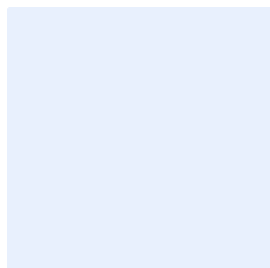


NSW statutory out-of-home care: Quality Assurance Framework

Section 3: The Quality Assurance Framework QAF

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Disclaimer

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1. Background

The New South Wales Department of Family and Community Services (FACS) commissioned the Parenting Research Centre (PRC), in partnership with the University of Melbourne, to develop a robust Quality Assurance Framework (QAF) and implementation plan for out-of-home care (OOHC) in NSW. The framework development comes as NSW changes the provision of OOHC from a government-funded – and mainly government-run – service to a government-funded, NGO-run service.

This framework is being developed in the context of a broader monitoring and major reform environment in NSW, which includes the NSW Office of the Children’s Guardian’s (OCG) development of OOHC accreditation standards (these were in operation since 2003, revised in 2010 and under review at the time of writing); the Australian Government’s release of national out-of-home care standards in 2011; the transition of OOHC to the non-government sector; and, Safe Home for Life reforms, designed to strengthen the child protection system through legislative change, new policy and practice and a re-design of how technology is used in child protection.

In this context, a new QAF for OOHC, incorporating new *Standards*, is the next step in improving outcomes for children placed in OOHC.

1.1 Introduction

The QAF described here has been based on the findings of the Narrative review (refer to Section 2) and further expanded to include the framework introduced in the United States as part of a major federal reformulation of child welfare services introduced by the Obama administration (DHHS, 2012) and the associated Framework for Well-Being for Older Youth in Foster Care (Hanson Langford & Badeau, 2013). These were chosen after an international review of existing frameworks and after consulting key stakeholders from FACS, peak organisations and non-government organisations (refer to Section 1 Context and Consultations).

The adaptation drew upon contextual knowledge of the NSW child welfare system, including policies and procedures, the interrelated roles and responsibilities of governmental and non-governmental agencies, and a strong push by government to improve outcomes by using rigorous evidence. In constructing the QAF, the Project Team sought to reflect several approaches or philosophies:

- The overarching goal of a child welfare service system is to ensure the safety, permanency and wellbeing of the children and young people it serves.
- These goals cannot be achieved without considering child’s development. For example, safety concerns differ by children’s age, as does a child’s capacity to understand and communicate their needs.
- The relationship between a child and their primary caregivers, as explained in theories of attachment, is key to understanding and promoting healthy development and wellbeing (Mennen & O’Keefe, 2005).

- A child’s environment (including parents, family, family networks, living space, peers and community) profoundly influences a child’s development.
- Culture, both inherited and as expressed in the home and community, is a lifelong influence on development and wellbeing. Although this is true for all children, the historical treatment of Aboriginal people in Australia, and their current over-representation in OOHC, makes an explicit focus on culture especially important for Aboriginal children.
- In order to improve outcomes, it is essential to use reliable and valid assessment measures for specified outcomes, in order to measure baseline functioning and progress over time. Children and young people who enter the OOHC system are likely to have significant physical and mental health problems, and other problems. Progress over time will reflect this.
- Individual outcomes should be measured by using longitudinal approaches that account for context. That is, it is insufficient to simply benchmark progress, without also accounting for individual, case-level, demographic and systems-level characteristics. The QAF should have numerous dimensions that reflect the complexity of children’s lives and development, all of which need to be considered when evaluating individual, agency, and systemic progress.

The QAF is an organising framework or structure setting out ‘what’ should be attended to, in order to improve outcomes for children in OOHC across three overarching goals (safety, permanency and wellbeing). The QAF does not describe the ‘how’ – the specific way this will be achieved. Instead, the QAF will enable each individual agency to map its own pathway to achieving these goals, in response to the particular needs of the children and young people they care for (Métis Commission, 2011, p. 9).

This report begins by explaining the seven domains that make up the QAF. Next it presents the use of data to benchmark, monitor, and report and measure outcomes against the domains, with guidelines for selecting measurement tools.

2. A quality assurance framework for out-of-home care

The QAF for OOHC is designed to enable agencies (both FACS and non-government organisations) to focus on the types of measurable, developmentally sensitive outcomes that describe the three main goals of the child welfare system: safety, permanency and wellbeing (see [Table 1](#)). Focusing on these individual outcomes, if measured well at the beginning of services and periodically thereafter, will allow agencies to reliably and validly track the progress of the children in their care. This brings the opportunity to change the timing and mix of services in a way that works towards these outcomes.

The QAF is distinct from, but complementary to, the *NSW Standards for Statutory Out-of-Home Care*. These 22 *Standards* set minimum requirements for accreditation as a designated agency in NSW.

Standards provide some of the essential elements upon which quality is built, but they do not articulate a process for improving child functioning across a range of outcomes. *Standards* are essential for ensuring that the conditions under which services are provided meet at least a minimal level of care, delivering some of the basic building blocks necessary for achieving better outcomes for individual children and young people. In other words, they are essential components of quality but cannot, in and of themselves, be counted upon to measurably improve outcomes for children/young people in OOHC. The proposed QAF assumes that the standards are in place and the QAF will provide a roadmap towards achieving specific child outcomes.

Table 1: Quality Assurance Framework for out-of-home care

Developmental Phase	Intermediate Outcome Domains			Well-Being Outcome Domains			
	Safety	Permanency	Cognitive Functioning	Physical Health and Development	Mental Health	Social Functioning	Cultural and spiritual Identity
Prenatal infancy (birth to age 2)	Maltreatment occurrence in OOH, maltreatment recurrence post restoration, accidental injury.	Timely and lasting legal permanence (restoration, guardianship, adoption), residential stability, least restrictive living environment, maintenance of family and other key relationships (birth parents, siblings, extended kin)	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior	To be developed with appropriate stakeholders with expertise in this domain
Early childhood (3-5)	Maltreatment occurrence in OOH, maltreatment recurrence post restoration, accidental injury, feelings of personal safety and security, presence of relationships that facilitate disclosure of risk and/or harm	Timely and lasting legal permanence (restoration, guardianship, adoption), residential stability, least restrictive living environment, maintenance of family and other key relationships (birth parents, siblings, extended kin)	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior	To be developed with appropriate stakeholders with expertise in this domain
Middle Childhood (6-12)	Maltreatment occurrence in OOH, maltreatment recurrence post restoration, accidental injury, feelings of personal safety and security, presence of relationships that facilitate disclosure of risk and/or harm, risk-taking behaviour	Timely and lasting legal permanence (restoration, guardianship, adoption), residential stability, least restrictive living environment, maintenance of family and other key relationships (birth parents, siblings, extended kin)	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior	To be developed with appropriate stakeholders with expertise in this domain
Adolescence (13-18)	Maltreatment occurrence in OOH, maltreatment recurrence post restoration, accidental injury, feelings of personal safety and security, presence of relationships that facilitate disclosure of risk and/or harm, risk-taking behaviour	Timely and lasting legal permanence (restoration, guardianship, adoption), residential stability, least restrictive living environment, maintenance of family and other key relationships (birth parents, siblings, extended kin), planning for transition to adulthood	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior	To be developed with appropriate stakeholders with expertise in this domain

2.1 Domains of the quality assurance framework

The QAF, which is set out in [Table 1](#) above, encompasses the three overarching goals of a child welfare system: child safety, permanency and wellbeing. These are arrayed across the columns of the QAF. Within these three goals are seven domains. Two of the seven are intermediate domains that describe features of care necessary for wellbeing (safety; permanency). The other five are wellbeing domains that describe specific aspects of a child's wellbeing (cognitive functioning; physical health and development; mental health; social functioning; cultural and spiritual identity).

The safety and permanency domains are both overarching goals and stand-alone domains, while the wellbeing section is multidimensional. All the domains should be considered holistically.

Each domain is further stratified by developmental stage (infancy; early childhood, middle childhood; adolescence) to reflect, in broad terms, necessary changes in the configuration of outcomes according to the age of the child.

The domains are defined as follows:

Safety

Children and young people have the opportunity and support needed to ensure that they are physically and psychologically safe and free from maltreatment.

Permanency

Children and young people have permanency and stability in their living situations, and the continuity of family relationships and connections is preserved.

Cognitive functioning

Children and young people have the opportunity and support needed to maximise their intellectual ability and functioning and to achieve educational success to their fullest potential.

Physical health and development

Children and young people have the opportunity and support needed to maximise their physical health, strength, and functioning.

Mental health

Child and young people have the opportunity and support needed to manage their mental health and wellness.

Social functioning

Children and young people have the opportunity and support needed to cultivate a strong and resilient self-identity, to develop supportive and nurturing relationships, and to feel hopeful about life and the future.

Cultural and spiritual identity

Children and young people have the opportunity, encouragement and support needed to engage with, and develop, their own cultural, ethnic, and spiritual identity.

3. Using data to benchmark, monitor and reporting using the quality assurance framework

The regular use of reliable and valid data is essential for improving outcomes and ensuring the safety, permanency and wellbeing of children and young people in OOHC care. If individual outcomes are measured and documented well, the resulting data can be used to guide individual practice, improve resource allocation at agencies, improve government supervision and accountability, and inform policy development.

Using data well requires the capacity to:

- monitor progress over time (DHHS, 2012)
- consider age and context (DHHS, 2012; Courtney, 1993)
- consider the broader systemic context (Wulczyn, 2008).

The selection of measures and indicators for each domain must therefore reflect these individual and systemic contexts, while also remaining comparable over time and, where possible, between a child's developmental stages.

4. Measuring intermediate outcomes: safety and permanency domains

The intermediate domains of safety and permanency are stand-alone domains and goals that describe the systems-level elements that facilitate child wellbeing. There is overlap with some of the OOHC *Standards for Accreditation*, in terms of the constructs themselves, but they are used here as outcomes to be worked towards and contextualised with the broader information contained in the framework.

Each element of the safety and permanency domains is further defined, with specific outcome measures proposed. To the greatest extent possible, outcome measures were chosen that are currently available, or will be available. Elements include some items that extend beyond the immediate mandate for FACS and non-government OOHC providers (for instance, maltreatment after restoration; stability of placement location in addition to the standard stability of caregiver) but that are nonetheless important measures of child safety and permanency.

Each element is considered at each stage of a child's development. While this brings substantial repetition of elements within a stage, the way in which items are measured and the outcomes for repeating elements are likely to differ substantially at different developmental stages.

4.1 Data indicators for the safety domain

The primary measure of child safety in each developmental stage is child maltreatment in OOHC. The absence of child maltreatment does not ensure child wellbeing, but the presence of maltreatment undermines wellbeing. Maltreatment is most easily measured using current child protection reporting mechanisms.

However, maltreatment may be under-reported (for instance, a child may not report child sexual abuse), there may be allegations that are false or unfounded (such as malicious reporting), and reports may describe events that occurred in the past (for example, reporting an earlier incident of maltreatment that occurred with a different caregiver). To account for these potential inaccuracies, we suggest that both reports of concern and risk of significant harm (ROSH) be considered, and that these be augmented with readily available information on Reportable Conduct allegations.

In addition, as children get older and become better able to express themselves, measures of a child's feelings of personal safety and security are incorporated into safety measures. Moreover, it is important for children and young people to have relationships with adults with whom they feel safe enough to disclose maltreatment, as well as discuss behaviours, plans or environments that expose them to risk of maltreatment. To that end, the safety domain incorporates survey tools that measure feelings of safety, the presence of safe adults with whom they can communicate harm or risk of harm, and the presence of behaviours that expose children and young people to potential maltreatment, injury or other types of harm.

Child maltreatment can also occur after the child has been restored to their parents, established guardians or adoptive parents. While these children and youth may have technically left state OOHC, their safety is still a concern, at both an individual and broader systems level. OOHC care providers and funders need to be made aware of whether or not efforts at permanency were successful, in order to improve services.

Yet another area of concern for child safety is injury, whether unintended, accidental or non-accidental. Although all children and youth are at some risk of experiencing an injury or of dying, many environmental and behavioural risks, if known, can be mitigated, thus preventing injuries and death. Attention to risky environments and behaviours can be facilitated by measuring known injuries, the presence of concerned and caring adults, and obtaining information from children and youth about their environment and their own risk-taking behaviour.

Table 2: Safety domain elements by development stage

Developmental stage	Element	Definition	Outcome measures
Ages 0–2	Maltreatment occurrence	Child maltreatment in OOHC	New ROSH Reportable conduct allegation
	Maltreatment recurrence	Child maltreatment post-restoration	New ROSH Post-restoration placement in OOHC
	Accidental injury	An injury occurring in OOHC or post-restoration	New ROSH Reportable conduct allegation Medical records Post-restoration placement in OOHC

Developmental stage	Element	Definition	Outcome measures
Ages 3–5	Maltreatment occurrence	Child maltreatment in OOHC	New ROSH Reportable conduct allegation report
	Maltreatment recurrence	Child maltreatment post-restoration	New ROSH Post-restoration placement in OOHC
	Accidental injury	An injury occurring in OOHC or post-restoration	New ROSH Reportable conduct allegation Medical records Post-restoration placement in OOHC
	Feelings of personal safety and security	Subjective feelings of safety and security	Self-report Self-report checklist / survey
	Presence of relationships that facilitate disclosure of safety and wellbeing concerns	At least one caregiver with whom the child has sufficient trust and ready access	Self-report Self-report checklist / survey
Ages 6–12	Maltreatment occurrence	Child maltreatment in OOHC	New ROSH Reportable conduct allegation
	Maltreatment recurrence	Child maltreatment post-restoration	New ROSH Post-restoration placement in OOHC
	Accidental injury	An injury occurring in OOHC or post-restoration	New ROSH Reportable conduct allegation Medical records Post-restoration placement in OOHC
	Feelings of personal safety and security	Subjective feelings of safety and security	Self-report Self-report checklist / survey
	Presence of relationships that facilitate disclosure of risk and/or harm	At least one caregiver with whom the child has sufficient trust and ready access	Self-report Self-report checklist / survey

Developmental stage	Element	Definition	Outcome measures
	Risk-taking behaviour	Child behaviours that put them at risk of harm	Self-report Self-report checklist / survey
Ages 13–18	Maltreatment occurrence	Child maltreatment in OOHC	New ROSH Reportable conduct allegation
	Maltreatment recurrence	Child maltreatment post-restoration	New ROSH Post-restoration placement in OOHC
	Accidental and non-accidental injury	An injury occurring in OOHC or post-restoration	New ROSH Reportable conduct allegation report Medical records Post-restoration placement in OOHC
	Feelings of personal safety and security	Subjective feelings of safety and security	Self-report Self-report checklist / survey
	Presence of relationships that facilitate disclosure of risk and/or harm	At least one caregiver with whom the child has sufficient trust and ready access	Self-report Self-report checklist / survey
	Risk-taking behaviour	Child behaviours that put them at risk of harm	Self-report Self-report checklist / survey

4.2 Data indicators for the permanency domain

The permanency domain is characterised by the provision of care that supports legal permanence, stability and key relationships. Legal permanence is defined as restoration of the child to birth parents, establishment of guardianship or adoption. While these represent potential exits from OOHC, their success over time is not guaranteed and should be measured as part of QA efforts. As with post-restoration maltreatment reports, guardianship or adoption in the safety domain, re-entry to OOHC is a sign that permanency efforts were not successful and that a different mix of services may have been needed.

Stability of living environment can be crucial for providing a sense of safety and predictability, both of which underpin wellbeing. Stability of OOHC is generally considered relative to the caregiver. However, stability comes in two forms: firstly, living with the same caregiver, which facilitates the formation of safe, stable relationships; secondly, living in the same residential location, which facilitates stable relationships with peers and community (for example, the same

school or recreation centre). Although these two forms of stability overlap, this is not always the case and, sometimes, difficult decisions must be made in the service of one or the other. Such decisions can have a profound effect on child wellbeing.

OOHC is based on the notion that, when children cannot remain with their parents, they should, whenever possible, be cared for by guardians, or be adopted and live in a family-like setting (Wolins, 1963). The concept of 'least-restrictive environment', although still controversial due to the fact that, at times, some children and youth require higher levels of care (Smyth & Eardley, 2008), is generally applied in both the philosophy of care and in associated OOHC legislation.

In terms of QA, the goal is to have children and youth spend the least possible amount of time in highly-restrictive environments, as these tend to be associated with poor outcomes. The proposed hierarchy of level of restrictiveness ranges from the least restrictive (the child is restored to their birth parent) to the most restrictive (secure residential care).

For these measures of permanency, the QAF includes measures that account for time. That is, children who leave OOHC to a legally permanent home are at risk of returning to OOHC, but this risk is at least partially dependent on the length of observation (that is, the percentage of children who are restored and followed for three months are less likely to return to OOHC than children who are followed for one year, simply because the latter are followed for longer).

The maintenance of family relationships is also considered as part of the permanency domain, with an emphasis on restoration and kinship care. Sibling relationships are also the longest relationships that most people experience in their lives, and are an important family tie to maintain (Shlonsky et al., 2005; Webster et al., 2005). Moreover, we know that children tend to return to their families of origin when they become young adults (Courtney et al., 2011). Assuring quality in the permanency domain, therefore, involves maintaining and supporting family ties, including support for visits and other forms of communication. However, although important, maintaining family ties can also be complex and, in some cases, potentially harmful. Caregivers are uniquely placed: they can be a significant relationship and can monitor, encourage, and facilitate significant relationships with others. The QAF thus includes caregiver reports on the quality of key relationships.

Similar to the safety domain, constructs and measures across time are similar but may have different meaning and context by developmental stage. For instance, the reasons for placing a child under 12 years of age into residential care would likely be very different from the reasons for placing an adolescent in a similarly restrictive environment. In recognition of the high needs and poor outcomes of young people in OOHC who are moving into adulthood, the adolescent developmental stage includes planning for this transition. For many years, the provision of training in independent living skills was considered important for these youth. However, recent evaluations of these approaches suggest otherwise (Courtney et al., 2011b). There is discussion about extending the support to age 25. This category remains unspecified in terms of measurement of outcomes and will be completed in consultation with key stakeholders.

Table 3: Permanency domain elements by development stage

Developmental stage	Element	Definition	Outcome measures
Ages 0–2	Timely and lasting legal permanence	Restoration to birth parents or the establishment of a legally permanent caregiver (kin guardian, non-related guardian, adoption)	Time to legal permanence Post-permanency re-entry to OOHC
	Residential stability	<u>Placement stability</u> : residing with a specific caregiver without changing placements <u>Residential stability</u> : residing in the same physical home without moving	Time to placement change in OOHC Time to residential address change in OOHC Time to residential address change in restored home
	Least restrictive living environment	Hierarchy of preferred living environments: <ul style="list-style-type: none"> • birth parent(s) • kinship care • authorised carers • residential care 	Time in care by placement type Movement to least restrictive placement type CAT scores
	Maintenance of family relationships while in OOHC	Relationships with family members and other key people in children's lives are maintained safely and sensitively Key relationships are supportive, safe, and secure	Rate of intact sibling placement Number of visits with birth parents Number of visits with siblings Number of visits with kin and significant others Caregiver reports
Ages 3–5	Timely and lasting legal permanence	Restoration to birth parents or the establishment of a legally permanent caregiver (kin guardian, non-related guardian, adoption)	Time to legal permanence Post-permanency re-entry to OOHC
	Placement stability	<u>Placement stability</u> : residing with a specific caregiver without changing placements and remaining with the same NGO	Time to placement changes in OOHC Time to residential address change in OOHC Time to residential address change in restored home

Developmental stage	Element	Definition	Outcome measures
	Least restrictive living environment	Hierarchy of preferred living environments: <ul style="list-style-type: none"> • birth parent(s) • kinship care • foster care • group care • residential care 	Time in care by placement type Movement to least restrictive placement type CAT scores
	Maintenance of family relationships while in OOHC	Relationships with family members and other key people in children's lives are maintained safely and sensitively	Rate of intact sibling placement Number of visits with birth parents Number of visits with siblings Number of visits with kin
		Key relationships are supportive, safe, and secure	Caregiver report Self-report Self-report checklist / survey
Ages 6–12	Timely and lasting legal permanence	Restoration to birth parents or the establishment of a legally permanent caregiver (kin guardian, non-related guardian, adoption)	Time to legal permanence Post-permanency re-entry to OOHC
	Residential stability	<u>Placement stability</u> : residing with a specific caregiver without changing placements <u>Residential stability</u> : residing in the same physical home without moving	Time to placement change in OOHC Time to residential address change in OOHC Time to residential address change in restored home
	Least restrictive living environment	Hierarchy of preferred living environments: <ul style="list-style-type: none"> • birth parent(s) • kinship care • foster care • group care • residential care 	Time in care by placement type Movement to least restrictive placement type CAT scores

Developmental stage	Element	Definition	Outcome measures
	Maintenance of family relationships while in OOHC	Relationships with family members and other key people in children's lives are maintained safely and sensitively	Rate of intact sibling placement Number of visits with birth parents Number of visits with siblings Number of visits with kin
		Key relationships are supportive, safe, and secure	Caregiver report Self-report Self-report checklist / survey
Ages 13–18	Timely and lasting legal permanence	Restoration to birth parents or the establishment of a legally permanent caregiver (kin guardian, non-related guardian, adoption)	Time to legal permanence Post-permanency re-entry to OOHC
	Residential stability	<u>Placement stability</u> : residing with a specific caregiver without changing placements <u>Residential stability</u> : residing in the same physical home without moving	Time to placement change in OOHC Time to residential address change in OOHC Time to residential address change in restored home
	Least restrictive living environment	Hierarchy of preferred living environments: <ul style="list-style-type: none"> • birth parent(s) • kinship care • foster care • group care • residential care 	Time in care by placement type Movement to least restrictive placement type CAT Scores
	Maintenance of family relationships while in OOHC	Relationships with family members and other key people in children's lives are maintained safely and sensitively	Rate of intact sibling placement Number of visits with birth parents Number of visits with siblings Number of visits with kin
		Key relationships are supportive, safe, and secure	Caregiver report Self-report Self-report checklist / survey

Developmental stage	Element	Definition	Outcome measures
	Planning for transition to adulthood	Efforts are made to provide young people with the support and assistance/resources needed to successfully navigate their passage from childhood to adulthood	To be developed in consultation with key stakeholders

5. Measuring wellbeing: selecting outcome measures

The wellbeing goal includes five outcome domains (cognitive functioning; physical health and development; mental health; social functioning and support; cultural and spiritual identity) that comprise measurable elements corresponding to each developmental stage. We chose this particular set of domains, which are derived from a number of frameworks and related literature, because no single framework we found comprehensively covered the domains of importance to NSW.

The elements within each domain generally describe core constructs that increase in complexity and number as the child moves through each developmental stage. Although there is potential overlap between some domains (for example, between cognitive functioning and physical health and development) and their respective elements, the categories are conceptually distinct. The inclusion of cultural and spiritual identity (which was not part of the USA models) reflects respect and support for Aboriginal and culturally and linguistically diverse heritages and their importance for child and youth development and wellbeing.

Conradi et al. (2014, p. 3) highlight the importance of accurately measuring children's outcomes. They point out that employing valid and reliable screening tools, in combination with case planning efforts, improve child welfare workers' ability to organise effective early interventions.

The use of standardised and tested instruments minimises the risk of biased assessment of wellbeing outcomes and resulting misdirected efforts to improve children's lives. From a practical perspective, this has far-reaching repercussions for an agency's service performance and, consequently, for the total continuous quality improvement process. Selecting measures that do not reflect children's true progress and development may substantially bias conclusions about the effectiveness of agencies' services. Selecting the wrong instruments is a barrier to effectively assessing an organisation's progress towards goals and objectives. It is a threat to the purpose of agencies' QA and continuous quality improvement efforts (see for example O'Brien and Watson, 2002).

Because of the potentially negative effects of measurement errors resulting from differences between reported and true outcomes, this topic has garnered a great deal of attention in the academic literature.¹ Yet the dangers of measuring outcomes inaccurately have not gained sufficient attention in practice. To address this shortcoming, the next section provides more detail on the reliability and validity of measurements.

¹ See for example Tourangeau et al. (1997), Kreuter et al. (2008), Sonnenberg et al. (2012), Au and Johnston (2014).

Although the importance of using standardised, reliable and validated instruments for measuring children’s wellbeing is indisputable, defining a suitable outcomes framework and selecting appropriate measures is complex. Conradi et al. (2014, p. 5) summarise an optimal instrument as one that is ‘useful, reliable and valid, provides helpful information, and translates easily into case planning without adding an undue burden to caseworker or costs to the system’. They also point out that there is no single tool that is suitable to measure wellbeing for all children and that the selection of preferred instruments has to be accompanied by cost–benefit analyses.

With these challenges in mind, the next section provides a guide to agencies for selecting the right measures for children’s wellbeing in OOHC.

6. Guidelines for selecting measurement tools

OOHC agencies operate in complex circumstances with a scarcity of resources. Their staff often have limited training and qualifications. The measures and approaches used must work within these limitations (constraint optimisation). This means an agency, when choosing instruments, cannot consider accuracy alone, but must also consider purpose, cost and administration requirements such as training and completion time (Conradi et al., 2014).

This approach is in line with the findings of the Narrative review, which highlighted that agencies need to balance the requirements for thorough, context-related monitoring and evaluation with stakeholder interests and resource restrictions (see for example CODMP, 1998).

In order to increase the effectiveness of the Continuous Quality Improvement (CQI) process and maximise the return from monitoring activities, outcome indicators that build on reliable and valid measures should be used where available. As previously mentioned, this minimises the risk of measurement error and enhances the likelihood of identifying areas for development.

Various sets of criteria have been developed in the literature to guide agencies in their choice of suitable outcome measures (for example, Thomas, 2006, p. 28) and some have been integrated into existing QAFs (as outlined in the Narrative review). For instance, the OACAS framework (2004, p. 19) suggests consideration of the criteria for choice of outcome indicators as established by Hatry (1999). The following points provide an overview of the criteria commonly highlighted in the literature.

1. **relevance** to outcomes being monitored – measurement tools must be relevant to the mission and objectives of the program, as well as to the outcome being measured
2. **administration** – qualifications of staff, and amount of time required (for both staff and clients)
3. **feasibility** – data collection must be feasible in the context of the service being provided
4. **cost of collecting data** – the cost of tools, staff time and effort should not be prohibitive
5. **comprehensiveness** – indicators must cover all possible effects
6. **effectiveness** – the outcome measurement instrument has been shown to effectively measure the outcomes of interest

7. **reliability** – the instrument has been shown to consistently and predictably measure the outcome of interest when used multiple times
8. **validity** – whether an indicator actually measures the outcome of interest.

7. Efficiency

Efficiency is a relative measure of instrument characteristics. The term ‘efficiency’ in this report is derived from the terminology used in the economic literature describing processes that are ‘non-wasteful’ (Mas-Colell et al., 1995),² and more generally denoting processes that either achieve a fixed outcome at minimum cost, or a maximum outcome at a fixed cost.

As described earlier, QA and CQI processes are subject to resource constraints. This forces agencies to carefully analyse and compare outcome measurement instruments based on their costs and benefits. In general, this report distinguishes between two aspects of efficiency: measurement efficiency and implementation efficiency.

7.1.1 Measurement efficiency

Measurement efficiency is related to the construct of measurement error in the statistical literature and is directly derived from the reliability and validity of an outcome measure. An instrument is efficient if its measurement error is lower than any alternative measure of a particular outcome.³ In other words, an efficient instrument demonstrates higher reliability and validity than its alternatives.

7.1.2 Implementation efficiency

This refers to all costs and resources needed to implement and administer the outcome measurement instrument. Considering the criteria listed in the OACAS framework (2004), this would include relevance, feasibility, costs of data collection, and comprehensiveness.

In particular, implementation efficiency can be assessed by comparing outcome measurements against the following criteria:

Data collection

- time for training staff involved in data collection
- time for administering the instrument
- human resources required for administering the instrument
- cognitive burden on respondents (risk of response bias or non-participation)
- financial resources required for data collection (e.g. booklets, venues etc.)

² This definition of efficient production lends itself to the QA setting, since the CQI process can be viewed as creating an output in the presence of resource restrictions. For a precise, technical definition of efficient production, see Mas-Colell et al. (1995), Chapter 5.

³ A necessary condition for efficiency is therefore that outcome measures are comparable.

Data analysis

- resources needed to analyse data (e.g. software, skilled personnel)
- comparability of results over time
- scalability of results (Can scores be aggregated? What is the reliability of aggregated outcomes?)

Reporting

- interpretability of outcomes (ease of understanding of results)
- comparability of results with other studies or indicators (also at aggregate levels)
- ease of translating results into recommendations and actions.

No single outcome measure will be efficient against all these criteria. Consequently, agencies will face trade-offs between implementation efficiency, validity and reliability of an instrument. Due to feasibility considerations, the best choice may not be the instrument yielding the highest reliability and validity, but may be the one with the relatively highest value-added when compared to other possibilities (see also Conradi et al., 2014). The best choice can therefore be defined as a balance between measurement efficiency and implementation efficiency. In other words, the preferred instrument is the one that minimises implementation costs while performing above a minimum standard for reliability and validity.⁴

8. Recommended measurement tools for wellbeing domains

We reviewed instruments in order to identify tools suitable for tracking wellbeing outcomes. This review was based on the child wellbeing outcome measures assessed by the Children’s Bureau of the Administration for Children and Families (2012) and reviews conducted by Strand et al. (2005) and Hawkins and Radcliffe (2006).

We assessed assessment and screening tools using the principles outlined in the previous section, wherever information was available. It is important to note that only readily available and free, or minimum cost, instruments were included.

The results of this review are shown in [Table 1](#). For each tool presented, we conducted a literature search for recent psychometric assessment. In total, six instruments were selected for recommendation. [Table 4](#) contains information on measurement of behavioural, emotional and social wellbeing; age range; cost and administration requirements; and psychometric properties.

Other measures, such as those for physical health and academic progress, can be obtained from administrative or other existing data sources, so are not included here (see [Table 5](#))

⁴ To help choose between numerous alternatives, tools such as balanced scorecards can be used to generate rankings.

Table 4: Selected instruments to assess children’s and young people’s wellbeing

Measure	Behavioural/emotional	Social	Age	Type of assessment	Training	Administration	Costs	Psychometric properties
Brief assessment checklist – children (BAC-C)	Derived from larger clinical mental health tool. Clinical-level mental health needs including those related to conduct or behavioural and emotional issues	Peer and caregiver relationship problems, pro-social behaviour	4–11 years	Caregiver report	Minimal	5–10 min	Free	<p><u>Reliability:</u> acceptable – good</p> <p><u>Validity:</u> face validity; construct validity compared with SDQ and Child Behaviour Check List. Normed on OOHC population</p>
Brief assessment checklist – adolescents (BAC-A)	Clinical-level mental health needs including those related to conduct/behavioural and emotional issues	Peer and caregiver relationship problems, pro-social behaviour	12–17 years	Caregiver report	Minimal	5–10 min	Free	<p><u>Reliability:</u> acceptable – good</p> <p><u>Validity:</u> face validity; construct validity compared with SDQ and Child Behaviour Check List. Normed on OOHC population</p>
Child and adolescent needs and strengths ¹	Behavioural/emotional needs Sexually aggressive behaviour problem presentation risk behaviours functioning	Strengths (family, interpersonal, relationship permanence) life domain functioning (family, social)	0–5 years	Mental health service provider report; parent report and teacher report are possible as well	Bachelor's degree with some coursework in mental health testing	10 min	Free	<p><u>Reliability:</u> acceptable – good</p> <p><u>Validity:</u> face validity only</p>

Measure	Behavioural/emotional	Social	Age	Type of assessment	Training	Administration	Costs	Psychometric properties
Child & adolescent needs & strengths; child & adolescent needs & strengths – mental health ¹	Behavioural/emotional needs Sexually aggressive behaviour problem presentation risk behaviours functioning	Strengths (family, interpersonal, relationship permanence)	0–18 years	Mental health service provider report; parent report and teacher report are possible as well	Bachelor's degree with some coursework in mental health testing	10 min	Free	<u>Reliability</u> : acceptable – good <u>Validity</u> : face validity only
Mood and feelings questionnaire (MFQ) ²	Depression, loneliness, feeling unloved		8–18 years	Child and parent report	Not defined	5–10 min	Free	<u>Reliability</u> : acceptable <u>Validity</u> : satisfactory – very well
Strengths and difficulties questionnaire (SDQ) ³	Conduct problems, emotional symptoms hyperactivity/inattention	Peer relationship problems, pro-social behaviour	6–16 years	Adolescent self-report (11–16); parents and teachers	Minimal	5 min	Free	<u>Reliability</u> : satisfactory – strong <u>Validity</u> : satisfactory – appropriate

¹ CANS: Lyons (1999); Anderson et al. (2003); Lyons (2004); Lyons (2008); Please note: Number of peer-reviewed, published psychometric assessments < 2

² MFQ: Angold and Costello (1987); Wood et al. (1995); Kent et al. (1997); Daviss et al. (2006); Hammerton et al. (2014)

³ SDQ: Goodman (1997); Goodman et al. (1998); Goodman and Scott (1999); Goodman (2001); Hawes and Dadds (2004). Please note: Extensive use and psychometric assessment of the SDQ in various countries, list of studies is not exhaustive. Hawes and Dadds (2004): Australian large community sample, report sound psychometric properties of SDQ.

^a Ezepeleta et al. (2013) report acceptable psychometric properties of the SDQ³⁻⁴ for identification of behavioural or emotional problems in preschool children

The timing and efficiency considerations for measurement dictate that, wherever possible, alternative measures of wellbeing should be sought. To that end, we undertook some initial consideration of, and documented, items that may be available from other sources. These sources may be currently available, are likely to be available in the near future, or should be considered for inclusion in Safe Homes for Life or other content management systems. Strongest among these are NAPLAN (National Assessment Program – Literacy and Numeracy) and other school information currently being made available by the Department of Education, health checks funded by NSW Department of Health (DOH), and administrative data from youth justice and DOH documenting the occurrence of services (for example, mental health services; psychotropic medication) and other important events (such as arrest). Also promising are strategies to follow youth post-transition to adulthood using administrative data from agencies such as Justice, NDIS, Health and Centrelink.

Table 5: Well-being elements that may be available from other sources

Developmental stage	Cognitive functioning	Physical health and development	Mental health	Social functioning	Cultural and spiritual identity
Prenatal infancy (ages birth to 2)	Health checks on entry and periodically	Health checks on entry and periodically	Health checks on entry and periodically		Care plan TBD
	Brighter Futures assessment	Brighter Futures assessment	Infant mental health referrals		
Early childhood (ages 3–5)	Health checks on entry and periodically	Health checks on entry and periodically	Health checks on entry and periodically		Care plan TBD
	Brighter Futures assessment BestStart	Brighter Futures assessment	Child mental health referrals		
Middle childhood (ages 6–12)	Academic achievement <ul style="list-style-type: none"> • NAPLAN • school attendance • number of school changes • grades • suspensions • expulsions • specialised education plan • special education services 	Health checks on entry and periodically	School entry questionnaire (baseline only)	School entry questionnaire (baseline only)	Care plan TBD
	School entry questionnaire (baseline only)	School entry questionnaire (baseline only)	Youth justice referrals	Youth justice referrals	
			Child mental health referrals	Child mental health referrals	

Developmental stage	Cognitive functioning	Physical health and development	Mental health	Social functioning	Cultural and spiritual identity
Adolescence (ages 13–18)	Academic achievement <ul style="list-style-type: none"> • NAPLAN • school attendance • number of school changes • grades • suspensions • expulsions • specialised education plan • special education services 	Health checks on entry and periodically	Youth justice referrals Child mental health referrals	Youth justice referrals Child mental health referrals	Care plan TBD

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