

Navigating the Australian child protection system: The importance of formal and informal support for carers to effectively provide care to children in out-of-home care

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Abstract

Children in out-of-home care (OOHC) are a vulnerable group who often experience poorer outcomes than their peers who are not in OOHC. In 2020–2021, there were approximately 46 200 children in OOHC in Australia, with 91% in a family setting with foster or kinship carers. Data from other countries show similar patterns indicating that foster and kinship carers provide care for most children in OOHC. To effectively provide children in OOHC with the care they require, including safety, stability, and connection, the carers need a social support system that equips them to meet the needs of these vulnerable children and to prevent the breakdown of placements. The study presented in this paper draws on social constructivist and critical perspectives to examine the formal and informal social support available to carers using data from a qualitative study investigating OOHC in Queensland, Australia. Our sample is 113 carers, caring for 194 children aged 1–12 years old. We find lack of integration across formal support systems and failure to recognize the invisible workload undertaken by carers are two key challenges faced by carers. Upskilling and stabilizing the child protection work force, as well as better training for carers, is also required. Addressing these issues will enhance the social support systems of carers and improve the safety, stability, and connection of children in OOHC.

KEYWORDS

foster and kinship carers, out-of-home care, support systems

1 | INTRODUCTION

This paper examines the social support systems available to foster and kinship carers of children and young people in out-of-home care (OOHC). OOHC is generally court-ordered overnight care for children under 18 years who have been removed from their families by a statutory child protection authority (CPA) due to child protection

concerns (Australian Institute of Health and Welfare [AIHW], 2022). Children placed in OOHC are a disadvantaged and vulnerable population, who have experienced trauma, child abuse, and/or neglect. They can face cumulative disadvantage across the life span, manifesting in poorer outcomes when compared with their peers on a variety of domains including mental and physical health, education, housing, and psychosocial well-being (Mendes & McCurdy, 2019). Despite being

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placed in OOHC as a means of protecting children, some continue to experience trauma and vulnerability due to disrupted relationships with their families and communities, as well as ongoing placement instability (Shah et al., 2016).

In Australia, there were approximately 46 200 children in OOHC in 2020–2021 (AIHW, 2022). Like other countries with colonialist legacies, such as Canada (Burge, 2022), New Zealand (Oranga Tamariki, 2022), and North America (Howze & McKeig, 2019), First Nations children are overrepresented within the Australian OOHC population (AIHW, 2022). In 2021, about 1 in 17 ($n = 19\ 500$) First Nations¹ children were in OOHC; a rate of 58 per 1000 children, which is 11.5 times higher than the rate for non-Indigenous children (AIHW, 2022).

In 2021, the majority (91%) of Australian children in OOHC was cared for in family-based OOHC, with 54% in kinship care, 36% in foster care, and 1.3% in other types of home-based care (AIHW, 2022). During the same period, most children in OOHC in the USA (79%) and England (71%) were also in either foster or kinship care (UK Government, 2022; US Department of Health & Human Services, 2022). This makes foster and kinship carers a key source of social support for most children in OOHC. Kinship carers are particularly important for Australia's First Nations children, with 54% of those in OOHC placed in kinship care (AIHW, 2022). The prioritization of kinship care for First Nations children, an element of the Aboriginal and Torres Strait Islander Child Placement Principle, is enshrined in the legislation of all Australian jurisdictions to protect their connection with family, community, culture, and Country (Krakouer, 2023).

In Queensland (Australia), where the study presented in this paper was conducted, in accordance with the *Child Protection Act 1999* (Qld), both foster and kinship carers are formally screened and authorized by the CPA before children are placed in their care. The key difference between foster and kinship carers is that foster carers are not usually known to the child prior to their placement, whilst a kinship carer is usually a relative, family member, close friend, or a member of the child's community as defined by their cultural beliefs (AIHW, 2022). In this paper, we use the term “carer” to refer collectively to both foster and kinship carers. We use the specific terms “foster” and “kinship” carer when a distinction between the two carer types is required.

In this paper, we focus specifically on supports available to carers in family-based forms of OOHC, namely, foster and kinship care. This is because the ability of foster and kinship carers to look after children in OOHC is inextricably linked to their own levels of support, including formal support provided by their interactions with multiple levels of the child protection system and informal support from friends, family, and community members (Piel et al., 2017). Carers who do not receive adequate support will be less able to provide adequate care for the children in their care. Our aim is to describe the kinds of social supports received by carers of children in OOHC in Australia, show how variations in social support affect a carer's ability to care for the children in their care, and highlight which formal and informal social supports facilitate or inhibit caring for children in OOHC.

1.1 | Interaction of carer well-being and outcomes for children in their care

Carers undertake significant caring responsibilities for children, who often have complex needs and behaviours (Sharda, 2022), when their parents are deemed by a CPA officer as unable to meet their care and protection needs (Piel et al., 2017). Carers must navigate multiple services within the child protection system, such as the CPA and foster/kinship care services, and external services such as public income management (Piel et al., 2017). They must also manage a series of interpersonal relationships, including with practitioners, biological families, and the child in their care (Piel et al., 2017). Many of the challenges carers face are associated with the operation of the OOHC system itself, including excessive bureaucracy, lack of information, and involvement in decision-making for carers, as well as CPA worker churn (Smart et al., 2022). Carers frequently report high levels of stress and frustration with their role which can have a negative effect on their well-being and ability to effectively manage the stresses of caregiving (Harding et al., 2020). These challenges have also been associated with carer attrition (Smart et al., 2022).

There is evidence to suggest that the unique challenges of caring for children in OOHC may lead to higher levels of stress and burnout than experienced by other parents (Harding et al., 2020; Sharda, 2022). Some studies indicate that kinship carers report higher levels of stress and mental health concerns (Harding et al., 2020) and less life satisfaction (Delfabbro, 2017) than foster carers. This may be due to kinship carers feeling obligated to continue in challenging carer roles to preserve family connection (McHugh & Valentine, 2011; McKeough et al., 2017). Australian and international literature also suggests that kinship carers are more likely to be older, single, unemployed, in poorer health, and have lower education and socioeconomic status compared with foster carers (Delfabbro, 2017; Qu et al., 2018). Addressing carer stress and burnout is important, given its association with poor placement outcomes such as the increased risk of placement breakdown, which can compound issues for the child in OOHC associated with attachment, anxiety, and behavioural problems (McKeough et al., 2017). The literature indicates that carers receive practical and emotional support for their role from both formal and informal support systems (Cooley et al., 2019; Piel et al., 2017).

1.2 | Formal support systems for carers who look after children in OOHC

Formal support for carers of children in OOHC typically includes child welfare workers, training, and financial assistance that can support carers and the children they look after (McHugh & Valentine, 2011).

1.2.1 | Child welfare workers

In Australia, carers are usually connected with an officer from the CPA and a practitioner from a community-based Foster and Kinship

Agency (FKA), which is specifically funded to support carers of children in OOHC. The roles of these workers may include assessing compliance with OOHC standards, assessing the social context of the carer, providing practical or emotional support, training, providing information, and assisting carers to make connections with other supports (Scannapieco, 2012). International studies found that carers valued child welfare professionals providing tangible and emotional support through open communication and by linking them to other services (Piel et al., 2017). They also valued their support to manage relationships with birth families, including contact arrangements and keeping them updated on changing circumstances for the family (Austerberry et al., 2013). Whilst support from child welfare workers can help reduce stress (Scannapieco, 2012), research findings indicate that carers would like improved relationships with, and support from, these practitioners (Octoman & McLean, 2014).

1.2.2 | Training

There is substantial variation in the amount and type of training available to carers in different jurisdictions and carer categories, with some having mandatory preparatory training covering carer rights and responsibilities as well as broader training aimed at developing carer skills and knowledge (Smart et al., 2022). An Australian study of 87 carers found carers felt unprepared for their role as a carer even after completing the mandatory training sessions (McKeough et al., 2017). Similarly, international studies (e.g., Hebert & Kulkin, 2018; Mallette et al., 2020) have found that carers believe they require more training to successfully undertake their caring role. Commonly identified training gaps include how to manage complex and challenging child behaviours; grief and relationship counselling; addiction symptoms; child protection policies and processes including court proceedings; medical training including cardiopulmonary resuscitation (CPR) and medication management; children's mental health; services they can access; burnout prevention; and managing contact with birth families (Collings et al., 2020; Hebert & Kulkin, 2018; Mallette et al., 2020; McKeough et al., 2017; Murray et al., 2011). Failure to address carers' identified training needs can compound stress, with implications for placement stability and carer retention (McKeough et al., 2017). Notably, studies have found that kinship carers often have less access to formal support and training than foster carers, despite being older, having fewer financial resources, and often less time to prepare for commencing the caring role (McHugh & Valentine, 2011; Smart et al., 2022).

1.2.3 | Financial assistance

The costs of raising children in OOHC are often greater than for other children, due to complex needs (Kalinin et al., 2018). Carers usually receive some financial reimbursement from the statutory CPA for looking after a child in OOHC, and in Australia, carers may receive additional financial assistance from the Federal Government via the taxation system (AIHW, 2022). Despite this, many carers experience financial strain,

and are not aware of all available financial supports, or need assistance to access the support they are entitled to (Smart et al., 2022).

Whilst adequate formal support can reduce carer strain and improve carer retention (Cavazzi et al., 2010), evidence suggests there is great variability in how supported carers feel by formal systems. Factors that contribute to carers feeling unsupported by formal support systems include inadequate information about the children in their care; being left out of decision-making; irregular contact with support staff; worker turnover; inadequate financial assistance; and placement termination without recognition of the relationship between carer and child (Cavazzi et al., 2010; Hughes, 2014). Common barriers to accessing formal support include lack of services in regional and remote areas, issues using technology to access services, long wait times to access services, lack of knowledge about supports or eligibility, and lack of time to attend appointments or training. First Nations carers may also be hesitant to access government services due to historical and contemporary child removal practices, systemic racism, or culturally unsafe services (Smart et al., 2022).

1.3 | Informal support systems for carers who look after children in OOHC

Informal supports can include family, friends, neighbours, colleagues, and other social connections that provide both emotional and practical support to carers (Scannapieco, 2012). Informal social support helps mitigate carer stress and is positively related to carer well-being (Sharda, 2022; Sharda et al., 2019). As well as providing emotional support, informal support systems can bolster the practical resources available to the carer, for example, the provision of transport, child-care, and advice about services that help to alleviate carer stress (Gleeson et al., 2016). For kinship carers and those carers with less access to formal supports, informal social supports may be particularly important support systems (Scannapieco, 2012). Research recommends that interventions to increase the well-being of carers should focus on raising levels of informal social support within their communities, for example, through support groups for carers (Sharda et al., 2019). Support groups can facilitate both emotional support from group participation and instrumental support through connections made in the group (Sharda et al., 2019).

Evidence suggests that both foster (Butler & McGinnis, 2021) and kinship carers (Hughes, 2014) are generally satisfied with the level of support they receive from family and friends. However, foster and kinship carers experience different challenges when navigating these informal networks. For example, kinship arrangements can increase the level of strain and tension of family relationships, particularly with the parent of the child in OOHC (Hughes, 2014). Irizarry et al.'s (2016) study on kinship carers also found that for many First Nations kinship carers, especially those that are grandparents, relationships with the child/ren's birth parents declined. For foster carers, the level of family and friend's understanding of the fostering role mediated their experiences of support from these networks (Butler & McGinnis, 2021). In Mallette et al.'s (2020) study, some foster parents reported using online and in-person foster parent support groups so that they could

access a support network who had first-hand experience, allowing for a deeper level of understanding of their experiences and support needs which was often lacking from other forms of informal support.

This paper seeks to add to existing knowledge by providing up to date data from a large qualitative sample of the experiences of carers in Queensland (Australia). It contributes by describing the types of supports carers access when navigating the child protection system and identifying the challenges and gaps they experience within this formal system. Specifically, the paper addresses two questions:

1. What are the sources and types of formal and informal supports that carers access when looking after children in OOHC?
2. What are the challenges and gaps in carers' formal supports that may impact their ability to care for children in OOHC?

2 | METHOD

In this paper, we examine qualitative data from a larger longitudinal study funded to investigate the journeys of children, their carers, and birth parents through OOHC in Queensland (Australia). There are several distinctive features about the OOHC system in Queensland. For example, there are fewer children in kinship care (40.9%) compared with the national average (54%) (AIHW, 2023). There is also a higher proportion of First Nations children in Queensland who are *not* living with their First Nations or non-Indigenous relatives/kin or other First Nations caregivers (48.7%) compared with the national average (36.7%) (AIHW, 2023). The data we report on comes from the first wave of semi-structured, in-depth interviews with carers.

The study is underpinned by both constructivist and critical epistemologies. Constructivism informs the study design as we recognize that people actively create and affix subjective meanings to experiences and objects through social interaction; a critical perspective means that we are cognizant of the role of social inequalities and power relations in shaping human experiences (Padgett, 2012). The adoption of a critical perspective is important given the overrepresentation of children from disadvantaged and First Nations families in the OOHC system.

2.1 | Sample

A purposive sampling approach was used to recruit Queensland foster and kinship carers who cared for at least one child in OOHC who met the following criteria: (1) The child was aged 1–12 years; (2) the child resides in one of the three study regions (Far-North Queensland; South-East Queensland; and South-West Queensland); (3) the child was placed in OOHC on a short-term or long-term Child Protection Order; and (4) the child/ren's carers were supported by one of the project's four Industry Partners, who provide FKA services.

Recruitment involved two stages. In Stage 1, the Queensland CPA produced a random sample of 486 children who met criteria one to four, as listed above. The four Industry Partners then provided the recruitment to the eligible carers via their FKA worker. Interested carers were able to contact the research team directly or provide their

consent to the FKA for the research team to contact them. This stage yielded 63 carers. In Stage 2, the project's Industry Partners distributed recruitment materials to all carers supported by their FKA who cared for children that met the criteria. This resulted in the recruitment of an additional 50 carers.

The final sample of carers for Wave 1 was 113 carers, who were caring for 194 children. Most participants were foster carers, female, and non-Indigenous. Carers ranged in age from 21 to 81 years of age (average 51 years). We note that the majority of carers was over 50 years of age, which is substantially older than the Australian average age for biological parents of children of 0–16 years. The average age of the commencement of parenthood in Australia is under 30 years. At the time of interview, they resided in households of between 2 and 16 people (average five people). Further characteristics of the participants are outlined in Table 1.

2.2 | Data collection

The sample comprised 113 carers. In most cases, the interviews were undertaken with each carer individually. But in 11 cases ($n = 22$ respondents), carers were in a personal relationship and wanted to be interviewed together. The interviews were conducted during the period July 2021 to August 2022. The Human Research Ethics

TABLE 1 Participant characteristics.

Item	Characteristics of participant	Total ($n = 113$)
Type of care provided	Kinship care	36
	Foster care	77
Gender	Female	91
	Male	22
Cultural identity	Aboriginal and/or Torres Strait Islander	11
	Non-Indigenous	102
Age (years)	20–29	4
	30–39	13
	40–49	31
	50–59	33
	60–69	28
	70–79	3
	80–89	1
Main income	Full-time work	46
	Part-time work	9
	Carer payment	45
	Reliant on partner	8
Experience as a carer (years)	Retired/prefer not to say	5
	<1	3
	1–5	57
	6–10	24
	>10	29

Committee at both The University of Queensland and one of the project's Industry Partners provided clearance for the study. A semi-structured interview protocol was implemented, covering four broad topic areas: (1) about you as a carer; (2) experiences of looking after the study-eligible child/ren in OOHC; (3) experiences of the OOHC system; and (4) relationship with the child's birth parent/s and/or extended family.

Interviews lasted between 37 and 268 min, with the longer interviews being undertaken with carers looking after multiple study-eligible children in OOHC in the target age range. Typically, interviews lasted 60–90 min where carers looked after up to two study-eligible children. In instances where the carer looked after more children who were eligible for the study, the interview took an additional 30 min on average per additional child. In these instances, carers could decide if they wanted to break the interview up over multiple sessions. Interviews were conducted via phone ($n = 47$), in-person ($n = 32$), and online platforms like Zoom ($n = 23$). Nearly all participants consented to the interview being recorded ($n = 111$). Two participants did not consent to audio recording, and the interviewer took written notes of those participants' responses. All interviews with First Nations carers were conducted by a First Nations research team member.

2.3 | Data analysis

Audio-recorded data were transcribed verbatim by a professional transcription service. The transcripts ($n = 100$) and written notes ($n = 2$) were then de-identified before being uploaded into NVivo, a qualitative analysis software program. All participants were allocated a participant code based on the chronological order of the interviews, commencing with CA001. Carers interviewed together as a couple were given the same root code and then distinguished by an additional number (e.g., CA033-1 and CA033-2). The de-identification of First Nations participants' transcripts was completed by First Nations members of the research team, in consultation with our First Nations Advisory Group.

Braun and Clarke's (2013) widely accepted guidelines informed the thematic analysis of the data. Initially, 10 researchers within the team familiarized themselves with the data of one transcript to begin creating an initial coding frame relevant to the research foci. To further refine the initial coding frame, the researcher team was then split into pairs, with each pair allocated to a different set of transcripts for review. The researcher pairs met to individually discuss their coding of their allocated transcripts, before then meeting back with the entire team to discuss any refinements and agreeing on a coding frame that would be applied to the full dataset. In addition to this process, the research team reviewed and edited the coding framework to ensure the research questions could be answered.

Once the transcripts were coded, a smaller team (authors A, B, C, and G) undertook thematic analysis of the data related to carers' experiences of formal and informal support systems. The first stage of this process involved refining the coding within the broader "parent" codes and then looking for themes within the data. For example, the

theme "navigating and fighting the system" emerged when we grouped together codes related to participants' concerns about "carer entitlements"; "red tape"; "rationed resources"; and "worker churn and variability." Throughout the analysis, the author team explored similarities and differences between the themes emerging in the data by different characteristics of the participants (e.g., length of time as a carer). Whilst most of the themes were shared across the interview data, points of difference or emphasis are discussed in the analysis.

3 | FINDINGS

We begin with an overview of the sources of informal and formal support carers reported drawing on when looking after child/ren in OOHC. We then turn to consider themes related to challenges and gaps in their formal support systems.

3.1 | Overview of informal support systems accessed by carers

Nearly all carers discussed how critical informal support was for helping them navigate the everyday challenges associated with caring for children in OOHC. There were three key sources of informal support that the carers in this study drew on for practical and emotional support. Two thirds of the carers used more than one source of informal support. Each of these sources will be discussed separately to explore the type of support they provide.

Family was the most prevalent source of informal support, used by nearly all carers in our study. The term family is used broadly to include their partner, older children, siblings, parents, and the child's family members. The most common type of support provided by family members was practical support in the form of everyday child rearing and minding activities such as preparing lunches, school drop off and pickups, and taking children to appointments. Carers described the family members as all working together to care for these children. Family support was especially important in times of emergencies, as this carer recalled "one night ... I was really sick, I had to call the ambulance ... I rang my sister at 10 o'clock at night, she came over, she sat with the kids" (CA013, Foster, Female, 62 years old). Many carers in our study relied on family members to look after the children in their care for short periods of time, such as over a weekend if it was within the 48 h window permitted by the CPA. In some cases, family members became formally approved carers so that they could look after the children for longer periods when needed.

Physical resources such as food, clothes, and assistance with housing were another form of practical support that family members provided to a few carers. In addition to practical support, a smaller group of carers used family members for emotional support such as parenting advice. Families also played the important role of providing a sense of social inclusion and belonging through accepting the foster child/ren as part of the family. A foster carer was appreciative of her parents for "treating [child] like one of our family and helping [child]

feel included" (CA002, Foster, Female, 42 years old). Similarly, a kinship carer was grateful that "[partner's] parents have really just adopted them being in our family" (CA024, Kinship, Female, 21 years old).

Approximately half of the carers drew on *friends and community members* for support. Community members included church members, work colleagues, neighbours, teachers, parents at the school, and community groups. Like family, friends and community members mainly provided practical support in terms of child rearing and minding and, to some extent, emotional support such as parenting advice and social get-togethers.

Approximately a quarter of carers in the study relied on *other carers*. They offered similar types of support as provided by family and friends, such as child rearing and minding and social get-togethers. Parenting advice and emotional support from other carers, however, was the most important and prevalent. One carer said, "Carers are a carer's best friend" (CA059, Foster, Female, 49 years old). Carers accessed other carers through support groups and through the training courses. Carer support groups allow carers to ask questions about things they are unsure of, for example, whether they can take photos of the child. Unlike most other informal support, carers are able to offer advice from their first-hand experience. In addition, other carers are aware of the need for confidentiality that friends and family may not understand, as explained by this carer:

I have a foster carer friend who has become a really great friend of mine. So having her, she's a great support. Because with the confidentiality, it's hard. You can't just talk to everybody about the situation and the children. But being another foster carer, she knows the confidentiality and she just understands.

(CA074, Foster, Female, 52 years old)

Some foster carers were concerned that their informal support network was shrinking. The reasons carers provided for the contraction of their support network included ageing parents that were too frail to help, parents who have passed away, older children starting families of their own, friends or family who have moved away, friends who did not support their decision to be a carer, partners who ended the relationship, and other carers who stopped fostering children. Sometimes, networks contracted due to the behaviour of the child they were supporting. One kinship carer commented:

And even my family won't help out with the kids. My mum used to, and she's got too traumatised by their behaviours and language and things like that she won't at all. So, I have no family support really. Some family members have tried.

(CA091, Kinship, female, 49 years old)

Shrinking support networks due to the behaviours of the child in OOHC was a challenge experienced by both kinship and foster carers.

One carer explained how they chose not to have friends, so they did not inadvertently disclose confidential information. Whilst another carer reported not having informal supports due to a lack of time to nurture them. She commented, "Informally, pretty much no one anymore. And no fault of anybody. I don't have time for friends, to be honest ..." (CA078 Foster, Female, 58 years old).

3.2 | Overview of formal support systems accessed by carers

3.2.1 | Child protection sector

All carers spoke of being connected to formal support systems as part of their caring role. The support was primarily provided through four sectors, child protection, education, health, and disability. As might be expected, the primary source of their formal support was the child protection sector. As formal carers, they were all entitled to financial reimbursement for their caring role. Some carers reported receiving extra payments due to the complexity of the child's care needs.

The CPA and FKA were the most discussed source of formal support for carers. Notably, a small subset of carers who had recently been appointed long-term guardianship of the child indicated that this reduced the involvement of the CPA and ceased the support from the FKA. The impact of this on the resources available to the carer and child was most noted in households with multiple children under different forms of child protection orders. Carers had mixed views regarding the level of support they received from both the CPA and/or their FKA. Some, like this foster carer, reported positive experiences:

I feel that the Department has been quite supportive. They visit quite often, which is good. If I feel that there is a problem or an issue with [child], I can ring and I can talk to them and they will offer me advice.

(CA004, Foster, Female, 63 years old)

As illustrated in this excerpt, carers generally felt supported when their allocated workers were engaged and responsive to their requests for advice or support. For many, their experience of support varied over time and was specifically tied to their working relationship with their allocated CPA and FKA workers. This meant many carers tended to engage with one worker over another. New carers and those who experienced frequent staff turnovers often felt less supported, particularly by the CPA, than those who had been carers for a longer period or had stable CPA/FKA workers and well-established informal support networks. Whilst carers usually had one FKA worker, carers who looked after multiple children, particularly from different families, often had a different CPA worker for each child. Many raised the policy of each allocated CPA worker being required to visit the home as disruptive to the children and saw this as an extra burden, rather than extra support for their caring role. For example, one carer remarked:

You just end up having a lot of Child Safety officers come through ... It's just interruption for the kids, because they don't always feel great when there's a Child Safety officer in the house. And if there's four, they've got to come to your house four times.

(CA012, Foster, Female, 40 years old)

Respite was another form of support carers reported accessing from the child protection system. Some carers had well-established patterns of receiving formal respite, whilst others did not access it or preferred to use more informal arrangements.

3.2.2 | Education sector

Due to the age of the children eligible for the study (1–12 years), the education sector acted as another formal source of support. Childcare and/or schools were raised in 100 of the 102 interviews. Carers of younger children often framed childcare as an opportunity for the child in OOHC to interact with other children and as an opportunity for themselves to have a break from being the primary carer. Whilst carers had mixed experiences, most identified some positive forms of support from *schools*:

I have a really good relationship with the school that my grandson was going to ... they have a brilliant head of special education and a special education department, which they were a fantastic support. And we worked very well together to get my grandson to a point where he's now in mainstream school and doing really well.

(CA104, Kinship, Female, 40 years old)

Carers valued those education providers who were communicative, willing to listen, and make adjustments to accommodate the child's needs.

3.2.3 | Health sector

The health sector was another commonly identified source of formal support for children and the carer themselves. The importance of having good primary health care from a paediatrician and/or general practitioner was identified in over half of the interviews. Whilst the majority of carers reported accessing the public health system, only a small number of the 54 carers looking after First Nations children reported accessing support via First Nations health services. A small group of carers who were financially secure reported that they used private health providers to expedite care for children:

But there's been lots of times with [child] over the years where the public health system, he needs something done and they can't get him in. So we got private

health cover when he was very little, and we've gone ahead on our own decisions and got him a private doctor who can do what needs doing quicker than having to wait.

(CA071, Foster, Female, 64 years old)

Carers, particularly of children with complex needs and trauma, also reported engaging with a wide range of allied health and medical professionals, including psychologists, counsellors, occupational therapists, speech pathologists, and Ear Nose Throat specialists. To access these services, many carers reported having or trying to apply for funding from Australia's National Disability Insurance Scheme, a national government-funded scheme to cover costs associated with a disability. Carers valued the additional resources that the National Disability Insurance Scheme could provide but found it to be a lengthy process. Children had to be assessed and receive formal diagnoses before being assessed for eligibility for the scheme.

3.3 | Challenges and gaps in carers' formal support systems

Four interrelated themes were identified across the data relating to challenges and gaps in carers' formal support systems: (1) navigating and fighting the system; (2) practical and emotional support needs; (3) training needs; and (4) poor integration of support systems.

3.3.1 | Navigating and fighting the system

Nearly all carers experienced the child protection system as complex. They shared an expectation that their CPA and FKA worker should act as a guide to help them navigate the complexity. Yet, dominant within the data was a view that carers often need to fight for information about how the system operates, including what supports and resources are available. Whilst some carers were angry about needing to fight for support, many remarked that these challenges were symptomatic of the system being under strain and under resourced. Three subthemes reflected different aspects of carers' experiences of navigating and fighting the system.

The first subtheme was *worker churn and variability*. Most carers indicated that they had, at some point in their caring journey, been supported by "good workers" within the CPA or their FKAs. These workers were characterized as knowledgeable, skilled, and available, acting as a guide through the child protection system. Stability of CPA and FKAs was highlighted as helpful for carers and children. However, many also experienced disruptions caused by frequent worker turnover:

the only thing that is frustrating and that I'm not agreeable with, but, again, it's out of my control and it's not something Child Safety control too, would be the turnover of caseworkers ... Because then the new case

worker comes in and has a different perspective and ... it's like, "Girl, we have the train rolling, jump on board. Let's go."

(CA048, Foster, Female, 29 years old)

As illustrated above, the need to build new relationships to get the new worker "up to speed" on the situation and adjust to their different approach was viewed as particularly disruptive by carers. These challenges were exacerbated when carers felt that their newly allocated workers had inadequate knowledge and skills or a poor working relationship with the carer or a lack of time to read the child's casefile. In one instance, a foster carer indicated that "depending on who's assigned to us next, if we don't click, then I won't use them for support" (CA020, Foster, Female, 38 years old).

The second subtheme was *rationed carer resources*. This reflected a view that resources and support that carers and children were entitled to from the CPA and FKAs were often not proactively offered. Instead, the provision of support was perceived by some to be reactive:

because of the escalating behaviour of [child] and the [police] call, that brought about a more solid response from [CPA], where they got him into a psych[ologist] or gave us the approval to have him to a psych sooner. It was kind of pushed through then.

(CA077, Kinship, Female, 58 years old)

In this instance, the carer was only able to access psychology support for the child after an "extreme outburst" that involved the police. The difficulty in managing highly challenging caregiving situations with limited support was particularly noted for older carers, who were also managing other age-related life transitions. Another subset of carers indicated that carers needed to know what support they were entitled to, to advocate for themselves to access it.

But it's like they try and avoid telling you that you can get support because they don't want to give it. And once you know that you can get those supports and you can just turn around and go, "I'm not doing this. If you want this to happen, then that's what you need to do," life is a lot easier.

(CA018-2, Foster, Female, 43 years old)

As illustrated above, this knowledge was perceived to come with longer experiences of caring.

For some, the constant need to ask for support meant that their engagement with formal OOHC support systems became somewhat adversarial, particularly when they needed to escalate matters by contacting the team leader/manager or other service providers to help get a response to their request:

... most times now I send the email to the [CPA] worker, as well as to our [FKA] worker, and she always

gets a copy. If I have to send a second one, it then goes to the team leader as well as the social worker, my worker, and she always includes it to her manager. And if we have to go further, then she also follows up to get the manager. Because it's just got that way that things are not getting done.

(CA026, Foster, Female, 70 years old)

A small number of carers indicated that they accessed advice and support from other carers they knew when they were unable to get timely responses from their CPA or FKA workers.

This was related to the third subtheme, *red tape and radio silence*. Paperwork and lengthy approvals processes, due in part to challenges contacting key workers, were identified as significant barriers to accessing support and resources, such as respite and childcare. For example:

[Respite] you've got to organise it and then you've got to get an ATC [authority to care approval] ... They've got to be approved carers ... So, it doesn't seem like a big deal until you've sort of got to get it all together.

(CA002, Foster, Female, 42 years old)

The burden of administrative requirements for accessing support was particularly noted for those in paid employment. One kinship carer described feeling "completely overwhelmed" trying to complete the paperwork and working (CA035, Kinship, Female, 60 years old). This carer also highlighted the negative impact of protracted approval processes on children:

And you can see why sometimes it falls down and kids slip through the cracks, because it takes so long to get help ... Nearly two years to get behaviour management plans in place. If they were in place 12 months or more ago, maybe [child] would never have been suspended.

(CA035, Kinship, Female, 60 years old)

There was a subset of carers for children where guardianship and decision-making rights remained with the birth parents. Many of these carers perceived the CPA to be unwilling to, or hesitant about, engaging with the birth parents, which could delay getting parental approvals for needed supports or actions. For example:

Because I worked full-time and running my business, I said, "I need this baby in daycare." I literally had to fight the system ... They [CPA] kept delaying getting her ... immunisation stuff, because they [CPA] didn't know how to engage the mum. So, I had to go and engage the mum and say, "Oi, I need to get her fucking vaccinated. Give me all your shit [documentation] so I can go get this done."

(CA050, Foster, Female, 35 years old)

Whilst this carer reported going directly to the birth parents to negotiate outcomes, most of the other carers in this situation left guardian consent processes to the CPA worker. Although these carers voiced frustrations at the lengthy process, they also indicated that they were eager not to anger birth parents in case they withdrew consent for travel or certain medications.

3.3.2 | Practical and emotional support needs

Carers commonly identified that a lack of practical and emotional support contributed to stress and burnout. Informal networks provided emotional and practical support (see Section 3.1), and there was a dominant view that formal support systems, particularly CPA and FKAs, should also contribute to addressing these needs. The carers' comments centred around three key subthemes.

Many of the carers critiqued the lack of *financial resources*, particularly for children to be involved in extracurricular activities, undertake health assessments, and implement home modifications that were not directly linked to the CPA's case plan. Carers felt that children then "missed out" on activities and other resources that could assist them. The greatest gap in financial support was noted by a subset of carers looking after children with complex health needs. One carer recounted that the cost of daily medical supplies like catheters, gloves, nappies, and wet wipes that she needs to send to day care exceeded the Complex Support Needs Allowance she received. In instances like this, the burden of covering these costs fell to the carer, placing strains on household budgets, particularly when there were multiple family members and children in OOHC within the home.

Whilst challenges and gaps in access to formal *respite* were noted across the data, it was the absence of short-term respite options that was most dominant in carer accounts. Many carers conceptualized short periods of respite as an opportunity for self-care and connection with their own informal networks of support, with one commenting "if you look after yourself, then you'll be a better carer" (CA002, Foster, Female, 42 years old). Given the special needs of children in OOHC, a small number of carers suggested that the FKAs should host a pool of approved babysitters or youth workers to help provide this support. For some carers, particularly those with extensive informal support networks—gaps in their formal systems regarding respite only became evident when their natural supports were unavailable:

Yeah, I just need that opportunity to say, "Hey, my family's not available, none of my approved people that are available. I need to call on another carer to just take him for an hour or two without all the complicated crap that comes with it"

(CA084, Foster, Female, 54 years old)

Carers indicated that their lack of knowledge about formal respite processes and the bureaucratic process of approving respite contributed to their difficulties in this situation.

The need for *transport* support was also raised by several carers, particularly by those who were responsible for managing the logistics of contact with birth families:

I have four of my own children with their own extra-curriculars and sometimes that can get in the way of me making plans for [child in OOHC] to meet up with her brothers ... If we had a youth worker that picked them both up from school and took them for a play and then we pick them up from there, so some of that burden was taken off us. Whereas, at the moment, that expectation is with us ... sometimes that's a bit hard.

(CA002, Foster, Female, 42 years old)

Like this foster carer, others also highlighted how a lack of transport assistance could prevent the child in their care from having more frequent family contact. This was particularly noted in households that included multiple children or had limited access to vehicles.

Carers linked the availability of practical support from formal support systems to their emotional well-being. However, a small number of carers stipulated that practical and emotional support should not be conflated. For example, a foster carer explained that whilst she would like emotional support from her CPA, she felt that asking how she was whilst picking up children for family contact was not appropriate, as she did not want to talk about the children in front of them. The need for emotional support from formal sources was particularly noted for carers with less experience.

3.3.3 | Training needs

This theme related to the knowledge and skills that carers required to feel capable to meet the needs of the child/ren in their care. Many carers felt that they had not received adequate training from their formal support systems, namely, the CPA or their FKA, in at least one area that impacted their caring ability or compounded the challenges of caring. Carers highlighted the importance of frequent and flexible training modules, with some suggesting the use of Zoom to reduce the burden of travel whilst still enabling connection with other carers. This was particularly important to carers in full-time employment.

Whilst carers identified a variety of training needs, including knowledge of legal and court process in OOHC, three dominant subthemes emerged. Most carers spoke of the need for training about *child development, attachment, and the child's unique support needs*. This subtheme was particularly dominant for carers looking after children with complex support needs associated with trauma, mental health, challenging behaviours, and disability. Carers employed in child-related fields were less likely to suggest the need for this type of training. However, for others, difficulties in accessing support from other sectors (e.g., disability and education), due to cost and lengthy waitlists, compounded the difficulties they experienced and reinforced their need for training. As one carer remarked, "It's a lot of waiting

and you've got traumatised kids and what are you supposed to do in the meantime if no one's providing you with support on how to manage those behaviours? We've been fumbling through ..." (CA035, Kinship, Female, 60 years old).

Training about how to *manage contact and relationships with birth families* was the second subtheme. Carers reported that whilst they were often the ones responsible for arranging and supervising contact with birth families, they felt unqualified and unprepared to do so. As one carer commented:

you're actually putting an inexperienced person ... most carers come in and they've got beautiful hearts and they want to save the world ... and then you take the children to a contact and the parent turns around and goes, "Yeah, you dog, cunt. Get the fuck out. Leave my kid alone." You're like, "Oh, shit. Hang on"

(CA058, Foster, Female, 54 years old)

Also included in this subtheme was the need for support to address children's challenging questions, particularly after contact visits, about why they cannot live with their parents.

The third subtheme was the need for training about the *child's culture*. This was dominant within the data of carers of children from different cultural backgrounds to their own. For example, despite it being a legislated requirement for First Nations children to have a Cultural Support Plan, the majority of carers for First Nations children reported that the child did not have, or the carer was unaware if they had, a Cultural Support Plan. For example, when this non-Indigenous foster carer was asked if the Aboriginal child in her care had a Cultural Support Plan, she replied: "Not that I'm aware of. No. But I would be interested if someone could put me on the path for that" (CA004, Foster, Female, 63 years old).

Keeping children connected to their culture is important for their sense of identity, belonging, and well-being (Krakouer, 2023). Given the importance of cultural support and connection for First Nations children, a future paper will explore this issue in more detail.

3.3.4 | Poor integration of support systems

Carers felt that the child protection system was poorly integrated with other sectors such as health, education, and disability support. This meant that children often "fall through the cracks" (CA046, Foster, Female, 38 years old). Two subthemes emerged, and the first was *convincing and coordinating*. This related to the work that carers needed to undertake to first *convince* the CPA that the child needed a particular type of support. For example:

I'll bring up concerns regarding possible assessments that needs a practitioner ... recommend that a [foetal alcohol spectrum disorder] assessment is done ... But then for Child Safety to say, "Oh, those could just be symptoms of trauma," and it's like, "Well, how do we

know until we've had them assessed?" ... I'm not an expert, I'm not a practitioner or anything, but I live with these girls, so I can see things ... So, maybe there's something in it.

(CA051, Foster, Female, 36 years old)

The second element of this subtheme related to the *coordination* activities, such as identifying services and supports, getting approvals or referrals, accessing waitlists, and then managing appointments. A lack of service integration often meant that carers felt like no sector wanted to take responsibility for supporting the child, compounding the amount of coordination they undertook:

... we have been pushing for a while now to try to get her help ... I think the Department has sort of pushed it back on the school and the school was saying, "We should be looking outside, for a specialist." ... so they send us to the GP, the GP will say, "Hang on, actually, you just need to go and get them [at school]," and it's been a lot of pushing it off onto somebody else ... So that's where we're having a bit of a struggle at the moment.

(CA046, Foster, Female, 38 years old)

The subtheme of *convincing and coordinating* was particularly noted for carers in employment with limited time and those living in regional areas with limited access to services.

The second subtheme was *mismatch of needs and support*. Many carers, particularly those caring for children with complex needs, indicated that other sectors were not "set up" or sufficiently trained for working with children in OOHC. This was particularly noted in the education setting:

The other challenges is school ... teachers not accepting children that suffer from trauma ... they're not educated around trauma. There should be a set subject in ... "Oh, this is a type of child, ADH, kids trauma, you name it, you're going to be teaching in your class. How are you going to handle?" Let's do some strategies around that.

(CA027, Foster, Female, 56 years old)

Carers remarked that this lack of understanding hindered efforts to integrate support and often resulted in children being excluded from school or other activities like holiday camps.

4 | DISCUSSION

This paper examines the social support systems available to carers who look after children in OOHC. Our findings show how carers draw on both formal and informal sources to provide care, support, and resources to meet the needs of children placed with them. Informal

support was mainly provided by family, friends, community members, and other carers. Carers noted the importance of both practical (e.g., transport, childcare, advice, and housing) and emotional support such as welcoming the child as a member of the family and social get-togethers. Formal support was mainly provided by the CPA, education, disability, and health sectors. Whilst carers identified factors that facilitated and enhanced their ability to care, their accounts also illuminated significant barriers, gaps, and challenges in their formal support systems that negatively impacted the provision of care.

Like other studies (Fergeus et al., 2019; Qu et al., 2018), issues associated with bureaucracy and red tape were commonly identified challenges. In some instances, carers elected not to access certain supports (e.g., respite) due to the approval process. These challenges were compounded by poor integration between the child protection system and key sectors such as health, education, and disability support. Together, bureaucracy and poor integration resulted in significant delays in children receiving required assessments and supports. This in turn placed further burdens on carers as they tried to “fumble through” in managing complex needs and behaviours on their own. This was identified as a significant source of stress for carers and, in some cases, contributed to the shrinking of their informal support networks. These findings reflect other studies, which identify complex behaviours as a top stressor for carers (Butler & McGinnis, 2021; McKeough et al., 2017) and a source of friction between the carer and others in their informal networks, particularly family (Mallette et al., 2020; Thompson et al., 2016).

An online and mobile app was introduced in Queensland in 2017 to help provide carers with improved access to tailored support and information, as well as platform for submitting reimbursement claims. Whilst the app is potentially useful for accessing information about available support services, it does not replace the need for providers to work together across sectors. Better integration of service provision across sectors is required to take the burden off carers attempting to navigate and access services needed by the child.

McKeough et al. (2017) identified that carers require more training to help mitigate the stress of managing challenging behaviours. We agree that training is required but argue that it alone is not sufficient unless systemic issues associated with poor integration and timely responses are addressed. Chambers et al. (2010) warn that delays in referring children in OOHC to services may prolong the identification of needs and impede the effectiveness of interventions. They suggest that “earlier identification [of difficulties] might increase stability of placements and educational functioning and enhance opportunities for reparative experiences” (p. 514).

Emerging from gaps in formal support, carers also highlighted the need for ongoing, flexibly delivered training that was responsive to the needs of the carer and the individual children they cared for. These needs were particularly noted in relation to complex behaviours, cultural connection, and managing relationships with birth families, similar to the findings of other studies (MacGregor et al., 2006). Like Smart et al.'s (2022) findings, the carers in our study saw training as an opportunity to build peer networks with other

carers. Whilst carers, particularly those in employment and regional areas, called for flexible online delivery, the development of training modules should focus on this dual purpose of knowledge building and connection. Our study and the extant literature (Mallette et al., 2020) recognize the importance of carer peer networks as an informal support for carers.

Similar to Fergeus et al. (2017), our findings recognize the important role that carers play in driving access to services to enhance the health and well-being of the child/ren they care for. The carers in our study undertook large, often “invisible,” workloads in seeking, accessing coordinating, and implementing support to assist the child in their care. We noted particular challenges for those who were time poor due to employment and those who lived outside metropolitan areas with limited access to services. This workload carried by carers was compounded by inadequate financial resources for their caring role. Previous studies (Fergeus et al., 2019; Randle et al., 2017) have also suggested that carer payments and allowances may not be sufficient to cover the costs of caring, particularly for children with complex health needs. Our findings support calls for greater recognition of and resourcing for the invisible workload carers carry. This will help ensure that carers have sufficient capacity and support to address the complex needs of children in OOHC.

The importance of the working relationship between carers and professionals, particularly CPA and FKA workers, was also noted. Aligned with existing knowledge (Smart et al., 2022), we noted variations in the support provided by CPA/FKA workers to different carers but also variations in support provided to individual carers over time due to worker churn. Despite mixed experiences, most carers identified at least one supportive CPA or FKA worker in their caring journey. However, nearly all the carers in our study also shared frustrations about the lack of communication and engagement, unskilled workers, inconsistent practice approaches, and feeling unheard. These factors are consistently identified within the literature and linked to broader issues such as high caseloads and worker churn (Smart et al., 2022). In this study, carers saw worker churn as a significant disruption to their support system, indicating a need to stabilize the child protection workforce. The issue of high child protection worker turnover is not unique to the Queensland context. The international literature routinely identifies the negative impact that turnover and staff shortages have for creating adverse work cultures and additional stress for the workforce (Griffiths & Royse, 2017; Rittschof & Fortunato, 2015).

Fractured and/or hostile relationships between the CPA, carers, and birth parents also created challenges for carers, such as experiencing abuse at contact or, in the case of parents retaining guardianship, delays in getting approvals. Like other studies (Collings et al., 2020), the carers were challenged by children's questions about birth families, particularly after contact. Confirming existing Australian findings (Collings et al., 2020), carers reported the responsibility for managing contact was often placed on them, a role they felt inexperienced and under supported in. This experience may vary from that of carers in jurisdictions where parent contact is seen as a CPA and/or FKA responsibility. Our findings speak to the need for reform

regarding how parents are engaged by both CPA workers and carers. There is a great need for research with agencies, carers, and birth parents to better understand how to bring these key stakeholders together to support children in OOHC.

5 | STUDY LIMITATIONS

Our findings need to be considered within the scope and limitations of this study. First, purposive sampling meant that participants only represent carers who receive formal support from four FKAs from three study regions in Queensland. Second, although the research team asked caseworkers to approach all carers who were eligible for the study, it is possible that there was some selectivity in who was informed about the study. Further, self-selection bias (those that agree to participate vs. those who do not) may mean that participants may have different experiences and characteristics from those outside our sample. Whilst our findings are not generalizable, our sample ($n = 113$) is large for a qualitative study. Aligned with the study's epistemological stance, our purposive sampling approach and use of semi-structured interviews provided rich insights into the experience of formal and informal supports for carers, enabling the research questions to be addressed.

6 | CONCLUSION

Foster and kinship carers look after the majority of children in OOHC, making them a crucial social support. By highlighting the complex and bureaucratic environment carers navigate when looking after children in OOHC, we have identified factors carers consider to aid their caring roles, including the importance of positive interpersonal relationships with formal and informal supports. However, change is required to ensure that children in OOHC are not disadvantaged by the operation of the formal support systems around the carer. We call for more integrated support systems where providers work together with providers outside their own sector to simplify the process and, in a timely way, put the support in place for the child to lessen the "invisible workload" undertaken by carers in coordinating the services across sectors. Further efforts to upskill and stabilize the child protection work force are also required. Addressing these issues will enhance the social support systems of carers and bring about greater safety, stability, and connection for the vulnerable children in their care.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflict of interest.

DATA AVAILABILITY STATEMENT

Due to ethical reasons, we are unable to share the data described in the manuscript.

ETHICS STATEMENT

This study received approval from the University of Queensland's Human Research Ethics Committee (2020001937). It also received ethical clearance, from UnitingCare's Ethics Committee (Healy 02092020). The study complied with ethical standards and the conditions outlined in the approval. All participants provided either written or verbal consent to take part in the study, in accordance with the study's ethical clearance.

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ENDNOTES

- ¹ The term First Nations will be used throughout when referring to Aboriginal and Torres Strait Islander peoples of the country now known as Australia.

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