities. There is also indication that children's behaviour at school improves with higher expectations for achievement. This model explains 24% of the variation in behaviour at school as indicated by *Adj* R^2.

Table 15

Final regression analysis predicting behaviour at school (*N* = 133)					
Predictor	**B**	***SE***	***β***	***R²***	***Adj R²***
(Constant)	.73	.51	.15	.26	.24
Male carer	.71	.32	.04*		
Learning disability/disorder	.66	.27	.03*		
Expectations for education	.57	.11	.00***		

†$p < .1$, *$p < .05$, **$p < .01$, ***$p < .001$.

Summary of findings from the survey research

Limitations

The survey research has important weaknesses and limitations that argue for caution in interpreting the results. Its cross-sectional design means that the analyses can only demonstrate that the proposed relationships between key predictor variables and education outcomes are feasible, and not that they are causal. It is also not possible to understand changes in education outcomes over time, and how children's pathway through OOHC influences academic achievement. The survey method and reliance on carers as primary respondents also imposed constraints in terms of the measures of education outcomes. However, we note that carers may well be the people who know the children best and as such are one of the best sources of information.

In terms of the survey sample, while the present study of 199 foster care and residential care children is substantial compared to much of the research in this area, the number of cases presented some statistical limitations. Moreover, it is unclear whether children receiving placement and support services from Anglicare Victoria and Wesley Mission Victoria are representative of the population of children in OOHC more generally. We note however, that Anglicare Victoria and Wesley Mission Victoria are both major OOHC providers and there is no indication that the Department of Human Services is selective in the young people placed in the care of either agency.

Descriptive analyses

Findings from the descriptive analysis show high rates of functional limitations among children in the sample. Specifically, more than one-third of the sample had a functional limitation due to a long-term health, medical or behavioural condition, compared with only 4.1% in the community generally.

These analyses also indicate that far fewer children in the CIAO sample were enrolled in a Catholic or other independent school compared to the general population of children. However, the data showed generally good support for education among carers as measured by speaking to the child about school, helping with homework, space for homework, access to the internet at home and the importance placed on children achieving good grades.

Education outcomes were not favourable. A high proportion of children had repeated a grade at school (23.7%), had experienced a change of school (60.2%), were not attending school on any days (18.1%), had wagged school in the past year (30.8%), or had been suspended in the past 12 months (14.7%). Scores on the teacher-rated SDQ also showed a heightened risk among the CIAO sample for emotional and behavioural adjustment problems compared to Australian 7-17 year-olds generally.

Although differences in the way the data were collected made direct comparisons difficult, it appeared that a slightly higher proportion of children in the CIAO sample looked forward to going to school compared to children in the general community (42.3% compared to 35.3%). The proportion of children/youth who read for pleasure and use of electronic media was also on par with community norms. Although it was difficult to compare outcomes due to the way data were collected, it also appeared that children's participation in organised activities outside school hours was comparable to the general population.

Cluster analysis

Cluster analysis was conducted to determine whether there were statistically discernable groupings of children and young people in the sample in terms of their individual and education characteristics. It revealed that although outcomes were relatively poor among the sample as a whole, negative outcomes and individual circumstances were concentrated in two of three groups; a 'damaged' younger group of children who were characterised by high rates of cognitive, emotional and physical disorders and extremely poor school achievement, and a 'disengaging' group that was less compromised but older and showing the least engagement and attachment to school. A third group of children, labelled 'doing well', appeared to be functioning on par with children and young people in the community generally

Regression analysis

The regression analysis reinforced the strong relation between cognitive functioning and repeated a grade (intellectual disability), overall achievement (learning disability), temporary suspension (ADD/HD), working hard at school (intellectual disability) and behaviour at school (learning disability/disorder). There was also indication that physical disabilities related to repeating a grade at school.

High expectations for education were related to overall achievement and not having been suspended from school, working hard at school and positive behaviour at school. Carer capacity to support education was also positively related to overall achievement and carer help with homework was also positively linked to working hard at school.

Chapter 4 - Case study research

Case study method

Case study method, properly used, has a number of advantages (Walton, 1972; Handel, Gilgun, & Daly, 1992; Gilgun, 1994; Mitchell, 1995). It allows exploration of complexity and inter-related factors. It focuses on the same unit of attention as does practice so that the issues of young people, their families, of practice and the service system as a whole, can be explored.

There are limits to conclusions that can be drawn from the case study method (Mitchell, 1995p. 123-125). These relate particularly to reliability, validity and generalisability. "Thick" and rich descriptive material (Geertz, 1973, p.6) and careful conceptualisation and care when making generalisations guard against these limitations.

Subjectivity and objectivity always intermingle in any research. The case studies in this report are constructed from the verbatim interview text in response to questions defined by the researchers and by the interpersonal interactions in the interview (which in turn are affected by the history, culture, social position and personality of both interviewer and interviewee). The case studies were written with a commitment to remain as true as possible to the reality of the interviewee within these human constraints.

Selection of cases

Six case studies were conducted as part of the CIAO project. Staff in OOHC from Anglicare Victoria and Wesley were asked to identify children and young people who may have experienced a significant impact on their education due to care system issues and who would be able to cope with the demands of the interview. Wesley Mission Victoria staff were asked to identify two young people who had dropped out of school. The four remaining young people were in the care of Anglicare Victoria. The aim had been for these four to be enrolled in school, but one of the young people identified for the case study research dropped out of school in the year of the research.

A generic plain language statement was prepared for DHS personnel, birth parents, carers, caseworkers and teachers and was used in reference to child participation in case study interviews as well as their own participation in a case study interview.

Prior to contact with young people, verbal consent to involve young people in the research was obtained from children's carers and birth parents where applicable (i.e., in the case of voluntary placements and custody to the secretary orders). Written approval was also sought from the appropriate delegate within the DHS region in relation to children on custody to the secretary orders and guardianship orders.

Once a shortlist of potential participants had been identified and the necessary approval protocol followed, young people were approached by their caseworker and asked whether they agreed to transfer their contact details for the purpose of research. Researchers then contacted young people who provided this consent by telephone to provide further information about the study and to obtain the child/young person's agreement to take part in a face-to-face interview.

Interviews were conducted at the young peron's home. A plain language statement was prepared for the young person and written consent was obtained prior to the commencement of the interview.

Members of young person's care team were also approached for their consent to be part of the research. This included the young person's carer, teacher, caseworker and, where appropriate, birth parent. Adult interviews were conducted face-to-face and written consent was also obtained from all participants prior to data collection.

In the two Wesley cases, researchers interviewed the young person, the carer and the caseworker. In the four Anglicare Victoria cases, researchers also interviewed the teacher. In two cases the birth parent was also interviewed.

With the consent of participants, interviews were digitally recorded then fully transcribed. Interviews with children and care team members took approximately one hour. The interviews followed a semi-structured interview format.

Analytic approach

A modified case study approach was used to analyse the case study data. Three researchers were involved in the analysis of case study material. The first researcher read the transcripts of all six cases and constructed an account of each young person, their educational outcomes and the factors that seemed to have affected these.

A process of cross-validation was then undertaken whereby the other two researchers made an independent assessment of the factors and relationships between factors that appeared to affect educational outcomes in two cases each. A critical review of the analysis conducted by the first researcher was then undertaken in the light of the subsequent analyses. All three researchers met to discuss differences in interpretation against the evidence in the transcripts until a consensus view was reached. Each case was then re-examined for evidence of the presence of agreed factors and inter-relationships. The data were also analysed in terms of the questions guiding the research, to see if patterns emerged across the six cases. These processes provided the basis for the findings and discussion presented below.

The account or stories of the six young people derive directly from the data from the research interviews. However, the case descriptions are informed and extended by theoretical knowledge, which guides professional practice and the care provided to young people in out-of-home care.

The theory and knowledge base is broad-ranging and covers long-established theory of attachment and the role of early parent-child, specifically mother-baby, relationships, through to much more recent developments in these areas. Research about the effects of violence and witnessing of violence on infant brain development is one such advance. Theory and knowledge about child development, child development in the context of abusive and neglecting parenting, and all of these in the context of the family system, family development, development across the life-span, and the social, economic, political and cultural environment of family life, are also relevant.

Additionally, various practice theories are pertinent, including psychodynamic, behavioural, solution-focussed, ecological, strengths and competency-based practice (for a small sample of some relevant theory, see Bowlby, 1969, 1973; Baumrind, 1989; Bartley, 2006; Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006; Bruner, 1990; Cicchetti & White, 1989; Elder, 1998; Fraiberg & Fraiberg, 1980; Fenichel, 2001; Fischer, 1989; Garbarino, 1992; Germain & Bloom, 1999; Hetherington, Lerner & Perlmutter, 1988; Rutter & Rutter, 1992; Kinney, Haapala, & Booth, 1991; Luthar, 2003; Meyer, Mattaini, & Lowery, 2002; Miller, 2007; Mitchell, 1995; Newman, 2008; Perry, 2006; Saleeby, 1996; Tierney, 1976; Valsiner, 1988; van der Veer & van Ijzendoorm, 1988; Spencer & Baldwin, 2005; Vygotski & Cole, 1978; and Vygotski, Rieber, & Carton, 1987).

Findings

Within case analysis

John: The case for specialised settings and specialist staff to respond to trauma

The pre-care context

John provides an example of the dramatic negative effect adverse experiences within the birth family, combined with failure of early intervention have on educational achievement. John entered care at the age of twelve, with little effective protection from patterns of family violence and mental illness within his family, which have known effects on a child's development (Perry, 2006). Indeed, there was much in his personality and behaviour to suggest that his emotional needs were inadequately met within his family. At 16, John's anger and anxiety were often unmanageable. He was involved in the juvenile justice system, felt adults could not be trusted and was compulsively self-reliant. He was deeply tied to his family and had adopted their sub-culture of exclusion (Tierney, 1976; Mitchell, 1995), alienation from the community and rejection of education as worthwhile or useful. While he recognised that he could not return to live with either of his parents, he desperately wanted to leave the residential unit and live with a family.

John's school experience

John's school life before entering care, from his first day at school when he fought with another child, was severely troubled. He completed primary school, but struggled at secondary school. He was suspended many times and began truanting. By the time he came into care, at the end of year seven, he had dropped out of school. John has no memory of any specialist assessment, or of any specialist service to engage or maintain him at school. His reflections on school were entirely negative, save for his affection for a few mates who were likewise truanting and/or facing suspension for smoking, use of other drugs and non-compliance with school rules and authority. He had contempt for students who did well at school and for all teachers – because they neither understood or cared about kids like him. In John's view they only cared about having power over students. He rejected the view that there was anything worth learning at school. He strongly believed that on-the-job learning was the only worthwhile learning for him.

John's care experience

John had multiple placements in foster care and residential units. He often absconded from residential care when he felt upset or angry. Staff stated that a suitable placement has never been available for John. Staff were entirely committed to John, determined to help him. Attempts were made to enrol him in an alternative school setting but no place was available. Residential care staff were catching every "teachable moment" during daily routines and activities and were actively exploring day program and apprenticeship possibilities. They were deeply worried about the continuing effect of trauma on John, the attitudes and values he had adopted from his birth family, and the effects these were having on him now; lack of trust, anti-authority, "lack of headspace" for learning, his general "touchiness" and his view of himself as a rebel who would "take no shit" from others.

John's future

John does not appear to be able to conform to a mainstream school environment and his needs appear to be beyond what a mainstream school can support. The case study material suggests John needs trusting and trustworthy relationships in both care and educational settings as a foundation for learning. Building these one-to-one relationships requires high levels of skill and consistency of carers. John needs a therapeutic care setting, where his history, culture and experience of trauma would be thoroughly understood and their negative effects ameliorated. He needs an educational setting with the same elements; one-to-one learning within a trusting relationship and a focus on applied learning. Time is running out for John. He is two years from reaching the leaving care age of 18 but many more years from being able to live an independent, constructive life within educational, work or home-life settings.

Dwani: Migration issues, culture clash and service system failure

The pre-care context

Dwani, now 16 years old, was resettled in Australia as a non-English speaking refugee about four years ago. She and her family had been refugees since Dwani's early childhood. Dwani's parents do not reside in Australia. Dwani arrived in Australia in the care of an older sibling. Dwani now has Australian citizenship.

Two years after arriving in Australia Dwani started coming home late. There was severe conflict in the family and Dwani was physically abused. Professional work with the family was unable to bridge cultural conflicts or enable Dwani to remain with her family. After an initial placement with extended family, which ended in conflict, Dwani was placed into a non-relative care arrangement.

Dwani's school experience

Dwani loved school, and felt she did well. An aide helped her with English. She had a couple of close friends from her country of birth. She moved schools when she was placed with her relatives, and again when she moved into care. On admission to a residential unit she attended school for one day and never returned. The care system was not able to ensure Dwani attended school.

Dwani's care experience

Staff did not fully understand why Dwani was moved straight into a residential care unit. No-one thought this was an appropriate placement for her. Dwani was extremely unhappy at the unit. In the interview she burst into tears when talking about how she felt there, and talked about how it was "like jail". It was entirely alien to her and she missed family life dreadfully. She began absconding, with stronger sanctions being enacted against her as time went on. She became pregnant. Strong efforts were made to find her a foster care placement as the residential unit was not seen as an appropriate place for a baby. No placement was able to be found. Then, one of her carers in the unit offered to foster Dwani. The foster parents provided care, first to Dwani, and then to her and her infant. They are committed to supporting Dwani as she takes up her mothering role, now and for as long as Dwani chooses.

Dwani's future

Dwani is an excellent mother with a securely attached and happy infant who is developing well. Dwani regularly attends her maternal and child health nurse service, and a specialist mother-baby group to receive support and education about child development, but two areas of her life remain problematic.

First, although Dwani visits her sister and other siblings, no-one is providing support to the family to resolve past conflicts and build stronger relationships that might sustain and support Dwani in the future.

Second, Dwani's future education is problematic. She knows she needs education to get a job and support her child. The closest mainstream school is not encouraging her return. Dwani and her foster parents can see dilemmas; how could Dwani return to a Year 9 or 10 class, when she is occupying a quite different developmental stage of life? TAFE is a possibility, but Dwani will need extra help with English and tutoring in any theory subject.

She also has to manage child care, travel by public transport and is on a very low income. Her further education is at risk without additional resources to address these difficulties. At a broader level, her choices are narrowed because she has to support her child financially. The time and money required to return to secondary education and proceed to university education (something those who know her believe her to be capable of) makes this path a difficult one.

Josh: On-going effects of trauma, the struggle for identity and ineffective education and care, despite committed and specialist endeavours.

The pre-care context

Josh was 14 years old at the time of the research. He had come into care when he was five years old. He had experienced loss and serious trauma in acute episodes, as well chronic trauma as the result of mental illness suffered by his mother and grandfather. He did not know the identity of his father, which is a source of pain and confusion in his attempt to develop a sense of who he is.[5] He was afraid of the mental illness on his mother's side and hoped for an alternative narrative from his father. The assessment of the specialist trauma counsellors involved in his care was that the trauma he experienced prior to coming into care continued to affect him, his developmental pathways and his educational performance.

Josh's school experience

Josh initially had a difficult time at school, because of his aggressive and unpredictable behaviour. Over time and with specialist counselling this behaviour improved and Josh began to enjoy school. He had high expectations of secondary school. He and his carer undertook a careful process of selecting his secondary school. This school was a severe disappointment to both of them. Staff were unable to handle negative interactions between Josh and teachers and Josh and other students. Josh never felt he fitted in or belonged. Josh and his carer persevered with the school until the final term of Year 7, and then changed schools.

The second school was committed to helping Josh. He was involved in alternative programs designed to build self-esteem, responsibility and relationships. He was given time-out with a sympathetic co-ordinator for misdemeanours. He was provided with extra help with work by this teacher, who kept close contact with Josh's carer. Although Josh had particular problems with learning; poor concentration and attention, hyperactivity, difficulty following instructions, and problems relating to, and co-operating with other students, he was seen as too intelligent to qualify for specialist services in class.

At the time of the research interview, Josh was attending school "off and on". He received a number of detentions and suspensions. Staff knew that Josh's previous experience of trauma was negatively affecting his learning. Josh was starting to define himself as unable to learn at school, as being only a "hands on" learner, despite his teacher and carer seeing him as capable of learning in other ways. The school recognised that their program was not meeting his needs, but could see no alternative.

Josh's care experience

Josh had five placements; two informal placements with relatives before coming into care formally, one residential care placement, and two foster care placements, including the stable placement in which he spent all but one year of his time in formal care. This last and lasting placement has been defined as therapeutic care, with the one carer. Josh has also received counselling from specialist trauma counsellors as part of his therapeutic care package. His carer has been devoted to him, but at the point of the interview was showing signs of distress that she was not able to meet Josh's needs, and that she was failing to help him realise his potential.

Josh's future

The teacher, the carer and Josh all felt frustration and uncertainty about Josh's educational future. The teacher and the carer both felt Josh needed an alternative educational program within the existing school, or in an alternative setting, with one-to-one teaching within a program tailored to Josh's strengths and interests, and integrated with the therapeutic efforts to remedy the effects of trauma. However, such a program was not available. His carer also needs ongoing and additional support to manage her feelings about Josh's slow progress, his low motivation and self-expectations, and his negative feelings about himself.

5 A major research project undertaken through the Alfred Felton Research Program, Who am I?, is currently exploring the ramifications for practice of central identity issues for children and young people in out-of-home care. See Cowling (2009) for a review of some of the issues.

Ben: Success and achievement - serendipity, sunny temperament and high intelligence, combined with early intervention and stable, committed, and enduring care

The pre-care and care context

Ben and his older sister came into care when Ben was three years old. They were placed together. They spent 12 months in reception foster care before being placed in a stable placement, where Ben remained for 10 years. Ben appears to have suffered little ill effect as the result of the circumstances that brought him into care. He has had limited contact with his mother, with whom he does not identify. He impressed as a highly motivated 15 year old, who believed in himself.

He was secure in his placement, and was attached to, and identified with, his carer. His carer had high expectations of him and matched those expectations with additional resources, planning to send Ben to a private school for his final two years of schooling. Ben presented as an intelligent, capable, mature young man with an easy temperament, appreciated by his teachers, his fellow students, his carer and care system staff.

Ben's school experience

Ben was achieving well at school and availed himself of additional opportunities provided there. His teacher, carer and caseworker all had high expectations of him; that he will do well to the end of his secondary schooling and go on to university.

Ben's future

Ben will move to a private school for his final two years at school. His carer and caseworker will continue to support Ben in his academic endeavours. It is very likely that the consistency and stability which has been the hallmark of Ben's story will continue.

Victoria: Achievement against the odds, with intransigent barriers to success despite concerted, skilled efforts of teachers, carers and therapists.

The pre-care context and care experience

Victoria, now 16 years old, entered care during her late primary school years, having experienced significant trauma in her family. She was first placed in kinship care, then, three years later, in therapeutic foster care, where she has been with the same carer for the last four years. She has received specialist counselling, and her carer receives additional support from the specialist counselling agency.

Identity formation has been problematic for Victoria, who retains strong connections with her mother. Victoria worries about her mother and does less well in her own life when things are going poorly for her mother. Although services are involved with her mother, Victoria has little confidence that her mother is receiving adequate help. Victoria has a strong and positive relationship with her carer. Victoria's behaviour in the placement has improved dramatically over the last two years, although the carer has enduring concerns about Victoria's motivation for learning.

Victoria's school experience

Victoria's school life has been difficult, but there has been considerable improvement in her behaviour and performance over the past two years. In Year 7, Victoria was always in trouble, needing alternative and modified (reduced) programs, special time-out arrangements, a very supportive co-ordinator, extra help with learning from committed teachers and involvement of the student welfare co-ordinator.

At the end of Year 10, she was seen as an "average" student in need of no additional or modified program. She no longer "stood out" from other students. Both her carer and her teacher felt she was not achieving her potential and expressed concern about her levels of motivation, but in view of her past history, everyone was pleased with her progress. All hope she will continue to the end of secondary school and follow the path she has chosen – a career in the travel industry.

Victoria's future

Victoria was well established in her placement and has a strong identification with her carer. She was no longer a "problem" student and achieved average grades, something unimaginable a few years ago. Lingering concerns centred in her motivation and lowered self-esteem. The effects of past trauma and her anxieties about her mother continue to interfere with her concentration and motivation, and limit her performance. The out-of-home care, education and specialist mental health systems seem to have reached an impasse. Despite their best efforts, they can not yet move Victoria to achieve to the level all believe she is capable of achieving.

Katherine: Trauma and disruption in care and peer network threaten positive effects of consistent and stable care and personal achievements

The pre-care and birth family context

Katherine entered care at the age of five. The system noticed that all was not well for her family for a year prior to her entering care, and respite care was provided to the family. However, family violence, parents unable to protect the children, and abuse of Katherine had lingering effects throughout her time in care, and ultimately, in conjunction with other factors, contributed to the breakdown of a long-standing and secure placement.

Katherine had contact with her mother during her time in care, but her mother received no services to build her parenting capacity or her relationship with Katherine. Nonetheless, when the placement broke down during Katherine's Year 12 she returned to her mother, after an intermediate stay with a second foster carer. At this point, Katherine and her mother fell through "service system cracks". The OOHC system is not funded to provide reunification support services. The family was also approaching the end of their eligibility for family services and family preservation services because of Katherine's age.

Katherine's school experience

Katherine was in Year 12 at the time of the research interview. She was an "average" student, who had achieved throughout her school career, with lapses in behaviour in the classroom. Her misbehaviour was handled within the normal schools structures and were not seen as warranting external or specialist intervention. Midway through secondary school conflict between Katherine and another student resulted in an intervention order against the other student. Forces entirely beyond Katherine's control meant the student remained in the school and Katherine found the ongoing presence of this person very difficult. Katherine's placement broke down during Year 12. She became depressed, had difficulty concentrating in class and refused offers of counselling. She withdrew from school.

Katherine's care experience

Katherine had been in care for 12 years, ten of them with the same carer. The placement had been secure and had survived a serious crisis and family re-organisation two years before it broke down. There was much bitterness on both sides. Katherine returned to her first foster carer and then to her mother. Katherine suffered disruption to her primary carer relationships, to her schooling, and to her relationships with her caseworker at this point.

Katherine's future

Katherine was clearly at a point of crisis and risk. It was unclear whether she and her mother were receiving help and support during the reunification period, or whether Katherine would receive support to finish her schooling. However, she was optimistic and determined that she would complete Year 12 and proceed to university. Katherine had internalised high expectations and a strong belief in herself, both perhaps originating from her relationship with her carer in interplay with her personal strength and resilience.

The care system had provided her with consistency of care and the support to get to Year 12. The school system had likewise played a part in her achievement. However the combined adverse effects of a number of unfortunate and unforeseen circumstances are now jeopardising her educational achievement. The outcome may depend on the extent to which appropriate support is provided to the family unit and to Katherine as a future student.

Cross-case analysis

The stories of the six young people who were the subject of a case study identified many factors which interacted with each other to assist, threaten or reduce educational achievement. The factors discussed below are those that appeared to be relevant in at least half of the case studies and sometimes in all of them.

The impact of trauma on capacity to engage in learning

Trauma affected the ability of five of the six young people to learn and to achieve at school at various points. The care system provided additional specialist trauma counselling for two young people, but while the effects of trauma were modified, carers and teachers, and in some cases, the young people themselves, could still see trauma interfering with their ability to learn. A number of the cases show the need for earlier intervention with birth families to prevent the serious effects of trauma.

> *"…the post traumatic stress stuff that he's got going on is making it difficult for him." (Teacher)*

> *"It's not her inability to learn...but she hasn't got the headspace to do it." (Carer)*

Mental health issues

As expected, the negative effects of mental health difficulties on learning was a problem in four cases. Depression was a concern in two cases, and one case had serious problems with aggression and impulse control (among other difficulties) and another case displayed a number of effects of trauma over the years she had been in care.

Two of the young people received specialist counselling for their symptoms and this had strengthened the ability of one of these young people to achieve at school. Two older young people were very resistant to receiving or following through with referrals to specialist help. One of these would only attend a general practitioner and her learning appeared to suffer as a consequence (she left school before completing Year 12). Staff struggled to gain the engagement with the other young person, so that his mental health issues remain untreated. This young person was not attending school, a day program or any training or employment activities.

Disrupted and current family relationships and identity formation

The combination of early experiences in the birth family, separation and loss and ongoing relationships with birth parents while in care affected the learning of at least three of the young people. In some cases these factors negatively affected the young person's identify formation, which further compromised learning. One young person wanted to maintain contact with the birth family. One wanted to go and live with an older sibling as soon as the sibling left OOHC. There was understanding of these factors by carers and teachers and in some cases, specialist counselling of the young people, but the issues remained. In one case more effective intervention with the young person's mother and communication to the young person about that intervention might have enabled the young person to concentrate better at an earlier point in her education.

> *"She is consumed with where her mother is, what mum is doing. Is she ok? It just consumes her." (Carer)*

Matters of identity formation during adolescence affected the learning of some of the young people by significantly disturbing their ability to concentrate in the school setting, or prioritise education in the face of identity issues and concerns. One teacher noted the improvement in one student after she identified more strongly with her carer. In relation to one young person's lack of knowledge of his father, his carer noted:

> *"He is so consumed – and rightfully as an adolescent – … to who he is. He says to me I don't have a dad, I don't know who I am." (Carer)*

She went on to say, that she thought he was really saying:

> *"I do all of these things because I don't know who I am. Am I mentally ill, am I sane? Am I good, am I bad? Am I smart, am I stupid? Am I Australian? Am I ethnic? I don't know who I am.*[6]*" (Carer)*

Questions of identity were limiting the ability of this young person to concentrate on anything else and illustrated the powerful combined effects of trauma and identity and the challenges for effective intervention. The carer of this young person believed he needed more assistance – a therapeutic educational setting, in addition to therapeutic foster care as well as the specialist counselling he was already receiving.

Capacity of OOHC system to respond to trauma

Lack of stability, unavailability of suitable placement

The six young people had been in care between 4 and 12 years and all had experienced a period of instability in care, though four had experience long term and stable placements. Three had been in their current living situation for 12 months or less, but one of these had previously been in a placement for 10 years. The other three young people had been in their current placement for more than six years. The four who had been in long term placement had been with the same carer for the vast majority of time. Five of the young people were in foster care, and one was in a residential unit. Two others had previously spent time in residential units. One young person had two placements and all the rest had three or more placements.

The data about the six young people tell a familiar story; that is, there are considerable problems in ensuring appropriate and stable placements for some children and young people. The case studies also highlight the importance of placement stability for good education outcomes.

> *"I didn't like — staying at [residential unit] 'cause it didn't feel like I was at home. That's why I didn't want to go to school..." (Young person)*

This young person had had three placements: an informal kinship care placement; a residential unit, and her current foster care placement. No-one understood why she was placed in a residential unit in her first formal placement. The cost for her was very high. While in the residential unit, she dropped out of school, jeopardising her educational future. She became pregnant, which has created barriers to her further education.

Another young person dropped out of secondary school as a direct consequence of placement breakdown. A third young person had had about eight placements in his four years in care. In part, this related to the lack of placement of choice for him – the unavailability of therapeutic foster or therapeutic residential care which was needed to address his personal difficulties as well as his alienation from learning and educational settings.

Workers and carers described the difficulties meeting the needs of two young people, one currently and one previously in a residential unit. The workers and carers felt that, although everyone did their best, a residential unit was not the best setting for either young person. There was not enough time to provide the individual support and attention that was needed to address major personal and educational difficulties. One young person needed consistent care and attention from carers, and this was difficult given the staffing structure of the residential unit. Both wanted a family setting and frequently absconded from the unit.

Both had shown that they were influenced by the negative behaviour of other young people in the units. Despite accurate assessment of their needs, the system was not able to respond to them and consequently, their education suffered.

6 See Cowling, 2009.

The need for therapeutic care

Two young people were in therapeutic foster care, with additional resources of specialist counselling for the young people and their carers. Both demonstrated the need for such care if they were to achieve educationally.

However, there appeared to be real difficulties treating the effects of trauma:

> *"I don't think she believes in her potential…she's distracted and not able to concentrate on school or even believe in her future." (Worker)*

> *"I don't concentrate on work." (Young person)*

> *"It's not her inability to learn...but she hasn't got the headspace to do it." (Carer)*

One of these young people had progressed from very poor achievement and inappropriate behaviour to being an "average" student who was not noted at all for problematic behaviour, but who was still achieving below her potential in the views of her teacher and carer. The other was struggling to succeed at school and still had a long way to go before anyone would say that the effects of pre-care trauma had been remedied. One other young person had great need for a therapeutic setting.

The carer who was interviewed was committed and skilled. Despite this, the residential setting was not able to provide the appropriate staff-to-young person ratio, level of consistency or the specialist interventions required on a moment by moment basis to bring about change in his behaviour and help him to learn. This young person was also not able to access specialist trauma counselling. As a result, he was not enrolled in school, not attending any day activity or training or vocational programs, nor was he employed nor likely to sustain any employment he might gain.

Maintaining effort and high expectations in the face of trauma

Maintaining expectations was difficult for everyone at times. The following quotes from a teacher, carer, young person and worker show that all struggled to maintain a sense of hope in the light of the young person's low motivation:

> *"His potential is completely untapped…. he's capable of going to university but at this point in time he is not going to make it." (Teacher)*

> *"…he has the academic ability to and .. he can have more choice in what he does." (Carer)*

> *"Well I would for everybody else [think finishing Year 12 was important] but I just can't be damned." (Young person)*

> *"I hope he finishes high school." (Worker)*

At times of stress, and with the most complex cases, workers, carers and teachers could all fall into the trap of seeing the young person's low motivation as the cause of underachievement, rather than a symptom of the young person's difficulties.

> *"She's pretty much got to do it on her own now" and "I'm not going to push you anymore." (Carer)*

> *"It's just sort of up to him to get sort of motivated to be able to actually attend. 'Cause we even offer him lifts to get there, so the transport thing is not an issue, it's just a matter of how he's feeling and what he's going through that's keeping him from being motivated to get up and go to school." (Worker)*

> *"She just wouldn't put in any effort whatsoever. …We tried a whole heap of different methods to encourage her. Working with the school we incorporated a diary structure where when the work was handed in the teacher would sign off on it. It just didn't work, she didn't do it. She was disruptive in class and the teachers basically lost interest in her." (Carer)*

> *"I think she could try harder...I just seem to have really high standards for her, that I think she is capable of." (Teacher, different student)*

Low motivation was a problem for three of the young people. Teachers recognised that other things were going on for the young people, but still believed that the student would do better "if only they would work in class", or "if only they would put some effort in". This was evident in committed and insightful carers too. One carer understood why the young person had difficulty maintaining motivation, but her frustration is evident in her statement "I've told her, you are nearly 17, it's up to you now."

Carers, teachers and workers of three of the most traumatised young people were confronting the problem of what to do when problems remain despite considerable effort from all parties.

> *"Spent a lot of time trying to work out what we can do and we try things and mostly they work for a week and then they don't." (Teacher)*

> *"I don't think there is anything else we can do." (Teacher)*

> *"It's a challenge to come up with the best fit for [young person]." (Worker)*

The workers, carers and teachers kept trying to help the young people. Some drew comfort from counting the small steps of progress. Some drew on a deeply held belief in the worth and value of each person. Some recounted their understanding of the pre-care situation and its ongoing effects on the young person as a way of understanding why progress was not as strong as they would like. Some used the caseworker or specialist counsellor to help them find strategies to help the young person. Although there were indications in some of the interviews of people feeling frustrated or helpless, the over-arching sense was of adults committed to helping the young people achieve as best as they could.

Suitability of mainstream schools and lack of alternative educational settings

There were numerous indicators that mainstream schools, as currently structured and organised, were not able to meet the needs of some of the six young people.

Absenteeism, truanting, suspension and school drop-out

Two young people had dropped out of school early. They previously had high levels of absenteeism and truanting. The comments of one of the young people suggest that he had experienced a number of suspensions. The rate of absenteeism was rising for one young person still attending, but who seemed to be 'disengaging' from school. The school suggested that withdrawal from school might be the best option for another student This student and one other young person had a higher rate of absenteeism than other students.

Despite high rates of absenteeism and truancy for four of the young people, the remaining two students were not truanting. One attended consistently and was never in trouble at school and the other had progressed from being a student with serious behavioural problems who was not achieving, to being an 'unremarkable' and 'average' student.

Lack of fit between learning and behavioural difficulties and specialist intervention in schools

None of the young people had a diagnosed learning difficulty, but the interviews showed that four had difficulty learning due to behavioural difficulties, emotional distress, anxiety or depression or the effects of previous trauma. Three had (or had had in the past), serious behavioural difficulties. Three had had difficulty with obeying school rules, defiance, and reckless behaviour. Three had experienced anxiety, depression or were withdrawn at school.

In response, the schools of four of the young people had put in place special arrangements including an aide to help with English, special arrangements for time out with sympathetic co-ordinators, modified (mostly reduced) programs, alternative programs of learning focussed on self esteem and information provided to teachers so they could understand the student, relate to them and administer discipline in an appropriate way. In four cases the carers had close relationships with the schools and there was reciprocal information flow to assist the young person. One young person dropped out of school early and we have no data on this aspect. The sixth young person was an excellent student and did not need any special assistance.

However, excluding the one student who had no need for special programs and another having an aide to help with English, none of the four remaining students received special education programs, despite learning and behavioural difficulties being present.

The teacher of only one young person was concerned that the staff did not have adequate training, and there is evidence in two other cases that staff struggled to manage these young people. Only one teacher identified being in care as an issue for the young person in the school situation.

Lack of fit between the needs of the young person and the school setting

The inability of mainstream schools to meet the needs of traumatised young people was recognised by both carers and the young people themselves.

> *"..he's not fitting into the 90% of the kids at school, let alone the education. He is even outside the 98% of the kids at the school according to the Vice Principal." (Carer)*

This concern raised by one carer summed up the frustration felt by carers of three young people. The young person referred to in the statement above was still attending school, but the issues had also been present for two other young people who were chosen for the sample because they were not enrolled in school. For all three, the mainstream settings were unable to meet their needs.

The frustration of the carer quoted above is echoed in the voice of another young person:

> *"Yeah. School's a load of crap. The teachers are bullshit. The other kids are immature, just little fuckin' rodents. It's just crap. School's crap. I'll never go back. Doesn't matter what anyone says. If anyone enrols me, I'm not gonna go back to school. 'Cause it's not for me." (Young person)*

Lack of appropriate and tailored alternative settings

Once carer was very clear on the need for an alternative setting, or an alternative program within existing schools, for the young person in her care:

> *"You know what? I've been off all year, I could've done something with some help or some guidance on what could be, 'cause I've been here all year, right? But there isn't any[thing] outside the box. It's that you go to this school and the school manages it but he's even outside the 98 percent of the kids at the school according to my V-P, who I respect him enormously, that, you know, if he's in the two per cent of the school, then he's not fittin'. So he needs something else….. Maybe just, like, have alternative ideas of education. Like, you know, I've often thought that maybe he's somebody... could have sent him to Steiner. You know, just where there's a gentler, sort of more creative place…. You know, I would've loved for him to just try a year at a Steiner school or a small school somewhere. I don't know, like the village school." (Carer)*

Carers and caseworkers of two other young people also felt that there was little chance of the young person in question ever returning to a mainstream setting. One of the young people stated that he will never return to school (see above). His carer and caseworker knew that an alternative program or setting staffed by highly skilled educators, with a very small staff-to-student ratio, with an emphasis on relationship between the teachers and the students and focussing on applied learning would be necessary for him to learn. The other young person needed a supported care setting where her difficulties were not exacerbated by the difficult behaviours of other young people in the residential unit as well as a supported educational setting where she as a young mother with limited English could return and complete her secondary education.

School as a complex social environment

All six students referred to the social aspect of school in a positive way. However, most of the young people had experienced difficulty in their peer interactions, which, in turn, impacted on their learning.

For the most alienated young person who had dropped out of school at the end of year seven, the only positive comment he made about his time in school was about his friends. However, he also referred in a derogatory manner to most of the students. Another young person liked his friends, but playing up to his reputation as class clown was negatively affecting his learning. One young woman had friends at school, but had taken out an intervention order against another student. Three of the six had been bullied at some stage in their school life.

Teacher skills and resources

The need for increased resources in schools

A number of the carers, teachers and caseworkers wanted extra resources for the young people for whom they were responsible. They wanted schools where staff would have the time and expertise to devote to the particular needs of the young people.

> *"Yeah, yeah, let's go to utopia. One on one. It'd be brilliant. You could trick him into learning because he'd be getting his social requirement." (Teacher)*

One carer expressed reservations about the level of skill and commitment of the teaching staff, but all other carers readily praised the teachers. However, they did see that teachers were limited in being able to address the needs of the young people as a result of the large class sizes and limits on the type of school program offered.

Effectiveness of planning structures and processes

Planning structures and processes were in place for all six young people. Carers, caseworkers and teachers referred to care team meetings where education was discussed. However, they seemed unaware of formal Individual Education Plans for the young people.

While all carers and caseworkers thought education was a high priority, some thought that education could not be the highest priority when the young person was deeply angry, upset or consumed by other emotions (which was the state for four of the young people, at different times in their school history, and for two of them, nearly all the time). Their view was that the emotional distress had to be remedied before the young person could concentrate on learning. Further, at the point of the research interviews, planning was not able to prevent one young person from disengaging from school, nor prevent another withdrawing from school midway through Year 12. Planning had not safeguarded the education of two other young people who had not been enrolled in school for the last couple years.

Commitment by teachers and school to young people in OOHC

At the point of the research interviews, two schools and their co-ordinators and teachers were making concerted efforts to assist two students. They both received high praise from the carers, despite the fact that one of these young people was disengaging from school.

> *"The co-ordinator would go and visit him daily…they sit down and talk to him and treat him as special, I'm hugely happy with their support." (Carer)*

> *"They've (school) bent over backwards trying to help her." (Carer)*

> *"I think it was probably more emotional support. I think educationally that was probably my domain. I tried, where possible, to help her with things to do with her studies. But there was, like, there wasn't a person who came and assisted her with that. I just sat down and we worked out what we could do with teachers and her studies and making things a bit easier where possible." (Teacher)*

Another student was achieving very well, but his carer was going to move him to a private school for his final two years of school, believing that he would be afforded more opportunities in an independent school setting. One young person had dropped out of school, despite considerable, but ineffective efforts to support her through two very difficult situations – a placement breakdown, and severe conflict with another student in the school. Carers of the two other young people who were not enrolled in school felt that mainstream school settings would not be flexible enough in both cases, and skilful enough in one case, to provide education to their charges.

Practice processes

Questions of professional practice always need to be placed in the context of time and resource constraints. Skilled staff can be prevented from enacting the highest levels of practice because of such constraints.

Individual assessment and planning

Individualised and tailored assessment and intervention are central to effective practice in OOHC. This worker identified the need for assessment:

> *"I guess when she had the baby her behaviours reduced but also I think going into home-based care placement was a really – something that she needed. And I suppose that's a sort of flaw in the system in that – I mean there's lots of flaws in the system – but that probably she was never asked what she wanted, what she felt she needed. And you know, it was about numbers, about her behaviours and what other people assessed for her." (Worker)*

In some way all of the cases demonstrated the need for vigilance in continuous assessment of need as the basis for intervention. In the case above, the consequences for the young person's education were serious; that is, she withdrew from school. Another case, where the assessment was exemplary, resulted in intervention from the carer, the specialist counsellor and the school to help the young person progress from low achievement and very challenging behaviour to being an average student.

The importance of time – past, present and future – for assessment and intervention also came to light. There were many instances of carers and workers trying to think of and plan for the future, but also of being locked into the present crisis, the immediate concern, the current idea or desire of the young person. This seemed to work against effective action directed towards engaging the young person in education or to altering the level of their educational achievement.

> *"—and she's changed her mind. I don't know what's changed her mind…But I didn't really play a role in going into great depth of detail of that. I supported her to return to [a particular school] if that's what she wanted but then she changed her mind. So we're looking at TAFE options, currently actually." (Worker)*

Effects of caseworker turnover

Two caseworkers had been working with the young person for a very short amount of time and this showed in their lack of understanding of the young person's history and the effect this might have had on the young person and their education. The four other young people were fortunate to have been with their caseworker for three years or more.

Effects of time and resource pressures on residential care workers and caseworkers

One worker was concerned about the lack of time to address the needs of a young person in the face of placement breakdown and difficulty maintaining her at school. He was concerned this negatively impacted on her educational achievement (she dropped out of school).

> *"Yeah, that's a tricky one, there's so much we can do. I think in her instance and in the last placement she had, it was difficult that she lived such a distance from school – school to placement – so it meant that, you know, I couldn't have as much face to face contact as I otherwise would've hoped, as well as [with] her carer. So I guess if one thing I could change is that maybe we did have more of that personal contact to set things in place." (Worker)*

Other workers in residential units talked about lack of time to devote to young people with very high needs. Others intimated the need for more training in order to make their interventions and time spent with the young people as effective as possible.

Administrative and managerial pressures on practice also impacted on assessment and intervention. Much has been written about the increasing tendency to standardise and regulate professional practice in child and family welfare, and the accompanying threat to effective practice that can result (Munro, 2005a; Munro, 2005b; Parton, 2006). There were glimpses of this in the interviews with caseworkers. For example, planning processes were faithfully enacted, but children were not necessarily any better off. One carer expressed frustration about this, and some of the caseworkers were concerned, but seemed unable to move beyond this point.

> *"You know how a parent would do anything for their kid?...That's what I need. I need people to go, 'Okay, [school name's] not working, what else have we got? What can we get the money for? You know..." (Carer)*

Culturally sensitive practice

Understanding culture is an essential part of assessment, since all human beings inhabit, reflect, enact and modify culture. The effects of culture clash were evident in two young people. One worker talked of the young person's sense of alienation:

> *"—and feeling like: 'well I'm not wanted anyway but now I'm not wanted even more'. And that's been a bit of a thing for her – about not being wanted and not feeling a part of things and being [from another country], feeling isolated and feeling that people stare at her. She's got quite a complex about all that as well, that she – that people, you know, see her as something different and not fitting in and that kind of thing, which I guess is completely normal for what she's been through, you know. I'd feel the same way." (Worker)*

It is not clear whether cultural difference in relation to child rearing, or the effect of being a refugee were properly taken account in intervention with this young person and, especially, her family. The consequence was removal from her family, placement in an unsuitable placement and cessation of schooling.

The second young person came from an Australian sub-culture, most probably an excluded family (Tierney, 1976; Mitchell, 1995). The carer was aware that this culture was one of the barriers to educational achievement:

> *"…Negative approach. Negative thinking about something. It's boring, it's too long, nothing interesting happening, no one understands him, can't see the use of it. I can't see why he would do it. 'Cause there's so many other people not at school and having a life. That's right, yeah, … lots of kids, why should I go to school. Other people don't do it and they turn out completely fine." (Carer)*

Change is much more difficult to achieve without understanding of and engagement with the cultural dimension. Understanding the cultural dimension is a necessary, time-consuming and sensitive, task. That did not happen for this young man, and he continued on his path of alienation from educational settings. He remained seriously educationally disadvantaged with no progress having been made in engaging him in education, training or employment.

The importance of strengths-based practice

Strengths-based practice can be difficult to maintain in the face of substantial barriers to achievement, although by and large carers, teachers and caseworkers managed to do so. There were glimpses here too, of the central importance of a strengths-based approach when things were particularly difficult or stressful. The approach gave confidence to one young person who had dropped out of school to return to education.

> *"She will, she will. She's very strong minded and she's got a baby at 16 that she takes care of and to me that's the hardest job in the world." (Carer)*

Strengths-based practice also seemed to be helping one young person gain some skills, despite his previous rejection of learning, and of educational settings. He was learning to count and read through helping the residential care staff cook the evening meal. He had also just gained his Driver's Learner's Permit.

> *"I think his confidence – not confidence, I think his mood is changing a little bit. He's smiling more and he's— I think getting his licence was a huge one. And I think he's, like, I've been here for four or five months and I can see he's slowly being more smiley and positive and talking more about future and talking less about I want to go to [alternative school] and be locked up so I can be with my friends. So that's key things slowly going down. And the one about I want to be independent, get my car, is going up. So whatever we're doing, obviously we got something…. right." (Carer)*

Carer commitment and expectations

All young people received concerted support for their growth and development within the care setting. Carers demonstrated considerable commitment to the young person in their care, regardless of whether they felt they could make a difference for the young person's educational achievement or not.

Carers of the two young people who had dropped out of school persisted in efforts to support the two back into education, training and employment. When one of these young people had been in a residential unit, the carers were not able to get her to go to school. However, when this young person moved to foster care the carer, while lacking confidence about her own educational achievements, provided enormous support so that the young person could return to education.

For the other young person who had dropped out of school a number of years ago, the efforts of the carers did not succeed. He clearly needed extra help many years before he entered care, and before he dropped out of school completely.

Carers of the other four were very mindful about the difficulties confronting the young people, supported them in homework, kept close contact with the schools, worked with and received support from specialist counsellors in two cases and from their supporting caseworkers in all cases.

However, two of the carers wished they could have more of an effect, because both felt the young person was not achieving their full potential. This was despite specialist counselling, therapeutic foster care and a school doing all within its resources to help the young person in one case; and despite therapeutic foster care, an excellent school and huge improvements having occurred for another young person.

However, all but the carer of one young person could see that their efforts were making a difference. Some felt frustrated that they were not having a dramatic impact, but saw factors outside of their control as the cause of this situation. For example, they believed that the young person's previous trauma, or current situation with the birth family were primary influences.

Another carer recognised the huge amount of support the young person was going to need as well as the importance of emotional support and simply wanted, and felt able to respond to this need.

Another carer had given up in the face of placement breakdown, and would not accpet any repsonsibilty for what had happened with the young person's education. Another two carers felt that they had done their part, but that the young person had to overcome their low motivation. Three saw the failure of the young person in their care to reach their potential lying with the lack of appropriate alternative school programs or settings. One carer, while convinced that she could make a difference for the young person, also felt that she and other carers could benefit greatly from more training and for more time for residential workers to be able to work on the educational achievements of the young people in their care.

Two young people had received tutoring, either currently or in the past, and one refused efforts of the carer to involve a tutor. One had no need for tutoring.

Whether the support for education within the care setting resulted in the young people doing their homework, though, was not straightforward. Of the three remaining at school, two did homework regularly, while one refused. Of the three who had dropped out of school, two had done homework and one had never done homework, seeing it as being as useless as the rest of school.

One carer showed commitment that seemed typical of the carers interviewed.

> *"Well at the moment we're in the process of planning for next year. We discuss it a lot about what her goals are. I'd have to make sure the environment is, like, quiet so she can study, which is going to be hard. But we do have a study and hopefully we'll be getting her a laptop as well so that she can get on the Internet and do lots of that sort of stuff, yeah.*
>
> *...I s'pose we could always, you know, we'd always help her with a tutor or things like that. But it is going to be hard work studying, looking after the baby and things like that. But we're here to help her so … I just want her to be her best. I'm not going to push her negatively, like, to, you know, go out and be a doctor or anything like that. But I know what she wants to do and I'm going to help her with that as much as I can." (Carer)*

OOHC and education systems working together

There were a number of case specific occasions where different systems did not work with full effectiveness to meet the needs of the particular young person. Due to the focus of this research, the most common difficulties between systems occurred between the education and care systems, but there were indications of difficulties between other systems and the care system as well.

The most common difficulty occurred in providing case management which maintained an integrated approach, drawing on appropriate and timely interventions from different systems (particularly education, OOHC and mental health) to ensure an outcome that was constructive for the young person and their family.

In three cases, trauma impacted on the young person's ability to learn in a classroom setting, and they appeared to need specialist support in the learning environment. However, because none of the three had been diagnosed with a learning disability, it was unclear where the responsibility to fund such support lay. In one of these three cases, placement breakdown part-way through Year 12 led to a new placement at a distance from the school. In this case, neither the school nor the care system were able to provide the level of support the young person required, and she dropped out of school without completing Year 12.

In another of these three cases, it had not been possible to find a placement in an alternative education setting for the young person.

In a fourth case, the school was unable to take in a student who had not attended school for more than a year and who had a baby to care for. The structure of the school program meant that it was difficult to align the young woman's social and educational developmental needs, and thus place her appropriately.

In one case, finding an appropriate education placement was rendered impossible by a court directive that the student not be placed in the one appropriate alternative school setting because of relationships between this and other students already enrolled in the school.

In two of the cases mentioned above, the lack of system integration and a lack of family focus had an impact on the young person and their family in a way that was detrimental to the young person's education.

In one case, the young person's anxiety that her mother wasn't being cared for sufficiently interfered with her learning. In the other case, the young person returned to her family after twelve years in care at a point when she was too old for the family to receive support for the reunification from family preservation or family services. Effectively, the family fell through the cracks, and the young person dropped out of school in the middle of Year 12.

Other individual child factors

Education needs

Only one of the young people had no specific educational needs.

All the young people showed the importance of relationships as a foundation for learning. For one young person, the relationship with the carer meant confidence and achievement.

> *"Yep, Tom always gives me a hand. …Yeah, if I need it, he'll always be there to talk about it." (Young person)*

For another, the lack of relationship meant rejection of the entire school system:

> *"A lot of teachers come in, they just tell us what to do, they don't muck around with us or nothing. ….Like, come out, take us outside and have a smoke, come and sit with us, talk to us, just, yeah ….I don't learn when I just sit there and look at a fuckin' teacher talkin' shit." (Young person)*

Three young people had specific needs for applied learning. The young person quoted above made it very plain that the only learning he would countenance was on the job learning. One of his carers had also found that she was able to teach him while they were doing things together, like cooking the evening meal. Another young person was thrown into motherhood and on-the-job learning with a committed foster carer who ensured she was able to take up her mothering roles effectively. One of the young people who was disengaging from school saw his only path as being applied learning. Three of the young people also showed the need for containment of aggressive or impulsive behaviours and uncontrollable emotion within the school setting.

Individual resilience factors

On the positive side, a range of factors such as temperament, capacity and intelligence emerged as helping achievement. These factors assisted one student to overcome enormous difficulties and begin to be seen as an average student. The same factors helped another do well throughout his school life. They helped a young woman cope with looking after a baby while planning her future. They helped another young woman to continue to plan her life with a sense of practical hopefulness despite a number of crises. They also helped a young man achieve to some level, in the face of the ongoing effects of trauma on him.

Summary of findings from the case studies

The case studies illustrate a number of factors which, in interaction with each other, seem to affect educational achievement. Childhood trauma and its ongoing impact on young people's minds, feelings and behaviour was a core negative influence on academic achievement.

A preoccupation with birth families also appeared to intrude on young people's capacity to concentrate and engage in learning. There was also indication of insufficient resources within the OOHC and school systems to respond to trauma and young people's specific learning needs, including a lack of therapeutic placements, flexible learning options and alternative education settings. There also appeared to be limits on the models of practice required to meet the needs of young people and support education outcomes.

There were also factors that appeared to contribute to positive change, growth and achievement in all six cases, despite less than optimal outcomes for some young people. These factors included a commitment to the young people among staff in both educational and care settings, skilful practice and intensive intervention, often in the face of inadequate resources care, as well as education staff working co-operatively to increase support to young people and maximise their ability to grow, develop and achieve. Finally, the young people themselves displayed a responsiveness to intervention and support and resilience against overwhelming odds.

Specifically, the stories of the six young people illustrate the need for:

- Early intervention to prevent trauma to children
- Specialised trauma services
- Culturally sensitive work
- Timely availability of appropriate placements
- Therapeutic care
- Alternative school programs within mainstream schools, alternative education settings and applied and one-on-one learning, including therapeutic educational programs where teachers are trained to address trauma-based behaviours
- Strong relationships with carers and teachers
- Supported and flexible transitions between primary and secondary schools and at the end of formal schooling, and
- Resources and supports for young people who have been in OOHC to enter tertiary education, beyond the end of wardship.

The discussion of factors involved in all the cases also highlights the need for practice which places an emphasis on:

- The effects of developmental stage and identity formation
- The effects of mental illness and poor mental health
- The importance of balance between crisis and the 'here and now', and understanding the child in the context of their history and future
- Individualised assessment and tailored intervention as compared to standardised and regulated professional practice
- Effective planning and case management processes
- High expectations that children in OOHC can achieve educationally
- Strengths-based practice, and
- Effective strategies to combat low motivation.

There is also evidence in the case study data to suggest that practice elements just identified require time and training for caseworkers and therapeutic staff. Carers also need time and training to support and maintain their commitment to the young people in their care. There also appears to be a need for workforce resourcing and planning to reduce staff turnover and ensure sufficient choice of placement type.

Chapter 5 - Conclusions and recommendations

Summary of education outcomes

The survey and case study research provided some important insights into the education progress of the current sample of children in OOHC.

Education outcomes: Poor for most, good for some

The survey research confirmed the picture of previous research, which suggests that children in OOHC do poorly academically. A high proportion of children had repeated a grade at school (23.7%), had experienced a change of school (60.2%), were not attending school on any days (18.1%), had wagged school in the past year (30.8%), or had been suspended in the past 12 months (14.7%). Scores on the teacher-rated SDQ problem scales were also noticeably higher than Australian benchmarks.

However, when these data were analysed more deeply, it was revealed that negative outcomes and individual circumstances were concentrated in two of three groups; a 'damaged' younger group of children who were characterised by high rates of cognitive, emotional and physical disorders and extremely poor school achievement and a 'disengaging' group that was less compromised but older and showing the least engagement and attachment to school. A third group of children, labelled 'doing well', appeared to be functioning on par with children and young people in the community generally.

Although the case studies focussed on some children with particular obstacles with respect to their education, these data identified some factors that made a positive contribution to education and learning outcomes. Specifically, the case studies suggested that early intervention is critical to the prevention of trauma, which so negatively affects educational outcomes. Other factors which seemed to contribute to achievement regardless of the nature and extent of education barriers and challenges were stability of placement, an expressed, long-term commitment (beyond termination of wardship) of the carer to the young person and the ability of both the care and education systems to respond to the talent, ability and needs of the young person in a flexible manner.

Early onset of problems

An important finding from the research is the early stage in development in which education difficulties are apparent. The most problematic of the three groups identified in the cluster analysis, labelled 'damaged', were mostly attending primary school. A high proportion of these children showed extreme difficulty conforming to a mainstream school setting, as indicated by the proportion who had been suspended and/or were enrolled in an alternative school setting. These children also performed the least well academically of the three groups and a high proportion also had cognitive problems such as an intellectual disability, a learning disability/ disorder and/or ADD/HD.

Factors related to education outcomes

There is considerable accord between the findings from the survey research and case studies on the factors that influence academic achievement among children in OOHC.

The profound effect of trauma

The survey research showed the high proportion of children in the sample who had a functional limitation due to a long-term health, medical or behavioural condition (36.7%). This is thought to be linked to traumatic experiences and stressful events while in the homes of the children's family of origin. The regression analysis reinforced a strong relation between cognitive deficits and education outcomes including repeating a grade at school (intellectual disability), overall achievement (learning disability), temporary suspension (ADD/HD), working hard at school (intellectual disability) and behaviour at school (learning disability/disorder).

The case studies also indicated that disengagement and poor academic performance has its root in the emotional and behavioural patterns that children develop in response to traumatic experiences and events. The psychological effects of trauma appear to include a preoccupation with the birth family and compromised identity development.

The case studies highlighted the need for earlier intervention for the children and their families to prevent trauma and its compounding effects. Data from one case study suggested that early intervention had protected the young person from the multiple and negatively cascading effects of trauma. Other cases suggested that the effects of trauma could be modified by highly skilful, specialist intervention within a therapeutic, stable foster care setting, with skilled and committed carers. Despite this, there was evidence of unavailability of appropriate placement and therapeutic services for some children with therapeutic needs and difficulty providing stable placement.

Difficulties conforming to the structure of mainstream school

As indicated above, many children in the sample were either enrolled in an alternative school setting or were not currently attending school. The case studies also indicated quite plainly that mainstream schools were a complex and alienating place for young people who had experienced significant trauma, even when teachers made intensive efforts to support them to stay at school and to engage in learning. The fact that 10.5% of children attending school were reported not to have any friends further highlights the difficulty some children have in navigating the social environment in schools. Further, the case studies showed that appropriate alternative programs within mainstream school or in alternative settings were not available for all three of the young people who needed them.

The role of carers in children's education

Information from the survey research and case studies highlight the role carers played in children's education. The regression analysis indicated that carer capacity to support education was positively related to overall achievement, and carer help with homework was also positively linked to working hard at school. The survey results also showed that carers had considerable positive input into children's learning, as indicated by the importance they place on good grades, help with homework and the structure of the home learning environment.

The case studies supported these findings and provide further evidence of the committed efforts of carers to assist those in their care to achieve well at school. In some cases, these efforts seemed to overcome substantial barriers, such that the young people began to show signs of improvement in their academic achievement. However, the case studies also showed that, despite considerable effort and encouragement on the part of carers, they were faced with multiple complex issues in the young people they cared for, including what they perceived to be poor motivation. Lack of carer engagement in education assessment and planning was also apparent.

Individualised assessment and intervention within a care team approach

The survey research clearly shows the diversity in education need and outcomes among children in OOHC. The case studies showed some instances where schools were able to provide a more flexible curriculum, put less pressure on students with complex emotional problems and provide skilled and sensitive discipline. However, they also highlighted significant professional development needs in relation to the identification of, and response to, education needs.

Teachers and caseworkers also appeared stretched in terms of their time and skill to develop individual education plans, address trauma-based behaviours in a school setting and support and engage carers. This seemed to relate to pressures such as lack of availability of appropriate placements to meet the needs of particular children, high case loads, frequent staff turnover, large class sizes and lack of specialised training. Poor access to specialised education resources, programs and settings also appeared to inhibit efforts to respond to children's education needs.

The importance of a relationship based approach

The case studies indicated that positive carer-child and child-teacher relationships lie at the heart of effective education initiatives for children who have experienced significant trauma.

Recommendations

Findings from the CIAO project indicate several targets for effective intervention to support education and learning among children and young people in OOHC.

The recommendations have been grouped in terms of the focus of their intended activity. However, it is important to stress that the recommendations should be read as a whole, and that their achievement requires a collaborative effort across a range of service systems, most notably, OOHC, education and mental health.

Strengthening OOHC effectiveness

Recommendation 1. Develop a fully resourced 'education-first approach' to assessment and placement services which prioritise a child/young person's education needs and aspirations.

Recommendation 2. Provide ongoing provision of placement and support until young people in OOHC complete Year 12 or an equivalent accredited qualification.

Recommendation 3. Provide training and support for carers and relevant community sector and DHS staff focussed on working with schools within a care team approach to respond to trauma-related behaviour.

Recommendation 4. Increase provision of choice of placement, including therapeutic placements equipped to deal with the effects of traumatic experiences and events. Placements need to recognise the diversity of the Victorian community by providing culturally appropriate support.

Recommendation 5. Improve access to mental health services and specialised trauma services (such as the Take Two Intensive Therapeutic Service) in OOHC and educational settings for all children who exhibit or are at risk of developing severe emotional and behavioural disturbance.

Strengthening education provision

Recommendation 6. Increase provision of teacher training and resources in both initial and continuing teacher education to assist teachers to respond to trauma-related behaviour.

Recommendation 7. Improve the scale and reach of targeted education supports and evidence-based alternative education programs and settings for children/young people across the age range whose learning is disrupted by the effects of trauma.

Recommendation 8. Strengthen the Individual Education Plan (IEP) by ensuring that the entire care team is involved in its development and implementation, including the primary carer for the child. The Plan should follow the child as they move home and/or school.

Recommendation 9. Implement a system to ensure that children/young people who drop out of school and cease to be enrolled can be identified and located, and strategies put in place to secure their re-engagement in education.

Strengthening cross-sectoral linkages

Recommendation 10. Improve the integration of assessment, planning and support across the OOHC, education and mental health systems, to enhance the effectiveness of case management and supports for each child in OOHC.

Recommendation 11. Develop a single system, sitting across and 'owned' by DHS, DEECD and the Community Sector to monitor, evaluate and review education outcomes among children in OOHC.

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