



CHILDREN IN OUT-OF-HOME CARE IN MALTA



Kummissarju għat-Tfal
Commissioner for Children

CHILDREN IN OUT-OF-HOME CARE IN MALTA

Key Findings from a Series of Three Studies
Commissioned by

THE OFFICE OF THE COMMISSIONER FOR CHILDREN

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Message from the Commissioner for Children

Ms Helen D'Amato

There is more than one reason why we should be pleased with the research that is summarily described in this publication. One such reason is that this work illustrates the principle that all efforts that are made towards bettering the situation of children should rest on a solid foundation of scientific research. In this respect, this tripartite piece of research is valid in that it replaces anecdotal evidence regarding out-of-home care for children in Malta with a well-rounded body of scientific facts. This means that the recommendations that are made in this report can be more easily understood and subscribed to when they are read in the light of the findings that are presented.

Another important element about this research is that it evaluates the outcome of out-of-home care solely in terms of the well-being of the children in care. This is important in view of the need to make out-of-home care in Malta more child-centred and less service-driven and ultimately more respectful of the rights of children.

This research studies the entire cohort of its target group of children and it underlines the principle enunciated in Article 2 of the United Nations Convention for the Rights of the Child, namely that the rights of children should be enjoyed by all children without discrimination, and that any disparity among children in the enjoyment of their rights is a matter of grave injustice.

Finally, it is the very subject-matter that highlights so prominently the importance of this research. The right of the child to be cared for in a social environment that is conducive to its well-being is easily the most fundamental of all the rights of the child since it is through such an environment that a child can acquire the emotional and psychological stability that is necessary to the enjoyment of almost any other right. Children thus are vulnerable because their overall well-being hinges on whether such an enabling environment is available to them. Children in out-of-home care are doubly vulnerable because of the disruptions in their natural family milieu and the difficulty in providing them with an alternative arrangement that can make up for the lack of such milieu.

This research should not be seen in isolation but in the context of local policy developments in the field of out-of-home care. In this respect, I would like to mention and applaud the strong investment that has been made in recent years to shift the balance of out-of-home care from residential care to foster care, the importance of which is strongly borne out by the findings of this research. This should in no way reflect badly on the care given by religious institutions. Rather it should be seen as a development that recognizes the fact that children's needs are best met in a family environment. We are also at a time where a much needed national strategy for out-of-home care is being formulated to map out the road ahead in this sector. I am confident that this research will provide a useful compass to chart such a roadmap.

I cannot conclude without paying thanks to Ms Carmen Zammit, the former Commissioner for Children, who took the visionary step of commissioning the research. Heartfelt thanks are due also to the research team, led by Professor Angela Abela, to the focus groups which helped set the parameters of this research and to the staff of the Office of the Commissioner for Children for their untiring logistical support. Finally, my sincere thanks goes to all the children who at the time

were in care, those who had already left the care system but were ready to share their experiences as well as the carers, social workers and teachers whose participation forms the very core of this research. The only way that justice can be made to their selfless efforts is by ensuring that this research is effectively used as a tool to improve the well-being of all children in care, and that further research is carried out, as suggested in the research report, to shed more light on the reality of out-of-home care in Malta.

Foreword

Professor Jane Aldgate, Professor Emerita at the Open University UK
Dr. Maureen Cole, Dean, Faculty for Social Wellbeing, University of Malta

The well-being of children is increasingly at the centre of current policy and practice affecting children across many countries. The UNICEF definition of well-being is one which has taken a broad view of well-being that can serve as a foundation for policy and development of services for children:

The true measure of a nation's standing is how well it attends to its children - their health and safety, their material security, their education and socialization, and their sense of being loved, valued, and included in the families and societies into which they are born (UNICEF, 2007 p. 4).

At one level, investment on children's well-being today helps ensure effective contributions of young adults to their nation's well-being tomorrow. Bradshaw wrote in 1990, that "In any society, children should be of primary concern – their well-being is not only an indicator of a society's moral worth, they are human capital, the most important resource for its national future" (Bradshaw, 1990 p.3). Children, however, are more than an investment for the future. They are individuals with rights and aspirations. The *UN Convention on the Rights of the Child*, (to which Malta is a signatory), is very clear that families and states, acting together, have a duty to promote those rights and give attention to various aspects of children's lives, including education, care, recreation, culture and health, and children's social behaviour.

We understand a lot more today about how children develop and the interweaving of connections and transactions between different parts of their world. We know, for example, that educational achievement can be a buffer against adversity and help to build resilience. We know that the mental well-being of children is connected to their physical health and nurture. Early development of the brain may be affected by closeness to and positive interaction with caring adults (Aldgate, Jones, Rose and Jeffery, 2006).

Increasingly, psychologists and others are clear that the most effective way to promote well-being is to work on strengths in children's development and not emphasise deficits. Most importantly, children can recover from negative experiences, such as separation or loss, provided they have "subsequent experiences that help build their resilience" (Schaffer, 1996, p.8).

Some children are particularly vulnerable because of their experiences of separation, rejection and loss. These include children deprived of a life with their families who spend a good deal of their childhood in out-of-home residential care. It is these children who are the subject of this trio of research. The remarkable trilogy of studies brings together hard evidence from Malta and beyond to provide an irrefutable case for a fundamental revision of the use of residential care for children in the Maltese Islands.

Malta has had children looked after in this way since the late 19th Century (Cassar, 1984). Although contemporary children's homes in Malta are far different from the early institutions, questions still remain about the size of homes, which children could benefit from their care and

how they should be run. Such questions can only be answered by empirical research that shows the impact of residential care on children at different stages of childhood and into early adulthood. In particular, there is growing evidence across many countries to affirm that, while residential care can offer a specialist therapeutic service, it is unsuitable for young children because it cannot offer the personal relationships of family care and attend to the fundamental issue of building strong attachments. Some of this knowledge forms the powerful evidence of the first study in this volume, juxtaposed with a snapshot of contemporary Maltese residential care for infants, that leaves much scope for change and improvement. This unequivocal evidence emerging from the literature reviewed in this first study together with the recommendations made will undoubtedly continue to strengthen the hand of policy makers, managers and practitioners in this field.

The second study provides hard data from the Maltese context, comparing children in the community with those in residential care, showing the complexity of children's development and how some children are missing out on their potential across emotional, cognitive and social development. This study should prove a landmark piece of work as besides including *all* children in care in Malta at the time, it also made use of research tools which allow for robust comparisons.

The profile of children in care that emerges from this study is painfully revealing in many ways. Notably, that children continue to be admitted into care on account of substandard housing; that twenty-eight children experienced more than four transitions whilst in care; that for the majority (217 children), the first experience in the care system was in residential care; and that for the majority of children in residential care, the child-to-adult ratio is of one adult to six children. On the other hand, the comparisons of profile and outcomes between Children in Residential Care and Children in Foster Care are encouraging and very useful pointers for policy development.

Similar evidence has provided scope for changing policies and practice elsewhere. Across the different countries of the United Kingdom, for example, children in the care system now have special attention paid to their educational attainment. The health of such children has become more of a priority, in line with the *UN Convention on the Rights of the Child (1989)*, making sure they have regular health checks, including dental and eye checks. One key to making sure children's well-being is achieved in all areas is through the use of clear assessment and review. In Scotland, this has been taken a step forward by using the same multi-agency well-being indicators for all children, and stressing the benefits of prevention and early intervention. The model also includes potential for specialist assessment and help for vulnerable groups like looked after children (Scottish Government, 2008).

Increasingly, children themselves have become competent commentators on their own lives, providing valuable insights into what is important for them. In the Maltese context, Galea-Seychell's (2012) study of foster children's views on connections with their own families provides powerful evidence of children's wishes for lasting attachments to both parents and siblings. Those who have been in care have much to add to the debate, as the third of the studies in this trilogy shows extremely well. The compelling and poignant memories of the care leavers should be essential reading for all policy makers and practitioners.

So what for the future in Malta? Clearly, the use of residential care needs a fundamental review. It would, however, be counterproductive in the course of this to remove the long-standing partnership between Church and state, which has provided some excellent services for children.

One experimental direction at present is the transformation of large institutions into smaller, more family like units, such as Don Bosco House run by the Salesians in Balzan. Another heartening development in this respect is the partnership between Aġenzija Appoġġ and the Catholic Church in Malta for the Co-Management of Residential Homes (Aġenzija Appoġġ, n.d.).

Malta has now an outstanding foster care service, thanks to the expertise and dedication of the team at Aġenzija Appoġġ. Kinship care forms part of this service, playing to the Maltese strength of continuing, extended family connections.

In the end, the question has to be asked, why do so many children continue to come into care in the first place? Where are the early intervention services in health and education? Where are the preventive services to offer troubled families the support they need to keep and nurture their children?

This trilogy of research studies is undoubtedly an excellent basis to spearhead a way forward for building and developing services to prevent the out-of-home care of some of Malta's most vulnerable children. The Commissioner for Children is to be congratulated on the publication of the research, which provides a firm foundation for any future developments in the co-ordination and development of services in the best interests of all children, especially of those most at risk.

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Preface

Prof Angela Abela

“I would like to tell you the entire story,” stated a young man, who had been placed in residential care at a very early age, when he willingly came to be interviewed by one of the team’s researchers at the Office of the Commissioner for Children. He wanted us to deliver his message to those that can effect change in what he feels needs to happen for children in care. Another participant specified that he desired the researchers to effectively relay the difficulties he had experienced. He feared he could not express himself in a voice that could be heard and noticed.

This publication, which incorporates the key findings of a series of three pieces of interrelated research projects on children in out-of-home care, has the specific aim of reaching policy makers about a population of children whose needs are rarely discussed in depth at a national level. We believe that the main reason for this lacuna is that these children are born in vulnerable and fragile families who are often marginalised by the rest of society to the extent of being left without a voice. It was therefore considered essential that the research would not stigmatise children in out-of-home care or demoralise carers who look after them.

The research agenda of the three studies was laid out by a focus group composed of major stakeholders and experts in the area of out-of-home care, who were appointed by the Commissioner for Children, in 2007, to help her formulate a national policy for looked-after children.

The first study is a literature review which considers the ill-effects of placements of children under 5 in institutions. The research that has been reviewed in this paper, as well as the conclusions reached by WHO and the UN Assembly of November 2007, make it abundantly clear that children under 5 should not be placed within a residential setting.

The second study seeks to build a psychological, behavioural and academic profile of children in foster and residential care in Malta, to identify those robust variables that have most impact on the psychosocial functioning of these children and to provide a picture of how these children are faring in the various care settings. The study includes *all* children in care in Malta from the ages of 5 until the age of 18 years and is the first of its kind to be carried out in this country. 270 children (154 placed in residential care, 108 in foster care and 8 in a mental health setting) were part of this quantitative study. Statistical results were kept to a minimum in the summary to facilitate understanding for readers who do not possess a statistical background. The recommendations, which are all borne out of the study, should provide policy makers with empirical evidence for future policy for looked-after children.

The last study adopts a qualitative approach and highlights the lived experience of children in long-term residential care, how they cope when they leave the care system at the age of 16 or thereabout, and their life outcomes after that. The recommendations proposed in this study come mostly from the participants themselves who provide us with important insights on the way forward.

As a research team working on these three projects, we deeply felt the responsibility that we were shouldering when exploring the needs of children in out-of-home care, and we were spurred on in our commitment to carry on this project, first and foremost, on their behalf. We present these

findings and recommendations, in the hope that the experience of out-of-home care can continue to develop into a therapeutic and supportive endeavour that brings out the strengths and the resilience of these children.

Acknowledgements

We would like to thank all those who contributed to the realisation of this major research project which consists of three studies, each focusing on a particular aspect of children in out-of-home care:

First and foremost, Ms Carmen Zammit, former Commissioner for Children, who in 2007 included looked-after children as one of her main areas of action in her three-year work plan. She was the one who inspired us to take this project on board;

Ms Helen D'Amato, current Commissioner for Children, who dedicated time and energy in seeing that this work was brought to the general public in the most professional way;

The focus group composed of all stakeholders and the experts in the area of out-of-home care for their advice and helpful feedback in the different stages of this research project;

The whole team at the Looked-After Children (LAC) Services within *Aġenzija APPOĠĠ* for their valuable contribution during the field work phase of Study 2. The social workers were the ones to make sure that our research instruments were duly filled and returned. Without their cooperation the study would not have been possible;

The teachers in schools, the carers in the residential homes, as well as the foster carers who helped us by completing the assessments when approached by the social workers from LAC services;

Special thanks go to Dr Liberato Camilleri PhD, senior lecturer at the Department of Statistics and Operations Research of the University of Malta, for his generous help and advice. Dr Camilleri not only reviewed our statistical work, but also worked out some of the more complex statistical analyses of Study 2;

The Director of the Children's Homes, Mons Zammit McKeon, and his team of social workers for their cooperation in tracing care leavers for the qualitative study, which is the third and last study. Thanks also go to the Rector, Fr Charles Said, and the team of social workers at St Patrick's Home; Fr Frankie Cini, Director, and his team of social workers at St Joseph's Home, as well as to Ms Marisa Cannataci, then Director at Conservatorio Vincenzo Bugeja;

Ms Suzanne Gili, Mr Glen Gauci and Ms Irene Muscat from the Office of the Commissioner for Children for gathering all the research protocols from LAC Services within *Aġenzija APPOĠĠ*, and inputting all the data in the Statistical Package for the Social Sciences (SPSS) for Study 2. They also transcribed all our interviews for Study 3;

The ten research participants, who we interviewed for Study 3, who trusted us with their stories. We hope that our renditions will bring forth the desired changes from policy makers in the country;

Mr Charles Sammut MA for his work as proofreader, translator of participants' quotes and copy editor.

Our families who so patiently and lovingly supported us in this endeavour, believing like us that the endless hours we spent on this piece of work would spur the much needed changes for children in out-of-home care.

Without the help, cooperation and support of all the above mentioned persons this study would not have been possible.

Biographies

Professor Angela Abela is the lead researcher of this series of three studies on children in out-of-home care. She was also one of the experts on the Focus Group appointed by the Commissioner for Children to help her formulate a national policy for looked-after children.

Angela is the Head of the Department for Family Studies at the University of Malta. She holds a PhD from the Tavistock Clinic and the University of London and a Master's degree in Clinical Psychology from the Université de La Sorbonne Paris V. She is also a practising clinical psychologist, a UKCP registered family therapist and a supervisor. She is a consultant in the area of children and families for Government, the Social Affairs Committee in Parliament, and the Standing Committee on Family Affairs. She is also a supervisor for professionals working in public social agencies in the area of children and families.

She has a long standing interest in children in out-of-home care and works as well as supervises various professionals working in the field. She has also sat on a number of committees and boards related to this area, including the Commission for Children's Homes in Malta and the Care Orders Board. In 2006, she was also appointed by Bishop Grech on an Inquiry Board to investigate alleged emotional and physical abuse in a Children's Home.

On an international level, she has worked extensively as an expert of the Council of Europe in the area of parenting children at risk of social exclusion and in supporting children and families living in poverty including children in out-of-home care. She has published in the area of children and families and supervision practice and is an associate editor on *Clinical Child Psychology and Psychiatry* published by Sage, and an International Advisory Editor of *Contemporary Family Therapy*; an international, peer-reviewed journal published by Springer Science.

Nadya Abdilla is a clinical psychologist and psychotherapist, currently working in private practice. She graduated with a Bachelor of Psychology (Honours) and a Master's degree in Clinical Psychology from the University of Malta. She also obtained post-graduate diplomas in Applied Systemic Therapy and Gestalt psychotherapy. Nadya has experience within the fields of mental health, residential therapeutic communities for adults and children, refugees and asylum seekers, and children and adolescents in out-of-home care. She has been involved in several research projects and is an occasional lecturer within the Department of Psychology at the University of Malta.

Claire Abela, B. Psy. (Hons.), PGCE, is currently working as a lecturer in Psychology at the Malta College of Arts, Science and Technology, teaching students who are following BTEC Diplomas in Health and Social Care. She has also worked with children who are in care within *Aġenzija APPOĠĠ* and as part of her voluntary work with children. Following her first degree, she has participated in various research projects.

Juan Camilleri is a practising registered educational psychologist with a Master's degree in Educational Psychology from the University of Malta and has worked with the Support Services Team at St Patrick's Salesian School since 2007. He has vast teaching experience with a focus on the inclusion of children with learning and/or developmental disabilities in mainstream

classrooms. He specialised in the area of literacy with a M.Ed. from the University of Sheffield. He has authored and co-authored papers that were published in international journals on matters related to child development, education, literacy and inclusion. He also lectures undergraduate psychology and education students on these issues.

Daniel Mercieca was one of the experts on the Focus Group appointed by the Commissioner for Children to help her formulate a national policy for looked-after children. He trained at the University of Hertfordshire (UK) and works as a dramatherapist in Malta. He specialises in work with children, adolescents and families facing emotional and behavioural difficulties especially in out-of-home placements. He coordinates a transdisciplinary therapeutic team at St Patrick's Salesian School and Residential Services and is also involved in research projects within the same area of interest. He facilitates a number of training workshops at the University of Malta. He is also trained in Applied Systemic Theory and is one of the founder members of the Creative Arts Therapies Society in Malta. He has completed training in integrative relational supervision.

Graziella Mercieca is a registered clinical psychologist. She graduated from the University of Malta in 2004 with a Bachelor of Psychology (Honours) and completed her Master's in Clinical Psychology at the same university in 2009. She has worked with children and families in various contexts including Eden Foundation, where she worked with children with Autistic Spectrum Disorder, and the Cana Movement. Graziella has a special interest in mental health and resilience and is currently working for Mount Carmel Hospital, where her client population includes children, adolescents and adults.

Study 1:

Considering the Effects of Institutional Placements on
Children Under 5

Key Findings

Study 1: Considering the Effects of Institutional Placements on Children Under 5

Key Findings

1.0 Introduction

This paper focuses on institutional care in Malta for children under five. It aims to present a picture of the current situation in Malta and provides a review of the international literature about the effects of institutionalisation on children under 5 in need of out-of-home care. A number of recommendations will also be put forward.

2.0 A Framework of Standards in the Area of Residential Care for Children

In terms of a clear framework of standards in the area of residential work for children, the United Nations Convention on the Rights of the Child “promotes responses other than institutional placement wherever possible, whilst recognizing the role that residential care can play for some children” (Ruxton, 2005, p.142). The United Nations General Assembly, held in November 2007, encourages states to promote family and community-based care over placement in institutions in situations where out-of-home care becomes necessary.

Browne & Hamilton-Giachritsis (2004) report that Malta is among 12 out of 33 European countries where more than two children in every 1000, under 3 years of age, are placed in residential care. Malta ranks 10th out of these 12 countries, many of which are ex-communist countries.

2.1 *Children under 5 in Institutional Care in Malta*

According to statistics obtained from the Office of the Commissioner for Children, (communication by email dated 24/11/08) there were sixty-two children under 5 years, who were in residential care in Malta and Gozo. Whereas twenty-eight of these are children of irregular immigrants or asylum seekers, thirty-four were Maltese.

Most children under 3 years who are placed in a residential home in Malta live at the Crèche of the Ursuline Order in Sliema, Malta. The Sisters of the Ursuline Order set up their first home in Valletta, over one century ago, in 1887 (Bonnici, 1991). By 1889

they were already receiving children whose parents passed away following an epidemic that had hit the country. By 1893, another home was opened in Sliema and these nuns received children who could not be cared for by their families. A request to accept/raise children of prisoners and sick parents was made by the government in 1912. Presently, the Ursuline sisters run 4 residential homes.

2.2 *Typical Setting in a Children's Home for Children under 5*

A Maltese psychology student carried out an ethnographic research in a particular section of a home for children under 5. The ethnographic observations made by Saliba in 2002 depict the constraints of institutional rearing. The researcher's observations highlighted inconsistencies in care giving, alongside difficulties in empathic attunement by the carers towards the infants in care. Saliba noted a low child-to-carer ratio (of around one to 7 toddlers) leaving little time for empathic attunement between the toddler and a primary carer. Children spent more time than is usually expected in their cots and did not have access to a consistent carer, also because children had to move from one unit to another. These institutional practices were, at times, justified by the residential staff. Contrary to current research, they believed that it was helpful for the children to move on to another unit as this helped them grow and that it was best to let the toddlers cope with their losses without much cuddling and holding. Saliba also noted a very rigid, demanding schedule and a high degree of stress on carers with an evident negative impact on their interaction with the children. The ethnographer also observed that some children were exhibiting delayed developmental milestones.

3.0 Literature Review

Clough, Bullock & Ward (2006), in a report commissioned by the UK's National Children's Bureau, point out that there have been at least 3 main reviews of research on residential child care. Our focus is on a recent study by Johnson, Browne & Hamilton-Giachritsis (2006) which involved a systematic review of the research evidence on the effect of institutional care on different aspects of child development: attachment, brain growth, social behaviour and cognitive development.

3.1 *Impact on Attachment*

In terms of the impact on attachment, Johnson et al.'s review includes 12 studies ranging from 1944 till 2002. In these studies, difficulties in attachment were measured through the variables of inhibited and disinhibited behaviour observed in infants, especially, in response to a stranger or separation from a main carer.

Of particular interest is the research of Tizard & Joseph (1970) which looked at the attachment behaviour of children raised in a high quality UK residential nursery. Upon comparison with a sample of working class children raised in families, significant differences were reported in terms of attachment behaviour indicating that children aged 2 years in high quality residential care were adversely impacted.

Wolkind's (1974) research established that there were significant differences in terms of disinhibition in a group of 5-12 year old children who were admitted into residential care before 2 years of age when compared to a group admitted after this age. This finding is concordant with Tizard & Hodges' (1978) study where ex-institutional children's responses resulted as being "over-friendly" when compared to a control group.

Smyke, Dumitrescu & Zeanah (2002) looked at inhibited and disinhibited attachment disorder in three different groups of Romanian children aged 4 to 68 months. The first group received standard institutional care with a 1:10 staff-to-child ratio, whilst the second group received higher quality care in a pilot unit within the same institution. The third group was a control group of children within the same culture who were never in institutional care. According to Johnson et al., findings from this study indicate that:

In terms of attachment, even apparently "good" institutional care can have a detrimental effect on children's ability to form relationships later in life. The lack of a warm and continuous relationship with a sensitive caregiver can produce children who are desperate for adult attention and behaviour. (Johnson et al., 2006, p.42)

In summary, 9 out of the 12 reviewed studies report specifically on indiscriminate friendliness, overfriendliness and/or disinhibited behaviour amongst children raised in institutional care.

It is important to note that the degree of adverse impact on attachment can be related to the degree of deprivation within an institutional set-up. It is also important to note that although attachment disorders in childhood are related to difficulties in forming secure relationships later on in life, these problems are not an inevitable consequence of early life in an institution. There are other mitigating factors that need to be taken in consideration such as the development of resilience and the interplay between biological and environmental factors (Wulczyn, Brunner Hislop & Jones Harden 2002).

3.2 *Impact on Neurological Development*

In the first three years of life, the human brain goes through the fastest developmental growth ever (Schoore 2001a, 2001b). According to Schoore (2001) the maturation of the brain is “embedded in the attachment relationship between the infant and the primary caregiver” (p 10). Sensitive and attuned care-giving promotes brain development whereas neglect suppresses it (Johnson et al., 2002). The brain will develop its neural pathways as a result of frequent stimulation. Pathways that are not stimulated become redundant and die. Research indicates that institutional set-ups do not manage to support the quality of attuned caring that promotes healthy brain development. Balbernie (2001) notes that neglect is very common in residential homes and can cause parts of the brain to atrophy with obvious consequences on language development. It is not yet clear whether children are able to recover completely from such deprivation.

3.3 *Impact on Social and Behavioural Development*

Johnson et al. (2006) reviewed 17 studies which examined the social and behavioural development of children cared for in institutions. Of particular interest is the study conducted by Vorria, Rutter, Pickles, Wolkind & Hobsbaum (1998) where they compared the social and behavioural adjustment of Greek children in long-term residential care with a matched control group of Greek children living in two-parent families. Most of the children in long-term care had spent the first two years with their

families. The institution was characterised by a good standard of physical care with a stability of care-giving staff yet with a low caregiver to child ratio. The residential care group was found to be more inattentive, less involved and more distractible at school than the control group. Moreover, parents and teachers tended to rate the children living in institutions as more disturbed.

Another interesting study conducted by Harden in 2002 compared adaptive behaviour and behaviour problems of a sample of infants (aged 9-30 months) raised in congregate care settings in the US with a group of children reared in foster families. The infants raised in congregate care scored significantly less than children in foster care on measures of communication and socialisation. Yet no statistically significant differences in terms of observed behaviour problems were found.

Johnson et al. (2006) remark that out of the 17 studies reviewed under this section, “16 reported some negative social or behavioural consequences for children raised in institutional care compared to controls or children who have spent less time in institutional care” (p. 48). Whilst “quasi-autistic” behaviour patterns observed in some of the severely deprived children improved once the child was placed in a family environment, restoring institutionally reared children to their natural family does not always lead to positive outcome as this depends on the quality of subsequent family life and the type of professional support offered to these families.

3.4 *Impact on Cognitive Development*

In terms of impact on cognitive development, Johnson et al. (2006) reviewed 13 studies: 12 studies provided evidence that institutional rearing impacted negatively on the cognitive development of young children. Yet studies also indicate that early intervention by placing the child into family-based care can result in recovery of cognitive development delays.

Barbara Tizard and colleagues researched a group of infants in institutional care at four points of their development. These children were placed in institutional care before the age of 4 months and were raised in an institution that supported a high level of care.

Tizard and colleagues' longitudinal research shows that whilst high level care in an institution does not result in cognitive delays for children, the same kind of high level institutional care negatively impacts attachment and socio-behavioural development in infants and children.

In terms of recovery, it is important to mention that research shows that the negative impact of institutional care on attachment is least amenable to recovery. In terms of the impact on socio-behavioural and cognitive development, the severity of impact seems to depend on the possibility of being cared for by a single care giver and recovery seems to be linked to the immediacy of intervention in terms of removal of the child into family-based care.

Another aspect of cognitive development that merited the attention of researchers was language development amongst institutionalised children. Research by Goldfarb (1944, 1945), Tizard & Joseph (1970) and Pringle & Tanner (1958) yielded results which showed clear deficiencies in language development amongst children cared for in institutions when compared to control groups.

3.5 *Deinstitutionalisation*

Dr Catherine Hamilton-Giachritsis, Professor Kevin Browne and others (2005) researched good practices in deinstitutionalisation within 8 European countries where 456 children under the age of 5 years were moved from residential care between 2004 and 2005. Within the countries researched, infants stayed on average 15 months in residential care when research shows that any stay for more than 6 months has the potential to damage brain development (Johnson et. al., 2006). The majority of the 456 children were moved into foster care or adoptive families and 20% were returned to their natural families.

In their account, the authors allow us to consider the complexity of a process of deinstitutionalisation that needs to be supported by a range of community support services in the areas of children's primary health care - family welfare and psychosocial support - which would all be working towards family preservation and support to at risk families. The need for preventive community services makes sense, especially when considering

that the above mentioned research shows that, perhaps, contrary to popular belief, less than 4% of children in institutional care are biological orphans.

Practices abroad have shown that it is impossible to do away completely with residential care (Rushton & Minnis, 2002) and some infants may need a temporary placement.

Dr Catherine Hamilton-Giachritsis, Professor Kevin Browne and others (2005) have identified 10 steps in the deinstitutionalisation process:

i. Awareness raising and advocacy for changes in the law

This would entail setting up initiatives that would help stakeholders understand why it is a good idea to close institutions, in spite of their attractiveness as philanthropic societies. The right to live in a family setting is to be highlighted and parents need to be empowered to bring up their own children. Necessary changes in the child welfare legal framework would need to be implemented within the rationale of our country's commitment to place children under the age of 5 in family-based environments. Changes in the law would need to include time frames for making permanency decisions for children. Other provisions in the law need to cater for voluntary placement.

ii. Assessment of the situation at a macro level

This includes undertaking a stock taking of the situation, looking at what is available and what are the alternatives.

iii. Undertaking an analysis of the situation at a micro level

This entails an evaluation of the needs of the specific children under 5 years of age who are living in an institution.

iv. Project design

At this stage, following the analyses at a macro and micro level, one would be in a position to set up a strategy which would prevent admissions into institutions and

provide alternative placements in families for all the children under 5 living in residential institutions.

v. Managing the process

Management needs to be at the hands of a joint steering committee, which would develop action plans and allocate resources within a set budget.

vi. Planning transfer of resources

Resources from the state to institutions will be reallocated for this joint project.

vii. Preparing and moving children

Within this phase children need to be prepared for their move following their assessment of needs. Alternative placement decisions need to be endorsed by the relevant authorities.

viii. Preparing and moving staff

The staff members at the children's homes are to be given the opportunity for retraining and redeployment.

ix. Logistics

The joint steering committee needs to take charge of the logistics involved in the move, ensuring that all steps follow the children's timetable rather than that of the adults.

x. Monitoring, evaluation and support

This process necessitates monitoring the transition from the initial stages.

3.6 *Summary of Literature Review*

Policy makers in the area of out-of-home care have access to 12 major studies in the area of attachment, 17 major studies in the area of socio and behavioural development and 13 major studies on cognitive development. These stand alongside evidence from the field of neurobiology. Such a vast body of knowledge has led researchers and policy makers to make conclusive remarks regarding institutional care. Johnson et al. (2006)

argue that evidence from research overwhelmingly shows the negative impact of institutional care when compared to family-based care.

Research in the area indicates that even being taken care of in good high quality institutional care, especially within the first 3 to 5 years of life, is detrimental in terms of attachment and socio-behavioural development. Research shows that there are features of institutionalisation that are problematic for the desirable development of children especially in the first 5 years of life. To this effect, Browne & Hamilton-Giachritsis (2005) have highlighted a number of good practices when embarking on a deinstitutionalisation exercise. They based their recommendations on research carried out within 8 European countries.

4.0 Recommendations

In the light of the research that has been reviewed in this paper and the conclusions reached by WHO and the UN General Assembly of November 2007, the following recommendations will be put forward:

- a. ***Children under the age of 5 should not be placed within a residential setting***, even if the institution supports a high level of care. This shift in practice involves considerable changes at a policy level.
- b. In circumstances when infants would need a temporary placement in an out-of-home care, and foster care placements would not be readily available, ***emergency placements should not be longer than 3 months and within a set-up that supports a high level of care*** (Browne, & Hamilton-Giachritsis, 2005).
- c. ***A process of deinstitutionalisation for children aged 0-5 years needs to be set up***. The state needs to take full responsibility for such a process, yet working in very close liaison with all the stakeholders. The ten steps suggested by Browne, & Hamilton-Giachritsis, (2005) may serve as useful guidelines in the process.

5.0 Conclusion

This review enables us to appreciate the crucial impact of the first 5 years of life on the development of infants who cannot be nurtured within their family of origin. Furthermore, it provides us with the evidence to safeguard the infant's right to be brought up in family based care. As Dixon & Misca maintain in their review: "the neglect and damage caused by early privation of parenting may be equivalent to violence to a young child" (2004, p.1).

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Study 2:

The Psychological, Behavioural and Academic Profile
of Children in Out-Of-Home Care in Malta

Key Findings

Study 2: The Psychological, Behavioural, and Academic Profile of Children in Out-of-Home Care in Malta

Key Findings

1.0 Introduction

This study focuses on the school performance and the psychosocial well-being of children in out-of-home care in various settings. It includes all the children in care in Malta, between the ages of 5 and 18 years, and is the first of its kind to be carried out in this country. Out of the 270 children who participated in the study, 154 were in residential care, 108 were in foster care and 8 children were in a mental health setting.

2.0 Aims of the Study

The aims of this study were threefold:

- a. To build a picture of the psychological, behavioural and academic profile of children living in out-of-home care;
- b. To identify those variables having an impact on the psychosocial functioning of these children;
- c. To compare children in residential care with children in foster care in terms of their psychological, behavioural and academic profile.

3.0 Conceptual Frameworks of the Study

The study adopted a **resilience** perspective. Children's strengths were specifically taken into account when building their profile. An **attachment perspective** informed our understanding of the children's needs. It highlighted the importance of relationships between caregivers and children and helped us make sense of the difficulties that these children have to contend with.

4.0 Research Methodology

4.1 *Research Questions*

In order to address the aims previously outlined, the following research questions were put forward:

- a. What is the psychological, behavioural, and academic profile of children in out-of-home care?
- b. Which are the variables having an impact on the psychosocial functioning of these children?
- c. Is there a significant difference between children in residential care and children in foster care in terms of their profile?

4.2 *Hypotheses*

Following a review of the existing literature, the following hypotheses were then made:

- a. Children living in out-of-home care have a higher rate of mental health problems that fall in the clinical range when compared with the general population.
- b. Children living in out-of-home care have mental health problems which are not adequately diagnosed.
- c. Children living in out-of-home care have mental health problems which are not adequately addressed.
- d. Children living in residential homes have more mental health problems which fall in the clinical range than children living in foster care.
- e. The mental health of children in out-of-home care is affected by several external factors.

5.0 The Research Tools

In order to address the previously listed research questions in the best possible way, it was decided that a quantitative research design should be used.

A demographic data sheet elicited demographic data and other additional information. In order to assess children's strengths and difficulties in various areas of their lives, namely the emotional and behavioural aspects, and social competence, children's caregivers were requested to complete the Child Behaviour Checklist (CBCL) and the Strength and Difficulties Questionnaire (SDQ) for the child in their care.

5.1 *The Child Behaviour Checklist*

The CBCL provides a broad description of the symptoms of emotional and behavioural disturbance, together with social competencies exhibited by the child over the past 6 months. CBCL scores are organised according to the following categories: Aggressive Behaviour, Anxious/Depressed, Attention Problems, Delinquent Rule-Breaking Behaviour, Social Problems, Somatic Complaints, Thought Problems, Withdrawn, Externalising, Internalising, Total Problems, plus Diagnostic and Statistical Manual (DSM) - oriented scales.

The CBCL has been reported to have good internal consistency with regards to competence scores (Cronbach's Alpha ranging between 0.63 and 0.79), empirically based problem scales (between 0.78 and 0.97), and DSM-oriented scales (0.72 to 0.91). Content validity of the competence and problem items of the CBCL showed that all items discriminated significantly ($p < 0.01$) between demographically matched referred and non-referred children (Achenbach & Rescorla, 2001). Content validity was not assessed in our sample since there were no translations or changes to the original tool done. Test-retest reliability was measured with a sample of 15 participants. Results from Cronbach's Alpha tests showed good test-retest reliability in all scales: Total Internalising Scale 0.809, Total Externalising Scale 0.789, Total Problems Scale 0.893, and Total Competence Scale 0.737.

5.2 *The Strengths and Difficulties Questionnaire*

Constructs measured by the SDQ include emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour. It has three different versions: the 'Parent', 'Teacher' and 'Self-report', the latter being for children aged between 11 and 16. The SDQ also includes an Impact Supplement Sheet, which was completed for all children. This assesses any effects on the children's functioning in their life in the areas of peer relationships, classroom learning, home life, and leisure activities.

The participants asked to complete these two research instruments were the persons involved the most in the care of the child. These included the child's parent surrogate: either the child's foster carer or residential social worker, or housemother. The SDQ was also completed by a teacher, who knows the child well, and children aged between 11 and 16 years also completed the Self-report version of the SDQ.

We used the Maltese version of the SDQ which had been revised and translated by Cefai, Cooper & Camilleri (2008) who had used this tool in a Maltese national study with children in primary and secondary schools. Since reliability and validity were found to be high when the Maltese version of the SDQ was used with the Maltese population, it was deemed unnecessary to reassess these factors in the current study, since the same version of the questionnaire was employed, and the same cut-off points were used to determine the degree of the children's difficulties and pro-social behaviour.

Foreign studies also present good reliability and validity of the SDQ with good detection of children's difficulties.

6.0 **Administration of Questionnaires**

Respondents of both the CBCL and the SDQ were assisted by their social workers, within the Looked-After Children's team within *Aġenzija APPOĠĠ*¹, who

¹ *Aġenzija APPOĠĠ* is the central national agency for children and families in need.

had previously received training in the administration of the two research instruments by the research team. By carrying out a case file study, the social workers also completed a Demographic Data Sheet which included important information about the children, such as their care history, family background, academic performance and health, among other demographic variables such as ethnicity and presence of a disability.

7.0 Ethical Considerations

Permission to carry out the study was also sought from the ‘University Research Ethics Committee’ (UREC) at the University of Malta. In order to preserve confidentiality, index numbers were used by the social workers so that nobody in the research team knew the children’s identity, while approval from the Education Division was sought to enable the social workers to deliver the SDQ–teacher form to the children’s teacher.

The help provided by the social workers was based on the principle of reciprocity: not only were they trained in the administration of the research instruments, but the profile of children in care was also updated, and the assessments obtained on the CBCL and the SDQ were put in the children’s files. In this way, all the children in care had a profile of their psychosocial functioning and their current attainment at school.

8.0 Operationalisation of the Research Questions

8.1 *Profile of Children in Care*

For the purpose of describing this sample, frequency distributions and descriptive statistics using raw data were obtained for all variables within the Demographics sheet; the CBCL Syndrome scales and DSM-Oriented scales; and the SDQ scales and the SDQ Impact Supplement Sheet.

Raw scores for both the CBCL and the SDQ were categorised to cluster children's scores in the 'Normal', 'Borderline' or 'Clinical' ranges as suggested by the tools themselves; this provided a snapshot of children's functioning.

Response rates and margin of error for the study were calculated. A sample of 270 participants from a population size of 291 guaranteed a maximum margin of error of 1.65%.

8.2 *Comparison of Children in this Study with Other Populations*

Using one-sample T-tests, children in this study were compared to a normative sample of children of the same age coming from 40 US states and District Columbia. Results obtained by children in the current sample were compared to results obtained by the above cohort in a non-referred normative sample, and in a clinical sample of children making use of mental health services, substance abuse services or specialised educational services. The analysis was carried out according to age and gender.

The results obtained on the SDQ were compared with the population norms in Malta, as presented in the above described national study by Cefai, Cooper & Camilleri (2008). The One-sample T-test was again used to compare raw scores obtained by Maltese students in the latter study, with the mean scores obtained by the children in care in this study. Children were categorised by gender, so a separate analysis was carried out for boys and girls.

8.3 *Identifying and Addressing Children's Mental Health Needs*

The CBCL DSM-Oriented scales were used in order to explore whether children's mental health needs are being identified, as these particular scales are more directly comparable to specific diagnostic labels used by professionals, such as those provided by the DSM of Mental Disorders (DSM).

Using cross-tabulations and the Chi-square test, these categorised scores were compared to mental health disorders identified by mental health professionals. The

children's formal diagnosis and scores obtained on the DSM scales were also similarly contrasted with the use of services that might address the children's mental health needs, namely the psychiatric services and psychotherapy.

8.4 *Examining Differences between Children in Foster Care and in Residential Care*

A comparison between children in foster care and in residential care was made. Children's characteristics as obtained in the Demographics Data sheet and their scores in the major subscales of the CBCL and the SDQ (all versions) were considered. An identical comparison was then carried out between children in residential care, in unrelated foster care, and in kin care.

A second step in the analysis was that of comparing the outcomes of children in residential care with those in foster care. In order to ensure that any differences in outcomes emerging between these groups could not be attributed to possible differences in the children's care history, children in residential care were matched with children in foster care on two important variables: specifically, the age of their first admission into care and the total duration of time they spent in care.

8.5 *Variables Affecting Children's Psychosocial Functioning*

In order to obtain a clearer indication of factors which may be affecting children's psychosocial adjustment to the care experience, the effects of variables outlined in the Demographics Data sheet and other relevant information about the child's competencies in extracurricular activities, social relations and school performance, outlined in the first section of the CBCL on children's SDQ and CBCL scores, were also considered.

The same analysis was then carried out with the sample of children being divided into those in residential care and those in foster care. In order to determine the particular combination of factors which would predict children's scores on the CBCL

and SDQ, as well as the relative importance of each factor when compared with the other factors, regression analysis was carried out.

For this analysis, only factors which were found to have a significant effect on children's scores in the previous analysis were considered. Analysis was first carried out among the combined sample, then among children in residential care, and subsequently among children in foster care.

9.0 Results and Discussion

9.1 Profile of Children in Care

Of the 270 research participants, 262 were Maltese and 8 were non-Maltese. The majority of the participants, 154, were living in a residential home. There were 56 living in unrelated foster care, 52 living in related foster care, and 8 were staying in a mental health setting. The majority of the participants, 50.6% (120), had been issued with a care order, while 38% (90) were in care through a voluntary placement. Only 11.4% (27) of the participants had a court order².

The children's age at their first admission ranged from 0 to 17 years ($M = 3.83$, $SD = 3.77$, mode = 0 years), whereas the length of time in care ranged from 47 days to 17 years 10 months ($M = 6.82$, $SD = 4.01$, mode = 11 years).

The reasons for entry into care were various, including issues related to the parents (see Table 1, overleaf), such as inadequate parental skills and mental health issues, issues related to the child (see Table 2, overleaf), which included exposure to abuse, and external factors (see Table 3, pg.26), which included substandard housing and homelessness. Multiple risk factors for one's admission into care were implied in most cases with the mean number of reasons being 5.25 ($SD = 2.79$, mode = 5).

² In this Study frequencies are expressed as a percentage of the number of responses, rather than the number of respondents, so that percentages would still add up to 100% in the case of missing values.

Table 1: Parental issues that influenced children’s admission into care according to the number of times they were cited

		Present		Not Present	
Parental Issues	Mental Health	100	37.2%	169	62.8%
	Rejection	68	25.3%	201	74.7%
	Marital Breakdown	91	33.8%	178	66.2%
	Single Parenthood	93	34.6%	176	65.4%
	Substance Abuse	75	27.9%	194	72.1%
	Imprisonment	38	14.1%	231	85.9%
	Inadequate Parental Skills	190	70.6%	79	29.4%
	Prostitution	65	24.2%	204	75.8%
	Other	50	18.6%	219	81.4%

Table 2: Child issues that influenced children’s admission into care according to the number of times they were cited

		Present		Not Present	
Child Issues	Emotional Abuse	100	37.2%	169	62.8%
	Sexual Abuse	28	10.4%	241	89.6%
	Physical Abuse	93	34.6%	176	65.4%
	Physical Neglect	136	50.6%	133	49.4%
	Emotional Neglect	142	52.8%	127	47.2%
	Behaviour Problems in Child	35	13%	234	87.0%
	Physical Disability	3	1.1%	266	98.9%
	Other	18	6.7%	251	93.3%

Table 3: *External factors that influenced children’s admission into care by the number of times they were cited*

External Factors		Present		Not Present	
	Substandard Housing	68	25.3%	201	74.7%
Other	14	5.2%	255	94.8%	

For the majority of the participants, 81.6% (217), the first experience in the care system was in a residential home setting, 11.3% (30) were initially placed in kin care, 6.4% (17) in unrelated foster care and 0.8% (2) in a mental health setting.

As can be seen in Figure 1 (overleaf), the majority of the participants, 42% (113), experienced no transitions while in care, 23.4% (63) experienced one transition, 15.2% (41) experienced two transitions, 8.9% (24) experienced three transitions, 3.7% (10) experienced 4 transitions while 6.8% (18) participants experienced 5 or more transitions.

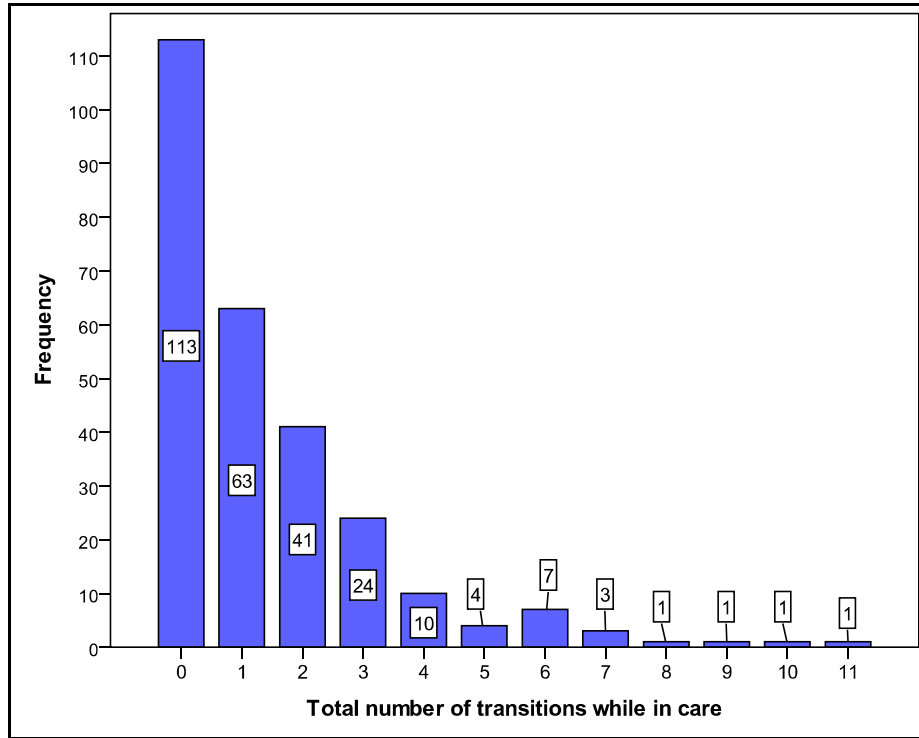


Figure 1: Number of transitions experienced by children while in care

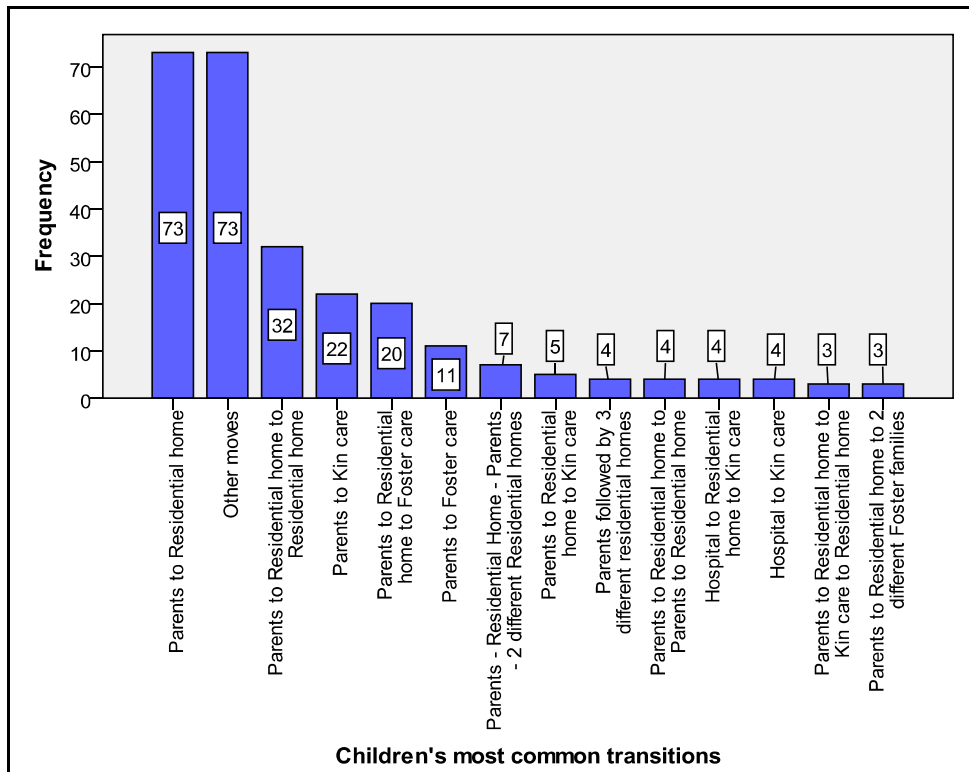


Figure 2: Children's most common transitions while in care

As shown in Figure 2 (previous page), these transitions happened for various reasons and included moves from one residential home to another, admissions into mental health settings, and moves from residential care into foster care.

Figure 3 (below) shows that the child-to-adult ratio varied considerably between placements. Whereas the majority of children in residential care had a ratio of 1 adult to 6 children ($M = 5.91$, $SD = 2.2$, mode = 6), the majority of children in foster care benefited from a ratio of 1 adult to 1 child ($M = 1.52$, $SD = 0.77$, mode = 1).

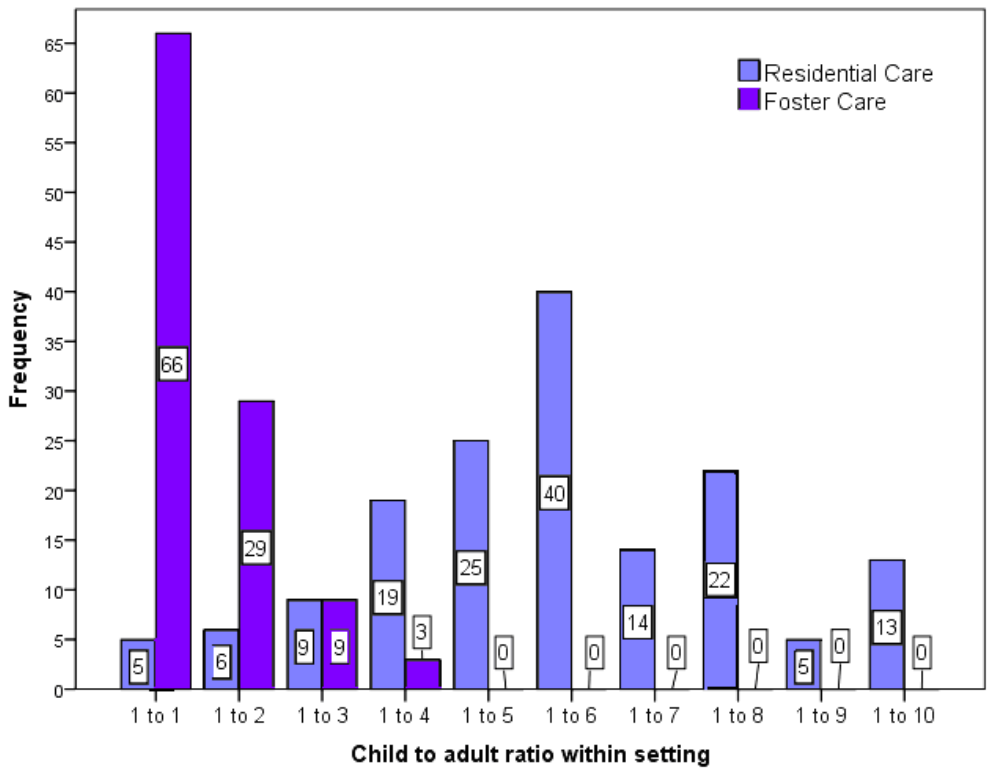


Figure 3: *Child-to-adult ratios according to placement type*

Though 22.6% (55) of the participants had no siblings in care, the majority of the participants 66.7% (162) had 1 to 3 siblings in care. A small number of respondents 10.7% (26) had at least 4 siblings in care. Table 4 (overleaf) presents the minimum, maximum, mean, mode, and standard deviation of the number of siblings, number of siblings in care, and number of siblings in same placement as child that our sample of children had.

Table 4: Descriptive statistics for siblings in care

	<i>N</i>	<i>Min</i>	<i>Max</i>	<i>Mean</i>	<i>Mode</i>	<i>SD</i>
<i>Number of Siblings</i>	267	0	12	3.40	2	2.35
<i>Number of Siblings in Care</i>	243	0	6	1.70	1	1.38
<i>Number of Siblings in same placement as child</i>	149	0	4	0.78	0	0.97

The number of siblings in care was compared to the number of siblings within the family to provide an estimated percentage number of children in care within each family. As shown in Figure 4: 34% (89) of the participants have 81% to 100% of their siblings in care. Whereas 20% (52) of the children had 41% to 60% of the children within their family that were in care, 21% (55) had 61% to 80%.

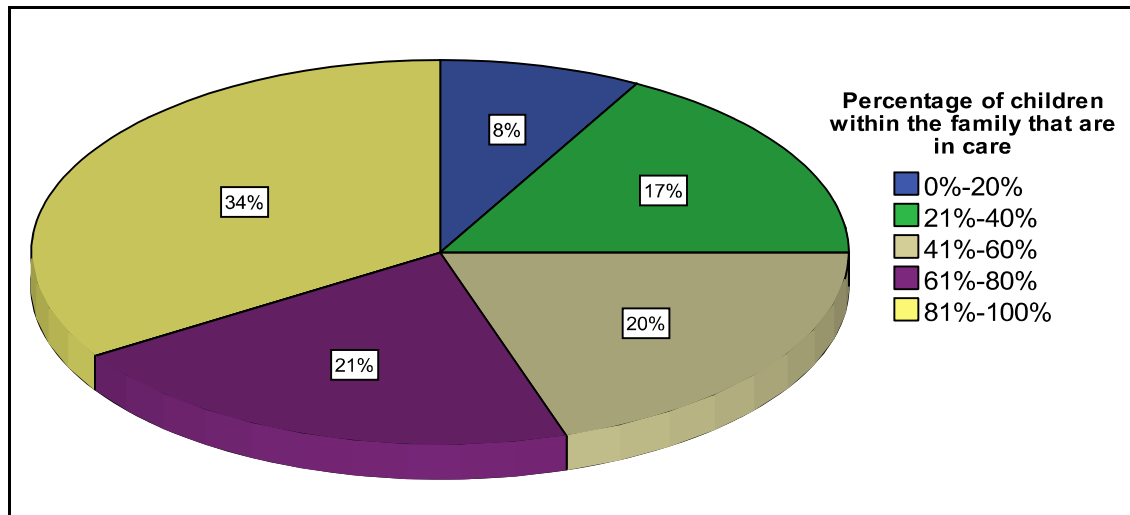


Figure 4: Percentage of children within each family that are in care

When the participants were rated by their carers with regards to how they got along with their brothers or sisters, they felt that the majority, 66.1% (123), had a relationship that was similar to that of other children they know, whereas 13.4% (25) had a better relationship, and 20.4% (38) had a poorer relationship.

With regards to contact with biological parents, the contact varied from no contact at all to daily contact. The type of contact also varied, whereby some participants had unsupervised contact while others saw their parents during supervised visits. When rated on their behaviour with their parents, carers thought that 47.3% (97) of the children had an average behaviour, 27.8% (57) had better behaviour, and 24.9% (51) had worse behaviour compared to that of other children.

As shown in Figure 5 (below), only a small proportion of the sample, 16.3% (34), had no close friend. The majority of the participants, 39.7% (83), had 2 to 3 close friends.

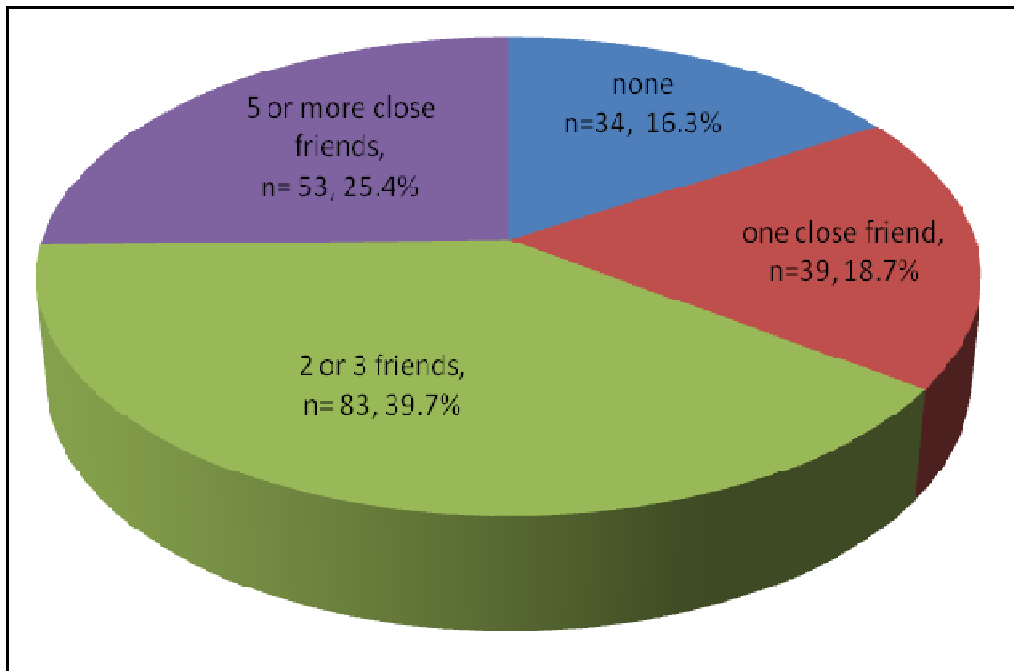


Figure 5: *Number of close friends*

40% (82) of the participants met with friends outside school hours less than once a week, while 32.2% (66) met their friends once or twice weekly, whereas 27.8% (57) met three or more times a week.. When rated on how well they got along with other children, the majority, 61% (128), had an average relationship, whereas 24.8% (52) had a better relationship, and 14.3% (30) had a poorer relationship compared to other children.

At the time of the study, 48.1% (130) participants were receiving psychotherapy sessions and 20.4% (55) were being seen by a psychiatrist. 9.3% (25) were attending speech therapy, 4.1% (11) were attending occupational therapy, 1.5% (4) were receiving physiotherapy, whereas 35.1% (95) participants had not received any professional help. Some of the participants were also receiving other forms of professional services, such as drama therapy, family therapy, and special education lessons. Help from a high support worker was being offered to 8.3% (20) participants. 17 of these participants were in residential care and 3 in foster care.

41.1% (111) of the participants were not receiving any professional services at the time of the study while 4.4% (12) were on a waiting list to start receiving a professional service.

Only 1.9% (5) of the participants were in Kindergarten. The majority, 52.8% (141), were in Primary school followed by 33.3% (89) in Secondary school. 3.7% (10) participants were following Tertiary education, while 5.2% (14) were no longer attending school as they were older than 16, which is the age limit for compulsory education in Malta. 3% (8) of the participants were attending a Special School. 23% (61) participants were receiving help from a Learning Support Assistant.

An analysis of the grades obtained in the three main school subjects during the previous year (where applicable) show that the Maltese grades of 134 participants ranged from 0 to 95 ($M = 52.41$, $SD = 22.2$), the English grades of 132 participants ranged from 0 to 98 ($M = 47.91$, $SD = 22.71$), whereas the Mathematics grades of 131 participants ranged from 0 to 96 ($M = 45.36$, $SD = 25.87$).

With regards to extra-curricular activities, 19.2% (43) of the participants did not participate in any particular sport. For those who engaged in a sport, the most popular were swimming and football. With regards to favourite hobbies, activities, and other games practised, 11.2% (25) participants did not engage in any form of activity, while the majority, 57.6% (129), spent time playing computer games (including PlayStation[®] games).

Half of the sample, 49.8% (111), was not a member of any organisation, club, or team. Of the remaining 50.2% (112) respondents, 14.3% (32) were members of a football club, 11.7% (26) attended MUSEUM (religious group), and 11.2% (25) attended a dancing group/school.

With regards to their ability to play and work alone, the majority of the children, 61.5% (128), were rated by their carers as comparing well to other children of the same age. Besides, 22.6% (47) were rated as performing better in this area than children of the same age, whereas 15.9% (33) were rated as performing worse in this area than same aged peers.

10.0 Further Results and Discussion

In this section answers to the research questions and hypotheses, highlighted further above, will be provided. A succinct discussion which takes into account the relevant extant literature will be provided.

10.1 Is there a Significant Difference between Children in Residential Care and Children in Foster Care in Terms of their Profile and Outcomes?

To answer the above question, six variables were taken into account: age on admission and length of time in care, scores on the CBCL and SDQ scales, relationships with others, educational attainment, contact with siblings and biological parents and importance of extra-curricular activities.

10.1.1 Age on admission and length of time in care

Irrespective of their type of placement, the majority of the participants spent well beyond 4 years in out-of-home care. Hence, they fit easily in the category of 'long-term care' as described by Schofield, Thoburn, Howell & Dickens (2007).

Nonetheless, a marked difference existed between the two groups in their age of entry into care and in the length of time they spent in care, in that children in foster care were more likely to enter care at a younger age and to spend more years in care. As

seen in Table 5, children in foster care had the youngest age of entry into care, with the average age being 2 years 2 months as opposed to 4 years 10 months for children in residential care. In addition, children in residential care spent an average of 3 years 5 months less in care than children in foster care, with the mean length of stay for children in residential care being 5 years 9 months, whereas that of children in foster care being 8 years 4 months.

Table 5: *Descriptive statistics for age on admission into care and total length of time spent in care categorised by type of child’s present placement*

		<i>N</i>	<i>Min</i>	<i>Max</i>	<i>Mean</i>	<i>Mode</i>	<i>St Dev</i>
Residential Care	Age on Admission into Care (in years)	158	0	15	4.87	2	3.73
	Total Length of Time in Care (in years)	153	0.50	17	5.76	4	3.89
Foster Care	Age on Admission into Care (in years)	106	0	17	2.29	0	3.28
	Total Length of Time in Care (in years)	108	0.13	17.83	8.32	11	3.69

10.1.2 Scores on the CBCL and SDQ scales

Children in foster care scored significantly better on all the 4 main CBCL scales which are the Total Internalising Scale, the Total Externalising Scale, the Total Problems Scale and the Total Competence Scale³.

Moreover, they also scored better than children in residential care on the Self-report, Teacher, and Carer versions of the SDQ on all the scales where a significant difference was observed.

³ The Internalising Scale comprises problems within the self and includes Anxious/ Depressed, Withdrawn/Depressed and Somatic complaints.
 The Externalising Scale consists of problems that mainly involve conflicts with other people and their expectations of the child such as rule-breaking behaviour and aggressive behaviour.
 The Total Problems Scale adds up the scores for Internalising Syndromes, Externalising Syndromes, social problems, thought problems, attention problems and other problems.
 The Competence scale is about the child’s functional strengths at home and at school with peers and in leisure activities.

The marked difference in outcomes between children in foster care and children in residential care also emerged when the two groups were matched on important variables: age of first admission into care and time spent in care.

Type of care received was the dominant predictor of the scores obtained in the eight main CBCL and SDQ scales. Children in foster care obtained significantly higher scores on 'Total Competence' and 'Pro-social Behaviour', and significantly lower scores in 'Total Internalising', 'Total Externalising', 'Total Syndrome', and 'Total Difficulty' in both the carers' and teachers' evaluations. These results are similar to other research findings carried out abroad (e.g. McCann, James, Wilson, & Dunn et al., 1996; Meltzer, Gatward, Corbin, Goodman, & Ford, 2003; Stanley, 2007).

Several factors might contribute to these results; the extent of early trauma sustained by the children could be one of the most prominent. For instance, a higher proportion of children in residential care when compared to children in foster care had issues related to sexual abuse ($\chi^2 = 6.46$, $v = 1$, $p < 0.05$), physical abuse ($\chi^2 = 16.09$, $v = 1$, $p < 0.001$), emotional neglect ($\chi^2 = 8.95$, $v = 1$, $p < 0.005$), and behavioural problems in the child ($\chi^2 = 6.8$, $v = 1$, $p < 0.01$) cited as reasons for the child's entry into care. Another possible factor that might contribute to the above findings is the low child-to-staff ratio which makes it quite difficult for the members of staff in residential homes to address each child's issue on a one-to-one basis. Moreover, there are inherent difficulties in the nature of group care which, in itself, exposes children to the distress and disturbance of other youngsters, thereby increasing vulnerability rather than strengthening psychological resilience (Richardson & Joughin, as cited in Kelly, Allan, Roscoe, & Herrick, 2003). This could also be one of the explanations toward the finding that children in residential care made considerably more use of psychotherapy and psychiatric services than children in foster care.

10.1.3 Relationships with others

Children in foster care scored significantly better than children in residential care on a number of variables related to building and sustaining relationships with others.

These included: having at least 4 close friends, meeting their friends outside regular school hours at least 3 times a week, and getting along with other children. These findings are similar to those that emerged in others studies, e.g. Meltzer et al. (2003).

In addition, the relationship between the children's ability to establish and sustain relationships and the scores on some of the CBCL and SDQ scales supports the findings of other studies (e.g. Golding, 2010; Fox & Berrick, 2007) which highlight the role of friends in children's well-being and socio-emotional development.

It seems that foster care is more likely to act as a buffer against the development of attachment or trauma-related difficulties. Therefore, from this point of view, children in residential care are at a disadvantaged position as they lack the provision of a consistent caregiver, which makes it difficult for the child to build trusting relationships.

10.1.4 Educational attainment

Similar to other research findings (Schiff, Nebe, & Gilman, 2006; Pecora, et al, 2003; McDonald, Allen, Westerfelt, & Piliavin, 1996), all children in care, irrespective of the type of placement, performed poorly in the three main subjects: Maltese ($M = 52.41$, $SD = 22.2$), English ($M = 47.91$, $SD = 22.71$), and Mathematics ($M = 45.36$, $SD = 25.87$). However, one notes that children in foster care did significantly better on literacy skills than children in residential care. Once again, this is similar to other research findings which note that children raised in residential care tend to have delays in language development (Johnson, Browne, & Hamilton-Giachritsis, 2006), poorer vocabulary, and less spontaneous language (Tizard & Joseph, as cited in Johnson et al., 2006).

10.1.5 Contact with siblings and biological parents

Compared to children in foster care, children in residential care not only have more siblings in care and in the same placement, but they also have more frequent contact with their biological parents and with their siblings.

Findings demonstrate that the impact of the child's contact with their family of origin was different for children in foster care than those in residential care:

- Whereas in residential care more frequent contact with siblings was related to better pro-social behaviour, the opposite emerged for children in foster care, that is, those with more contact had lower pro-social scores.
- On a similar note, for children in residential care, unsupervised contact with one's mother was related to a higher degree of difficulties whereas in foster care those who had supervised contact demonstrated more externalising behaviours than those who did not require supervision.

These findings bring forth the possibility that different dynamics are at play in considering the impact of contact with one's family of origin among the different care placements. Moreover, they clearly bring forth the importance of further research into the differential impact of foster and residential care on contact with one's family of origin.

10.1.6 Importance of extra-curricular activities

A key factor linked to quality of care was the opportunity to engage in extra-curricular activities. The predictors of scores on the 'Total Competence' scale for both groups of children were:

- Belonging to an organisation.
- Meeting with friends at least 3 times a week.
- Engaging in sports.
- Having at least one hobby.
- Participating in chores.

Such activities have been linked to the development of resilience in looked-after children as they expose them to situations where they have to master new skills, as well as, apply problem-solving and emotional-solving skills to deal with challenging situations (Newman & Blackburn, 2002; Stein, 2005).

10.2 Do Maltese Children Living in Out-Of-Home Care have a Higher Rate of Mental Health Problems that fall in the Clinical Range, when compared with the General Population?

Three sources of information were used to establish the prevalence of mental health problems among children in out-of-home care, namely reviewing a formal diagnosis given by a mental health professional, the children's scores obtained on the CBCL and the children's scores obtained on the SDQ. Scores obtained on the CBCL scales allowed comparison with normative⁴ and clinical⁵ samples of children from the USA, whereas scores obtained on the SDQ were compared with a normative sample of Maltese children⁶:

- 82.2% of children (n = 222) did not have a formally diagnosed mental health problem.
- Among the 17.8% of children (n = 48) who had a formal diagnosis 10.4% (n = 28) were diagnosed as having ADHD, making this the most common diagnosis given. Among the other less mentioned diagnosis given were conduct disorder, ODD, encopresis, anxiety disorder or comorbid conditions. None of the children were formally diagnosed as having an affective disorder, a somatic disorder or an attachment disorder.
- Children in out-of-home care scored significantly worse than the normative American population on all the competence and syndrome scales of the CBCL, as can be seen in the tables presented in Appendix A.
- On the other hand, children in out-of-home care performed variably when compared to a clinical sample of American children, as detailed in the tables in Appendix B.

⁴ The non-referred normative sample is composed of a randomly selected sample of American children, from 40 states, who did not make use of any specialised mental health services, substance abuse services or special educational services during the past 12 months. Standardised norms are provided for the Child Behaviour Checklist on the basis of this sample (Achenbach & Rescorla 2001).

⁵ The clinical sample is composed of American children who had used mental health services, substance abuse services or special education services over the last 12 months. They have been selected from a larger random sample of children from 40 American states (Achenbach & Rescorla 2001).

⁶ The normative sample of Maltese children is composed of 10% of the total population of children in Maltese primary and secondary schools in 2006 (Cefai, Cooper & Camilleri, 2008).

- Young girls in out-of-home care (6-11years) showed significantly less difficulties than a clinical sample of American children in all scales of the CBCL (as seen in table B3, Appendix B). Young boys showed significantly less problems on the internalising, externalising and total syndrome scales than a clinical sample of American children (as seen in table B1, Appendix B).
- Older boys (12-18years) showed less externalising problems than the clinical sample, however they presented a similar level of difficulties on the internalising, competence and total syndrome scales (see table B2, Appendix B). On the other hand, older girls in out-of-home care presented with similar competence scores to those of a clinical sample. However, they manifested less behaviour problems than the clinical sample on the remaining three scales (see table B4, Appendix B).
- A large number of children (47.62%, n = 100) in out-of-home care scored within the clinical range of the CBCL competence scale, meaning that they experience functional difficulties at home, at school, with peers and in leisure activities. When considering children's scores on the internalising scale we note that most children (52.38%, n = 110) scored within the normal range of scores. Very similar proportions of the participants scored on the normal (46.19%, n = 97) and clinical (42.86%, n = 90) ranges on the Externalising scale. A closer look at the scores obtained on these scales indicates that children manifest a greater prevalence of externalising rather than internalising problems. Possible contributing factors for this finding range from having an early separation from primary caregivers, failing to develop a secure attachment and adequate internal working models, developing a hostile attributional bias and experiencing difficulty with trusting others, to mutual modelling of deviant behaviour. When the scores on the Total Syndrome scale are analysed one can note that 43.33% (n = 91) of children scored within the normal range, whereas 40.95% (n = 86) scored within the clinical range. These figures indicate that whilst the majority of children in out-of-home

care do not present difficulties in these respective areas, a considerable number of children do experience such difficulties.

- When considering children's scores on the SDQ one can note that both males and females show similar levels of pro-social behaviour to a normative sample of Maltese children, according to the children's own self-reports and teachers' reports, though not carers' reports. However, both boys and girls showed higher levels of overall difficulties when compared to their same age Maltese peers, as indicated in Appendix C.
- This data indicates that children living in out-of-home care have a higher rate of mental health problems that fall in the clinical range when compared with the general population. This is comparable to the international literature (Armsden, Pecora, Payne & Szatkiewicz, 2000; Baker, Kurland, Curtis, Alexander & Papa-Lentini, 2007; Goodman & Vostanis, 2002; Kelly, Allan, Roscoe & Herrick, 2003; McCann, James, Wilson & Dunn, 1996; Meltzer, Gatward, Corbin, Goodman & Ford, 2003; Stanley, 2007). Particular life circumstances in the formative years: experiences of loss and separation related to their admission into care, their care experiences, and difficulties related to adjusting to a different care environment, all contribute to an increased risk of mental health problems among children placed in out-of-home care.

10.3 Are Mental Health Problems among Children in Out-Of-Home Care being Adequately Identified and Addressed?

Data emerging from children's scores on the CBCL together with information regarding any formally diagnosed mental health problem and the children's service usage, specifically of psychotherapy and/or the psychiatric services, was used to address these questions.

10.3.1 *Are mental health needs being adequately identified?*

- A considerable discrepancy emerged between the number of children with a formally diagnosed mental health problem (17.8% of the sample, $n = 48$) and the number of children who scored on the clinical range in any of the CBCL subscales (49%, $n = 132$), indicating an overall trend of formally under-diagnosing.
- Scores obtained on the CBCL were comparable to those obtained among children in out-of-home care in Australia, Scotland and Britain (Chambers, Saunders, New, Williams, & Stachurska, 2010; Meltzer et al., 2003; Millward, Kennedy, Towlson & Minnis, 2006).
- When analysing the scores obtained by children on the DSM-Oriented scales of the CBCL, one can note that out of the 210 who had the CBCL DSM oriented scales duly filled in, nearly 1/5 of the children (18.1%, $n=38$) obtained scores within the clinical range on the Affective problems scale. No formal diagnosis of affective problems was given by professionals. Also, no formal diagnosis of somatic problems was given by professionals, although a very small minority scored within the clinical range of this scale (4.29%, $n = 9$). Nearly 1/4 (23.3%, $n = 49$) of children scored within the clinical range on the Anxiety problems scale. Scores in this regard were associated to formal diagnosis given by professionals, as were scores relating to Attention Deficit/Hyperactivity Problems, where 15.71% ($n = 33$) of children scored in the clinical range. On the other hand, there was no association between the formal diagnosis given by professionals, the scores obtained by children on the Oppositional Defiant problems scale, and the Conduct problems scale. Nearly 1/5 (18.6%, $n = 39$) and 1/4 (24.76%, $n = 52$) of children scored in the clinical range of these respective subscales.
- Essentially, children who had a formal diagnosis obtained significantly higher scores on the Total Syndrome scale of the CBCL ($M = 57.33$, $SD = 32.55$) compared to children who have no diagnosis ($M = 46.33$, $SD = 31.4$, $t(202) = 2.01$, $p < 0.05$) and on the Total Difficulties scale of the

SDQ as indicated in both carers' ($M = 19.12$, $SD = 7.54$ vs. $M = 14.93$, $SD = 7.18$, $t(224) = 3.38$, $p < 0.01$) and teachers' reports ($M = 6.92$, $SD = 7.5$ vs. $M = 13.15$, $SD = 7.22$, $t(194) = 2.8$, $p < 0.01$). This means that the chance of being formally diagnosed by a professional as having a mental health problem is related not to presenting difficulties in one particular sphere, but rather to a higher degree of overall symptom severity.

10.3.2 How are the mental health needs of children in out-of-home care being addressed?

- The majority of children in out-of-home care (54.81%, $n = 148$) attended either one or both of the mental health services (psychiatry or psychotherapy). Children who have a formally diagnosed mental health problem are more likely to attend psychotherapy ($\chi^2 = 7.26$, $v = 1$, $p = 0.007$) or have psychiatric follow-up ($\chi^2 = 58.7$, $v = 1$, $p < 0.001$) than those who are not.
- A considerable number (48.2%, $n = 107$) of children who do not have a formal diagnosis also benefit from these services. This is because they present a sufficient degree of difficulties to warrant a referral even without a formal diagnosis. In fact, children who make use of either of these services score considerably higher on the Total Syndrome scale of the CBCL ($M = 53.87$, $SD = 33.56$) than those who do not make use of these services ($M = 41.46$, $SD = 28$; $t(201) = 2.83$, $p = 0.005$).
- 67% of children having 1 score within the clinical range of the CBCL scales receive services. This is directly comparable to data from international studies e.g. Tarren-Sweeney (2010) where 60% of children scoring in the clinical range receive mental health services.
- Psychotherapy, rather than psychiatric services, is more often used to address presenting mental health difficulties. Children's CBCL scores are significantly associated to their use of psychotherapy ($\chi^2 = 8.6$, $v = 1$, $p = 0.003$), not use of psychiatric services.

- 19% (n = 9) of children in out-of-home care who have a formal diagnosis are not receiving any services. Also, a number of children still have a formal diagnosis notwithstanding the fact that they obtained scores within the normal range of the CBCL scales. Is this an indication that a diagnosis “sticks” to a child even though s/he is not manifesting any significant symptoms?

In summary, a considerable number of children are receiving mental health services. This need for mental health services is being identified and met according to the child’s overall presenting problems. Essentially, it seems that a needs perspective, rather than a system based on formal diagnostic labels has been adopted.

10.4 Which Variables Have an Impact on and Predict the Psychosocial Functioning of Children in Out-Of-Home Care?

In order to establish which factors have the greatest impact in predicting the overall psychosocial well-being of Maltese children in out-of-home care, 4 aspects were considered in greater depth. These included looking into what predicts problematic behaviours or difficulties among this population, what is more predictive of internalising problems in the children, and what predicts externalising behaviours. In order to prevent further stigmatising these children, this study looked into not only the aspects predicting difficulties within this population, but also into what aspects are most predictive of their strengths, by using the strength-based scales on the CBCL and SDQ.

In order to address these aims several regression models were fitted for each scale. Regression was used to identify significant predictors of CBCL and SDQ responses and rank them according to their contribution in explaining the total variance in each respective scale.

10.4.1 What factors predict strengths among children in out-of-home care?

In order to address this question, children's strengths were operationalised through the scores they obtained on the Total Competence scale of the CBCL and the Pro-Social scale of the SDQ. This data indicates what factors predict a good level of functioning socially, at school and in extracurricular activities, and what promotes considerate, helpful, kind and caring behaviour towards others. Moderate to large effect sizes were found indicating that the variables mentioned below identify to a very good degree what predicts children's strengths in these areas.

Better scores on the strength-based scales were obtained among children with the following characteristics:

- Younger children.
- Females.
- Those who attended speech therapy.
- Those reported as coming from a single parent family as a reason for the child's admission into care.
- Children having good peer relationships.
- Those involved in extra-curricular activities e.g. sports, hobbies, belonging to an organisation, and performing chores (better scores).

Lower scores on the strength-based scales were predicted by the following characteristics:

- Parental substance abuse identified as a reason for admission into care.
- Inadequate parenting skills identified as a reason for admission into care.
- The child presenting with behaviour problems prior to admission into care.

- Experiencing multiple transitions during the time spent in care.
- Use of specific services such as occupational therapy and psychotherapy.

10.4.2 What factors predict children's overall difficulties among children in out-of-home care?

The children's overall level of difficulties was assessed through the use of the Total Difficulties scale of the SDQ and the Total Syndrome scale of the CBCL. Both these scales capture children's overall difficulties in several areas of functioning including emotional difficulties, conduct and behaviour problems, hyperactivity and inattention problems, somatic complaints, and social and thought problems. The variables identified in this study have managed to capture a large amount of the variance in the difficulty scores obtained in this population, with the listed variables predicting a quarter of total difficulties identified by teachers and close to half of the difficulties reported by carers and youths.

Having the following characteristics predicted a higher degree of overall difficulties:

- Inadequate parenting skills identified as a reason for admission into care.
- The child presenting with behaviour problems prior to admission into care.
- Experiencing multiple transitions during the time spent in care.
- Lack of participation in sports.
- Making use of the psychiatric services.
- Having a High Support worker.
- Having a greater number of siblings in the same placement.
- Having unsupervised contact with the mother.
- Being male.

- Being young.
- Having no or few close friends and poor interpersonal and peer relations (35% of the children reported having none or only 1 close friend).
- Having poor sibling relations.

10.4.3 Which clusters of factors most commonly impacted children's overall outcomes?

- Various adverse life experiences prior to entering into care contribute to predicting children's overall strengths, difficulties, and internalising problems. However, it was not specifically one particular pre-care experience that negatively impacted functioning in all these areas. Rather different experiences played a role in the development of diverse problems:
- Experiences within the care system.
- Children's involvement in extracurricular activities was identified as a resilience-building factor. This was in tune with other research in the Anglo-American literature (Newman & Blackburn, 2002; Stein, 2005).
- The risk of multiple transitions emerged as a prominent factor. Placement stability is clearly a very important factor in improving young people's overall psychosocial well-being. It has also been shown to have serious consequences not only on children's current well-being but also on long-term outcomes (Del Valle, Bravo, Alvarez & Fernanz's, 2008).
- Several services are being put in place to address children's psychosocial difficulties. Making use of a high support service and the psychiatric services were both predictive factors indicative of worse functioning. However, it was mostly psychotherapy that indicated its predictive power over several scales of functioning.

- Gender predicted functioning in 3 out of the 4 areas assessed. Boys are more at risk for having more overall difficulties, more externalising behaviour difficulties, being less socially versed, and having a lower overall level of competence based strengths.
- Interpersonal competence and having adequate peer relationships emerge as a significant predictive factor among children in care. Having (more) friends, meeting them often and having a good relationship with them were all aspects indicative of positive functioning.

11.0 Recommendations for Policy

- a. Children in foster care are doing significantly better than children in residential care in terms of their psychosocial functioning, and in their ability to build and sustain relationships. These findings persisted when children in foster care and children in residential care were matched on age of first admission into care, and time spent in the care system. *The trend to place an increasing number of children in foster care should be stepped up, given that the environment in foster homes seems to be more conducive towards the well-being of these children.*
- b. Children exhibited higher levels of overall difficulties when they were placed in residential care during their infancy. This finding substantiates Study 1 on the effects of institutional placement for children under five (Abela, Abdilla, Abela, Camilleri, Mercieca & Mercieca., 2012). *It is highly recommended that children below the age of five be placed in foster care.*
- c. Predisposing factors which featured as predictive variables for children's entry into care included substance abuse and inadequate parental skills. These factors highlight the need for better support services to vulnerable families with very young babies. *The perinatal mental health outpatient service could be one of the first ports of call for pregnant mothers attending the clinic. Well-baby clinics are also ideal settings from where*

families with young babies could be attended to in the community, since they reach all families and may alert us to difficulties when they arise. In this respect, families who do not turn up for visits need to be contacted and encouraged to attend.

- d. Children's behavioural problems prior to their admission into care also featured as a predictive variable in their overall functioning during the later years. *Programmes catering for difficulties in early childhood, prior to admission into care, could be offered to these parents and families as a first resort* (See Hutchings, Bywater, Daley et al., 2007 for similar intervention in the UK).
- e. Findings in the study show that children in out-of-home care exhibit a number of behavioural and mental health problems. The school performance of these children is also poor. *The need for a detailed educational and psychological assessment, as soon as a child enters into care, is believed to be a cost effective intervention in a young population at high risk of developing mental health problems.*
- f. The children's school progress indicates that they need more support at school, and to be encouraged to strive for the highest possible level of education. *The Education Division needs to give these children top priority focusing on early intervention, and on social and emotional literacy. Valuing the importance of interagency work between educational authorities, social care and mental health agencies is very important. Educators need to connect with these children in a meaningful way*
- g. The findings show that children in care, who experienced a higher number of transitions, manifest a higher prevalence of externalising difficulties. *There is a need to minimise transitions. One way would be to minimise placements in mental health settings. For this to happen, residential homes need to have a setup to cater for children exhibiting challenging behaviour. This requires further training of carers and staff, supporting*

them in identifying and working on risks for potential placement breakdown at an earlier stage. There should be investment in smaller community-based homes, such as the one launched in 2008 by the Salesians (Don Bosco House in Balzan), as an alternative to St Patrick's, which would also minimise transitions.

- h.** Children not taking part in sports or extracurricular activities exhibited a higher prevalence of symptomatic behaviour. *Children are to be encouraged to take part in sports or other extracurricular activities that help them to relax mentally. Hobbies, too, have been found to have a positive effect on children in out-of-home care.*
- i.** The study suggests that friendships have a beneficial impact on these children. *Different carers and teachers need to be more curious about children's social networks so that these relationships are enhanced.*

12.0 Suggestions for Further Research

Some of the findings that have come out of the study are inconclusive and merit further investigation:

- a.** More research is warranted to help us understand why siblings in the same placement exhibited more externalising problems than other children who either had no siblings in care, or whose siblings were placed elsewhere. What are the factors that contribute to such behaviour?
- b.** Similarly, the contrasting findings regarding pro-social behaviour between children in residential care and in foster care when relating with their siblings, need to be explored further. Another intriguing finding is that children in foster care, who had supervised contact with their mother, exhibited more externalising behaviour than those whose contact was unsupervised. The opposite was found with children in residential care,

where children who had unsupervised contact exhibited more difficulties in their behaviour.

- c.** Whilst we know that almost 48% of children in out-of-home care were attending therapy during the data collection period, we do not know which therapeutic approaches are adopted by therapists and psychologists when helping these children. We also do not have any idea about the effectiveness of therapy for these children. The current study has provided a snapshot view of the services received by children. However, there is an urgent need to monitor the effectiveness of the therapeutic interventions on a long term basis for children in out-of-home care. This auditing exercise needs to be carried out, taking into account the current trend whereby large numbers of children in out-of-home care remain undiagnosed.

- d.** We also need to understand why those children who were identified as coming from single-parent families as one of their reasons for admission into care, fared better in out-of-home care than those who did not have this identified as one of their reasons for admission into care. Within the general population children coming from two-parent families fare better than those coming from single-parent families (Cefai, Cooper & Liberato 2008). How is the situation of two-parent families different in the dissimilar contexts?

- e.** A qualitative research study delving into how these children form and sustain friendships and the meaning they give to them, will also shed important insights on how friendship contributes to the well-being of this population of children.

Some of the areas for further research are quite important and merit forming part of a research agenda in the area of out-of-home care in Malta.

13.0 Conclusion

In line with international research, this study has confirmed that Maltese children in out-of-home care have complex mental health needs brought about by pre-care experiences and by experiences in the care system itself, often including trauma and disruptions in attachment formation. To be addressed effectively, these needs call for a concerted approach involving educational authorities, social care and mental health agencies.

This study also provides us with empirical evidence, which informs the direction we need to take when caring for children in out-of-home settings. These children flourish more, function better, and form life-sustaining relationships when brought up in a family setting. In this sense more investment needs to be put into foster family care. The study has also alerted us to the fact that babies and infants do not thrive in an institution, and as such should not be placed in one at a very tender age. Other residential homes, however, have an invaluable role to play, as they transform themselves into therapeutic communities for children who may need more intensive care that cannot always be provided within the home.

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Study 3:

Exploring the Long-Term Outcomes of Youth Leaving Care

Key Findings

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Key Findings

1.0 Introduction

Many children placed in children's homes in Malta are expected to leave care at the age of 16 or thereabout. Empirical evidence was needed to investigate the long-term outcomes for these children, once they leave the care system.

2.0 Aims of the Study

This study explores how youths who move out of the residential care system experience the transition and settle down. Their stories take into account their life circumstances at the time of the interview and their whole life story narrative. This whole life story account concurs with the literature, which indicates that experiences prior to being admitted into care, the children's experiences in the care system, as well as the conditions of the transition itself all impact the long-term outcomes of children in out-of-home care (MacDonald, Allen, Westerfelt, & Piliavin, 1996).

3.0 Conceptual Frameworks of the Study

The study 'attempts...to generate understanding through sharing first-hand experience' (Gergen, 2009, p. 66) and as such will focus on personal meaning and sense-making from the participants' perspective.

A **social constructionist framework** which gives value to the voices of ten youngsters who experienced life in out-of-home care invites them to 'tell their story'. "The attempt here is to increase the public understanding of these lives and an appreciation for the challenges people (they) confront" (Gergen, 2009, p. 66).

Attachment theory also helps us make sense of the children's needs for love and affection and the impact of the presence (or absence) of significant persons in their lives (Bowlby, 1973, 1979, 1980, 1988; Schore, 2001).

Studies in the area of resilience also shed important light on how these youngsters bounce back from adversity. Resilience is about overcoming the odds, coping, and recovery, in spite of the different risk experiences that this group of persons typically goes through (Rutter, 1999; Schofield, as reported in Stein, 2005).

4.0 Research Methodology

Since this research's purpose is to understand the life experiences of persons who previously lived in a residential care facility for a period of time throughout their childhood and/or adolescence, Interpretative Phenomenological Analysis (IPA) was deemed a particularly suitable qualitative research methodology to analyse the data gathered. This method's uniqueness is that it provides a systematic collection of new knowledge about how an objectively known phenomenon comes into being through the meanings given by those who have experienced it.

As part of the reflexive approach adopted throughout this research (Moustakas, 1994), a group interview, led by a counselling psychologist, was conducted with the research team prior to the process of data analysis and writing. This interview revealed that the research team strongly wished to give a voice to children in residential care and provide ample evidence for policy makers to hopefully effect change in the field of residential care. They all agreed that in some circumstances children could not be brought up in their own families. However, institutional care was not these children's best option. In the case where foster care in family homes was not possible, small group homes, where children lived like in a family, were considered to be the next best alternative.

The study targeted children who were in residential care between 1999 and 2002 from the age of 13 until they reached their 18th birthday. After obtaining approval by the Research Ethics Committee of the Faculty of Education and of the University of Malta, the Children's Home Office succeeded in tracking 23 participants who met the criteria. Ultimately, the number of persons available for the research interview was 10. Once located, the participant's consent to be interviewed was requested. In all, 9 in-depth interviews were carried out, including one with two brothers, who wished to be interviewed together.

Due to the sensitive nature of this study, a number of ethical considerations arose including the potential exploitation of vulnerable people, possible harm or distress, and the potential risk that the participants would be identified by readers. Arrangements were made with the Commissioner for Children and *Aġenzija APPOĠĠ* for participants' referral to *Aġenzija APPOĠĠ* should the need arise. Each participant's identity was carefully masked to ensure that privacy and confidentiality was strictly safeguarded.

Data transcriptions of this research were instrumental in enhancing reliability. Moreover, blind peer review of the interviewer's analyses further enhanced reliability. Respondent validity gave our participants the status of co-researchers. Each participant was given a summary of the interview's themes, following the transcript's theme analyses. Participants gave their view about the summary's faithfulness to their statements during the interview. Besides ensuring the study's validity (Cresswell, 2007), this approach further promotes an emancipatory perspective to our research by privileging the participants' voices in telling their story.

5.0 Findings

The nine interview transcripts generated 12 superordinate themes which in turn generated a cluster of related themes. Box 1 provides us with the 12 superordinate themes (for a more detailed table with superordinate themes and related subthemes see original study):

Box 1: *Superordinate themes*

1. **Supportive relationships and positive practices whilst living in care.**
2. **Important yet sometimes ambivalent contact with family of origin: always in the background.**
3. **Context around admission into out-of-home residential care.**
4. **Psychosocial well-being whilst living in care.**
5. **Yearning to belong whilst experiencing rejection, shame and stigma.**
6. **Negative experiences whilst in care.**
7. **The needs of children with behavioural difficulties and the response by the care system and the mental health services.**
8. **Leaving care: A harsh transition for the children.**
9. **Innumerable needs faced upon leaving care: a desire for more protection.**
10. **Extent of distress experienced after leaving care.**
11. **Coping upon leaving care – voices of resilience.**
12. **Proposing a way forward.**

5.1 *Supportive Relationships and Positive Practices whilst in Care*

All participants spoke of a supportive relationship they experienced, for some time, whilst living in residential homes. The quality of relationships with carers emerged as very significant when participants recalled positive experiences in residential care.

Five participants spoke specifically about the characteristics of what they perceived as effective carers within the residential home. A number of participants spoke of the benefits of meeting an adult who could act as a mentor. For Alexia, the residential home seems to have been a safe haven providing protection away from her unsafe, abusive home, at least for some time. Alexia emphasised the ability of the nuns who cared

for her to make her feel special, loved, valued, and wanted. Raymond spoke about his respite foster carer whom he described as a guardian angel being there for him in the worst moments. Simon mentioned that the most effective care givers were those who could contain instances of challenging behaviour. He passionately spoke of an enduring relationship with an adult who genuinely cared and remained available through rough times. In terms of supportive relationships, Luke highlighted practical acts that carers carried out, such as making leisure resources available to children. He also emphasised the help received at school:

“There were people ready to teach, because, wherever I went, teachers were ready to help and teach me” (ll. 1052-3)

“U kien hemm min jgħallmek, għax it-teachers għaldaqstant, kull fejn mort ippruvaw jgħinuni u jgħallmuni” (ll. 1052-3)

Together with Samuel, Luke also emphasised the sibling-like relationships with the other boys living at the residential home, which he described as being even more significant than the one he had with his siblings.

Becky spoke about a particular nun whom she perceived as a mother substitute as she showed genuine interest in her. She also appreciated the psychologist who followed her. She described this relationship as a containing one within which she felt valued and important. Becky expressed her appreciation towards the nuns: “if I did not have them, I don’t know where I would have ended up...it’s the truth” *“ara li kieku ma kellix lilhom ma nafx fejn jien...il-verita”* (l. 188).

It is interesting to note that whilst all participants could speak about positive experiences within out-of-home care, Abigail could not.

5.2 Important yet Ambivalent Contact with Family of Origin

For Raymond, Daniel, Samuel and Luke, their biological parents remained important. The importance that Samuel, Abigail, and Raymond gave to the relationships with their siblings, despite the difficulties they experienced to keep in contact, seems to

be in line with the importance given to relationships with parents. The sense of going back to one's roots emerged as important not only for Raymond but also for Luke, Daniel and Samuel who went to live with a relative, sometimes in inappropriate settings, once they left residential care at 17 years of age.

While living with his biological parents as a young boy, Samuel had experienced bitter conflict and violence at home. Whilst in care he spent long stretches of time without meeting them, yet he spoke fondly of his father who died of alcohol abuse.

Luke seems to have been able to maintain a positive relationship with his biological mother:

“She could not give us a lot of things, but I always appreciated her.” (l. 41)

“Ma setgħatx ittina ħafna imma jiena dejjem apprezzajtha.” (l. 41)

Yet, he spoke about how hurt he feels when he tries to understand why his mother gave up on taking care of him and his brother. Managing the ambivalence of relating to parents one cannot live with, may help us appreciate the intensity of contradictory emotions that these children have to contend with.

Raymond's experience with his parents was further complicated as he discovered who his biological father really was in his teens. Initially, he was led to believe that his mother's partner was his biological father. Eventually he started to question this man's identity and was able to meet his real biological father. His journey of discovery is quite remarkable, yet the fact that he managed to make sense of his story without any support is even more significant.

Some participants also spoke about support by the family of origin while in care. Simon spoke fondly of his mother as he recounted how she came to his defence when he was allegedly slapped by an adult whilst in residential care. Alexia found her father's support when she was recovering after trying to commit suicide because her partner had cheated on her. This meant a lot to her as she was also pregnant and in need of a place to stay at that point in time.

Whilst for all other participants, contact with family remained in the background, Abigail actively wanted to distance herself from the family within which her abuse took place. Her internal narrative mirrors the same level of severity and thus supports her intention to dissociate herself and disown her family.

5.3 *Context around Admission into Out-Of-Home Residential Care*

Many of the participants were abused and lived through harrowing traumatic events to the extent that their lives were in danger at the time of their admission into care. These circumstances included very chaotic life styles due to alleged severe abuse and living with alcoholic parents which led to unsafe situations.

Abigail, Becky, Raymond, Simon, Alexia, Samuel, and Luke, all spoke about difficult circumstances caused by abuse within their family of origin that led to their admission into out-of-home care. One participant spoke thus about the severity of the abuse endured:

“My mother never wanted me...I remember she had many wine bottles...instead of giving me a feeding bottle she used to dip the pacifier in the wine, or whiskey so I would go to sleep; she always wanted to get rid of me” (ll. 48-55)

“Jiena ommi qatt ma riditni...Niiftakar kellha fliexken ta’ l-inbid...flok ittini l-bottle tbill il-gaḥaḥa go l-inbid jew l-whiskey biex norqod, dejjem teħles minni” (ll. 48-55)

Interestingly, when one of the participants was asked by the researcher about her age when she was being abused at home, she replied:

“I have no idea...because I used to be so...they used to treat me so badly that you do not even know how old you are... [but] I remember it clearly, she would open the door and, once again, down to the cellar I went, I remember it, she would push me down the stairs, bam, and she would lock the door.” (ll. 59-65)

“M’għandix idea, għax tant kemm kont...kienu jittrattawni ħazin li lanqas idea la kemm ikollok żmien...[imma] niftakar veru ċar li kienet tiftaħ il-bieb u erga’ ġol-kantina, niftakru da, kif tiftaħ il-bieb, timbuttani t-taraġ, bum, għal isfel u tagħlaq.” (ll.59-65)

This young woman could not recall her age yet she could vividly remember the door that led to the place of banishment and punishment. She spoke about the dynamics of abuse and how she was led into having to keep the physical abuse a secret and not tell her father.

In Alexia’s story the care system was surprisingly not enough to protect her from the abuse at home. At a particular point in her life her father took her back into his custody and rejected the possibility of his child being adopted. This resulted in further abuse:

“Then my father took me from the care home situated at (name of location)...and I ended up at this one, his sister, do you understand? I don’t remember how old I was exactly and I was treated badly again. I...she used to lock up the fridge with a padlock...the dog was treated much better than me...school...my school things, my satchels were torn, only one of my two shoes had a sole, I used to feel dirty and sad. So I spoke to my guidance teachers at school...and they took my case in hand and warned me not to say anything to my aunt about going into care and they assured me that they were soon coming to take me away.” (ll. 160-71)

“Mill-istitut ta’ (isem tal-post) reġa’ ħadni missieri...u spiċċajt għand din, jiena, li tiġi oħtu, qed tifhem...ma nafx kemm kelli żmien eżatt ma niftakarx, u ergajt, ġejt ittrattata ħazin. Jiena...issakkarli l-fridge bil-katnazz, l-keġb aħjar minni...l-iskola...l-affarijiet ta’ l-iskola...basktijiet imqattgħin, biż-żarbun qiegħ iva, qiegħ le...hekk kont inħossni maħmuġa u mdejqa allura kont kellimt il-guidance

*teachers, l-iskola li kont immur jiena...u irrangawli qaluli titkellem
xejn maz-zija u qaluli daqt niġu għalik...” (ll. 160-71)*

Interestingly, Benjamin seems to have made sense of his admission into out-of-home care as just another normal phase in life and we were left wondering whether he actually needed to be in out-of-home care.

Simon spoke about how his child protection social worker empowered him by accompanying him to visit various residential homes, in order to see what they were like, prior to his admittance. This made him feel some control in the process of admission.

5.4 Psychosocial Well-Being whilst being in Out-Of-Home Care

Trauma and its impact on participants emerged as a theme within this super-ordinate theme. Simon presented the overall environment within residential care as rather challenging with occasional aggressive outbursts between residents. One wonders how such an environment impacts children who have already been exposed to violence within their birth families. Simon aptly described the impact of trauma in the following manner:

“I used to get cross very easily, for example, if someone shouted at me or something like that, I would just lose it since I would imagine those moments when I used to live with my mum, everyone shouting at you, it’s like you would have been suffering so much that you would not want anyone else to hurt you any more...” (ll. 252-7)

*“Għax kont niżblokka jiġifieri, tipo, kif xi hadd kien jgħajjat miegħi
jew hekk, nintilef, għax kont ingib immaġinazzjonijiet ta’ meta kont
għand ommi, kulhadd jgħajjat miegħek, kulhadd tkun tipo...il-kelma
eżatt qisek tkun tant muġuġħ li ma tkunx trid min iweġġgħek iżjed...”
(ll. 252-7)*

Under the impact of trauma, as the child’s survival and self-protection systems take over (Heard & Lake, 1997, 2001), it becomes difficult for the child to differentiate between caring and threatening acts. When speaking about his present life, Simon

stressed stability and also his recovery from this trauma. The residential care experience seems to have provided him with a restorative experience where adults could soothe him and thus reinstate safety (Cairns, 2002).

The pervasive impact of trauma on identity can be appreciated in Becky's struggle in the following quotes:

“...because I did not know who I was, I did not even know where I was, because I did not even believe I resided in Malta, as I simply thought that I lived in a world...I don't know...really” (ll. 1382-9)

“...*għax ma kontx naf min jien, ma kontx naf fejn jien, għax lanqas kont nemmen li qiegħda Malta, kont naħseb li qiegħda go dinja...ma nafx...bis-serjeta...*” (ll. 1382-9)

The identity challenges typical of adolescence develop into a truly complex struggle when superimposed with the impact of trauma and the stigma of living in residential care.

Alexia described how she coped through promiscuity, which included flirting with older men, and wanting to get pregnant, at all costs, by anyone. Coleman & Cater (2006) connect this to unmet needs for love and affection.

Samuel spoke about his experience thus:

“That I was not loved much...so I ended up numb and not in touch with my feelings.” (ll. 362-3)

“*Li ma tantx kont maħbub...allura ġejt bla feelings ma tantx inħoss.*” (ll. 362-3)

One wonders whether blocking off feelings was an essential psychological defence mechanism for Samuel.

In terms of dealing with psychological pain, Daniel explained that within the residential home there was the possibility of seeking emotional support. Abigail also spoke about the need to speak out in order to be able to cope, yet she felt that carers and professionals were not really aware of how she felt. Throughout his interview, Simon accentuated how he coped by acting tough.

5.5 *Yearning to Belong whilst Experiencing Rejection, Shame, and Stigma.*

Benjamin perceived living in care as acceptable but for many other children it was a constant reminder of rejection by one's family. Daniel described the experience of living in out-of-home care as "surely not normal" "*mhux normali zgur*" (1.10). He summarised his life in residential care as growing up with a sense of insecurity which "is enough to break up someone so young" "*li hi bizzejjed biex tkisser lil xi hadd daqshekk zghir*" (1.25). It left him feeling like he had to grow up too quickly.

For Samuel, "I don't know what a family means" "*li familja ma nafx x'inhi*" (1.360) was the most difficult aspect of living in residential care alongside rejection.

Luke did not seem to have processed the pain of rejection by his mother. He is still trying to make sense of her decision and feels he has lost the opportunity to be with his father who passed away. Stein (2005) highlights the need to deal with such a persistent sense of longing, but one wonders what could heal this unmet developmental need in children who live in residential care. During the interview Raymond found the experience of having to recall his childhood and teen years as difficult, perhaps painful. His internal struggle speaks about the shame related to the experience of not fitting in. He felt this humiliation when he needed to explain his situation to his girlfriend's parents. Moreover, Raymond attended a church school where he was one of few children who lived in out-of-home care.

According to Daniel, some people describe the home where he lived as a place which hosts "...children of the wayward" "*...fal ta' l-imqarbin*" (1.189) He felt treated as an outcast by the general public and judged this as an "old-fashioned and ignorant mentality" "*mentalita antika u mentalita nJORANTA*" (1.66).

Becky spoke extensively about the effect of this stigma on her development:

“The nuns accompanied me, and I used to say look at me, I am with the nuns and they are with their parents, you do feel it, you strongly feel these emotions, even on parents’ day for example” (ll. 205-7)

“Kienu jwassluni s-sorijiet, kont ngħid ara jiena mas-sorijiet u dawk mal-ġenituri, tħosshom ta dawn l-affarijiet, ħafna tħosshom anke parents’ day eżempju” (ll.205-7)

Samuel explained that “the fact that I lived at a children’s home was always on my mind” *“dejjem kienet f’rasi li qiegħed f’istitut”* (l. 462). The manner in which Alexia spoke about shame may help us understand the interplay between internal factors and external factors in the generation of shame and stigma (Kaufman, 1985):

“...because it’s like over there when you start growing up, you are becoming an adolescent, you are embarrassed to be seen with the nuns, I know that you don’t have anything to be ashamed of, because the nuns went out so that I could go out too. They took me to the countryside, among the trees, and they used to bring along a thermos flask, and I really used to enjoy myself just as long as there were no people around.” (ll. 414-8)

“...għax qisek hemmhekk tibda tiżviluppa inti, tibda ssir tfajla qisek tistħi mas-sisters, erhilu m’għandnix għal x’hiex, huma kienu joħorġu, s-sisters, biex joħorġu lili, jeħduni ġol-kampanja hekk qalb is-siġar, nieħdu t-thermos u dan, u jien kont nieħu pjaċir sakemm ma kienx ikun hemm nies.” (ll. 414-8)

5.6 Negative Experiences whilst in Care

A number of participants in our study spoke about alleged abuse or abusive situations they witnessed whilst living in residential settings. Simon and Becky spoke about having been hit by carers whilst living in residential care. Becky described how on a particular occasion the nun on duty caught her masturbating in bed and she was

smacked for her behaviour. She also spoke about, allegedly, having been sexually abused at 8 years of age by a maintenance man whilst in residential care; the impact of this alleged abuse was devastating:

“I felt dirty, but it was not my fault, and I used to cut myself because I felt really low...I used to say: ‘Dammit, I am living in a home and I am still suffering?’” (ll. 625-30)

“Kont inhossni mahmuġa u ma kienx it-tort tiegħi u kemm kont naqta’ idejja...hekk qed inhossni hekk...Kont ngħid: ‘Istja qiegħda ġo istitut u xorta qed inbati?’” (ll. 625-30)

When abuse allegedly occurs within a setting that is meant to offer protection, the sense of disappointment, desperation, and hurt must be truly devastating. This calls for systems that are open to scrutiny and operate within a framework that supports the implementation and auditing of standards.

Becky also spoke about how living in an institution seemingly limited her life choices. Though at a point in her life, one particular nun paid for her private tuition, this was not always possible and she could not pursue ballet lessons. She added that had she been raised up in a different environment, she might have fulfilled her potential.

There were other instances when participants mentioned how the care system failed to ensure a continuity and stability in care. Abigail spoke about how the frequent changes in care impacted her development:

“I did not even know how to write my name (l. 434)... I never had an education as I lived a chaotic life...at the care home...then my father would help me escape from the home, I would stay away for about one or two weeks and then I would go back...I lived in such a confused state that I have not received the sacrament of Confirmation up to the present day” (ll. 441-4)

“Jiena qas kont naf nikteb ismi (l. 434)...ma tghallimtx skola ghax kienet imgerfxa l-hajja tieghi...l-istitut...jerga’ jharrabni missieri, nagħmel ġimgħa ġimagħtejn, nerga’...jiena fil-fatt tant kemm kelli tgerfix lanqas Griżma ma għamluli, għadni sa llum il-ġurnata bla Griżma.” (ll. 441-4)

Luke spoke about the fact that food was frequently not enough for all the boys. He spoke about occasions when the food given would be “expired” *“maqtuġħ”* (l. 299). Luke was also very passionate about the fact that children need to be heard and they should not have to wait to become adults to be believed. He was particularly angry at religious congregations that he perceived as not living up to their ideals. He described an overall picture of residential homes as closed systems which were tough to penetrate and where children lost their rights. He expressed anger at the fact that some children were not allowed contact with family members. During the interview Luke came across as still being angry about the alleged harsh experiences that he went through. Moreover, the negative experiences that he seems to have endured with the nuns and the priests seem to have negatively impacted his religious beliefs. The theme of ambivalence towards religion featured prominently in Samuel’s interview.

Preferential treatment was also mentioned by Daniel as a characteristic of ineffective carers. Luke also mentioned that at times the most challenging children were labelled and some care workers discriminated against them. Samuel explained that within the mixed gender home, in his perception, “the girls received preferential treatment” *“il-bniet aktar ippreferuti kienu”* (l. 43). He also expressed his disappointment that the children and members of the religious congregation who lived on the same premises did not share the same standards of living.

Becky’s anger was directed towards what she perceived as an unjust system. She referred to an episode during which she was about to be fostered by what is known in the local residential care system as a social contact, but her father did not consent to this. She was very upset about this and to make matters worse her social contact, slowly, stopped seeing her.

One other participant regretted the fact that because her father was resolute about “wanting to keep” all his five children, she was not adopted when there was a clear opportunity for this to happen. This draws our attention to the need for liaison between the legal and out-of-home care systems in order to be able to deal effectively with such situations and if necessary revoke parental rights.

One participant also felt betrayed by the system when his/her abusive father was found guilty by the court, yet the father did not serve his prison sentence but was sent to a psychiatric hospital because, according to the participant, he was related to someone in power who allegedly spoke up for him.

This sense of having experienced an unjust system was also echoed by Luke who expressed anger at the fact that his parents sent him into a residential home and that he lost the right to have access to his family. He sees this as unjust:

“...because you have not only taken him away from his parents, but also from the life he grew up in ...” (ll. 45-7)

“...*għax inti qtajtu mhux mill-ġenituri biss, mill-ħajja li dan kiber fiha...*” (ll. 45-7)

5.7 *The Needs of Children with Behavioural Difficulties and the Response of the Care System and the Mental Health Services*

In our conversations with the participants, several of them complained about the harsh treatment they received because of their rebellious behaviour. The issue of inappropriate punishment also emerged within this theme. Luke spoke about alleged physical punishment. He also spoke about inept and unsafe practices such as when boys who misbehaved were supposedly sent to bed without supper or told to sleep “under the stars” “*taħt l-istilel*” (l. 52). “Under the stars” meant that you just grab the mattress without any blankets and you have to sleep downstairs in the open. He spoke of other situations where adolescents were made to sleep in a corridor.

Becky also spoke of an authoritarian and coercive attitude whilst Samuel also recounted how he was forced to eat all his food whether he liked it or not. By its very essence food and feeding can be an extremely nurturing part of the adult-child relationship, yet this does not always seem to have been the case.

One of the participants spent a long time living within the psychiatric hospital. She did not perceive such hospitalisation as having been helpful or effective in addressing her challenging behaviour.

A male participant also spoke in this way about the stigma:

“they just shove you into Mount Carmel⁷. You are stigmatised. No they kept me there with the adults.” (ll. 91-2)

“jitfghuk Mount Carmel. Għalik tkun name ħażin. Le, mal-kbar kienu tefghuni.” (ll. 91-2)

The verb “shove” “jitfghuk” (l. 91) implies a sense of coercion and power which must have had a negative psychological impact on these children. Three participants did not experience the mental health service as having met their needs and as appropriate in helping them deal with their difficulties. One of them said that she spent two birthdays at the psychiatric hospital and although the residential home staff still brought her cakes and organised a party for her at the hospital, she still recalled those moments as humiliating.

The participants mentioned above were all admitted into the psychiatric hospital through police involvement who escorted the children there:

“I had been taken there under police order and the first time I was sent to Ward 10 until they took me to YPU...then I spent 4 months in ward 6 with the adults. First in ward 10, then ward 6 and finally at YPU. I was the youngest one, I was 14 years old.” (ll. 893-900)

⁷ Mount Carmel is the national mental health hospital.

“jiena bil-pulizija dhalt eh u l-ewwel darba ward 10 tellghuni, qabel ma niżluni l-YPU...u mbagħad għamilt 4 xhur ward 6 mal-kbar. L-ewwel ward 10, ward 6 u mbagħad YPU. U jien kont l-iżgħar waħda, kelli 14...” (ll. 893-900)

Responding to unruly behaviour through hospitalisation and confinement especially if prolonged, may further aggravate the rebellion. A particular participant explained how in fact following admission her behaviour deteriorated in a downward spiral.

5.8 *Leaving Care: A Harsh Transition for the Youngsters*

Although youngsters living in care were aware that their departure from care was imminent, many said that they were not involved in the decision making process prior to leaving the care facility, which often occurred hastily and without the necessary preparation.

Abigail, aged 17, felt that professionals were not sensitive to realise that she was unhappy with being placed in a home which catered for persons with learning difficulties when she had to move out of the residential home within 24 hours.

Samuel felt that leaving care was a leap in the dark and meant having to grapple with a lifestyle which not only surprises any care-leaver, but can also lead to pain and suffering:

“There were some who suffered. For example as far as I am concerned I suffered and did not at the same time. I had my mother. I had a mother who was not really that good, so and so. There were people who were worse off than me. There were those who had no one and they had to fend for themselves immediately.” (ll. 209-11)

“Hemm min bata. Per eżempju, kif rajtha fuqi, bejn batejt u le. Għax kelli lil ommi. Jien forsi kelli lil ommi, li forsi ma tantx kienet tajba,

hekk u hekk. Kien hemm min kien hafna aghar minni. Ma kellu lil hadd u mal-ewwel irid jara x'se jagħmel." (ll. 209-11)

The female respondents claimed that they were not prepared in terms of relationships with men and sexual issues:

"I had no one to teach me and I was not savvy enough to know what to avoid because I felt I did not know anything at all, or to tell you to take some precaution for example...nothing ..." (ll. 475-9)

"ma kellix tagħlim biżżejjed u min jiftaħli moħħi, per eżempju oqgħod attenta, tagħmilx hekk, jew tagħmilx hekk jew jgħallmuk ċertu affarijiet għax ma kont naf xejn, jew uża affarijiet per eżempju...xejn." (ll. 475-9)

Nearly all interviewees claimed that they were still too immature when they left the residential care setting when still in their teenage years.

Daniel succinctly describes that time as very challenging and characterised by chaos:

"A huge mess, psychologically traumatic but although difficult, you have to see how to survive. You have to take the best from each situation." (ll. 431-2)

"Tahwid kbir, tkissir tal-moħħ imma ifhimni, diffiċli biex toħroġ minnha. Trid tipprova tieħu l-aħjar minn kull sitwazzjoni." (ll. 431-2)

Raymond went to live in a slum. During the interview he recalled that it was such a hard time that he prefers to avoid even just thinking about it now after so many years.

5.9 *Innumerable Needs Faced Upon Leaving Care: A Desire for More Protection*

An immediate concern, once out of care, was money and the need for the financial help necessary to cope with life's basic necessities. Soon after leaving care at 16, many of the respondents such as Alexia passed through a very turbulent time and was not able to cope adequately not only financially but also emotionally:

“I have the rent to pay...I pay for everything, myself, from the social welfare benefits that I get...and I cannot go out to work as I have little children...everything, everything. This is how I spent my life till the present day, I cry all the time, all the time, because nothing is working in my favour.” (ll. 275-7)

“Spiċċajt bil-keru, nħallas kollox waħdi, bir-relief, bit-tfal ma tistax taħdem...minn kollox, minn kollox. Il-ħajja tiegħi, vera, sa llum, nibki, ara nibki, nibki għax m'hemm xejn favur tiegħi.” (ll 275-7)

She not only got pregnant at 16 but also had an abusive partner who finally abducted her son when he was born. As a result, she ended up with no support whatsoever.

One of the biggest challenges that the persons interviewed all spoke about, is that of finding a stable job and being able to rely on a steady source of income. Many had to take on various jobs as long as they had some money to keep going. The fact that many did not possess any academic or vocational qualifications made finding the right job all the more arduous.

Another common experience among care leavers, which reflects an unstable lifestyle, was the necessity to seek or frequently shift living arrangements which often were far from ideal and resulted in quick-fix but inadequate shelters. Samuel reflected on the absolute necessity of needing the support of family and friends when he said “on your own, you don't cope very easily” *“waħdek ma tantx tkampa”* (l. 569). Alexia states:

“I ended up homeless, with a little girl in tow, and I slept at strangers’ homes until I found this place where I am staying now.” (ll. 390-2)

“Spiċċajt b’tifla, barra, jiena, u spiċċajt irqadt għand in-nies sakemm sibt hawn fejn qiegħda.” (ll. 390-2)

Some of the participants in this study, particularly the women, tended to rely heavily on social assistance. Abigail and two other participants spoke of always having been on social benefits in order to maintain themselves and their child/children. It emerges clearly from this theme that these youths do not have a stable family support network, have limited or no financial resources, are often lacking in necessary functional life skills, and are likely to have not obtained sufficient educational success that can lead to meaningful employment opportunities.

5.10 *Extent of Distress Experienced after Leaving Care*

The risks the participants faced once outside were multiple, and included abuse, alcohol and/or drug addiction, single parenthood, and difficulties to enter and sustain long lasting relationships. Studies clearly suggest that youths leaving care, face many more challenges than their peers (Wertheimer, 2002; Tweddle, 2005; Maunders et al., 1999).

Simon, for example, experienced severe isolation after leaving the care facility at age 18:

“I spent 7 years living alone and I know how difficult it can be, the fact that you go in and you just find darkness.” (ll. 567-9)

“jien għamilt 7 snin ngħix wahdi u naf kemm hi iebsa jiġifieri, dik li tidħol u ssib id-dlam” (ll. 567-9)

Alexia discovered her partner’s betrayal, only after she was pregnant with his child. She attempted suicide and was admitted into a psychiatric hospital. Luke also had an alcohol problem and dabbled in drugs. Some overdosed on drugs, while others spent

some time in prison. Raymond found easy access to drugs and became addicted to heroin for a while. Becky concludes with this personal reflection:

“For me personally, it is that when they leave the care home they should find someone to greet and support them. I know a lot of my friends, who left with me, who have all ended up homeless. I am sorry to say that half of them have died of an overdose. There is lack of attention...and it's true that we don't seek help. But then who is going to seek help if they have just come out from a residential home? One just wants to go out and discover the world, no?” (ll. 137-41)

“Għalija personali hu, li meta joħorġu mill-istituti jsibu lil xi hadd jilqagħhom għax jiena naf hafna hbieb tiegħi li harġu miegħi kważi kollha fit-triq. Jiddispjaci ni ngħid li nofshom mietu b'overdose. Pero' hemm nuqqas ta' attenzjoni u vera forsi ma nfitxux għajjnuna. Imma dan, min ha jiġi jfittex l-għajjnuna jekk għadu hiereg mill-istitut? Imur jiskopri d-dinja vera?” (ll. 137-41)

Many of the interviewees stated that building and especially sustaining long-term relationships is a challenge. Several were eager to have their own family and ensure that their children are brought up at home by them as their parents, possibly in an attempt to unconsciously compensate for that loss of family life they did not have as a child.

Another female respondent felt she had no choice but to marry at a very young age in order to have some financial security at the cost of changing religion and finding herself in a very abusive relationship. One other female participant had a baby from a man who did not acknowledge his child. Subsequently, she entered into a marriage of convenience with another man who took care of her and the child. A different participant ended up in an abusive relationship with a foreign man who also abducted her son. Her planned and voluntary teenage pregnancy hastened her out of care in the hope of living a better and independent life dearly loved by a caring partner, but she was very disappointed:

“I thought I was going to be better off, it is not true at all...I wanted to get pregnant by him so I could leave that place. But whoever acts like

me; they will be committing a grave mistake, because now I have ended up an emotionally broken woman.” (ll. 274-5)

“Jien mingħalija ħa nkun aħjar, ma jkun vera xejn.....ridt noħroġ pregnant minn tiegħu biex nitlaq minn hemm. Pero’ min jagħmel hekk vera jkun żball, ah, għax illum il-ġurnata spiċċajt imkissra.” (ll. 274-5)

5.11 Coping upon Leaving Care – Voices of Resilience

Daniel’s words succinctly introduce the topic of resilience and the determination of many of our interviewees to survive life after care, despite having so many odds against them:

“The fact that you learn that you can survive on your own is already an important step in life.” (ll. 799-800)

“Titgħallem li isma’ you can survive on your own diġa hu pass importanti fil-ħajja.” (ll. 799-800)

Samuel clearly stated that the support and advice of various care workers were important factors in helping him find the necessary stability. However, ultimately, he believed that his own resilience was crucial.

Luke’s description of a positive outcome was also echoed by Simon who claimed that he is satisfied with his current life:

“At present, I think I consider myself a family man and I am doing very well. You may ask but how is your life different from that of other people?...It’s not, but I have what I want. I have my own house; I have a wife and a son. I know that once I finish work I return home and there is someone to greet me.” (ll. 661-5)

“Illum nahseb li, ifhimni, nista’ ngħid li raġel tal-familja, miexi sew ħafna. Tipo, tghidli x’hajja differenti għandek minn ħaddiehor? M’għandix, imma għandi dak li rrid. Għandi post, naf li għandi l-mara u hemm it-tifel. Naf li meta spiċċajt ix-xogħol naf li hemm xi ħadd li se jilqagħni, qed tifhem.” (ll. 661-5)

The theme of children constantly came up and is a leitmotif that runs through most of the interviewees’ narratives. Their resolve to love and bring up their children to the best of their abilities is truly striking. Becky tells us how she managed to renounce drugs and now focuses entirely on bringing up her son.

After his previous lifestyle of drugs and gambling, Raymond felt settled now and expressed a strong sense of accomplishment and satisfaction at having created a family to call his own:

“Now I am better, as I have settled down...settled and comfortably off. I lack nothing. I found a good girlfriend. You understand? At present she is not working as she is staying home to take care of our son, until he is a little older. We really are very careful. If you are careful, you can do anything...you don’t need loads of money to live a good life.” (ll. 839-42)

“Aħjar issa, issetiljat...u...issetiljat u komdu eh. Ma jonqosni xejn aktar. Sibt tfalja bil-għaqal. Fhimt? Bħalissa mhux qieghda taħdem għax biex tieħu ħsieb it-tifel sakemm jikber u hekk. U noqogħdu bil-għaqal. Jekk tkun bil-għaqal tagħmel kollox.....m’għandekx bżonn flejjes kbar biex tgħix hajja tajba.” (ll. 839-42)

When still young, Becky attached to another girl with whom she had a lesbian relationship. Meanwhile, she also got pregnant and had a baby that two women cared for, together. Although recently this lesbian relationship came to an end, it remains the most significant and long-term relationship she has had to date. Abigail also found a lot of support from a boyfriend who took on a caring and fatherly role towards her.

The support, the care-leavers had from some of their mentors, also bolstered their resilience. Samuel, like Robert, related how a contact with a particular social worker was particularly helpful in those years after leaving care.

Similarly, Raymond gratefully owed a lot to the support a supervisor at work gave him:

“There was a lot of support even at my workplace because I even had problems in that area and with the problems I had, I could never work...He supported me a lot...even up to now.” (ll. 690-1)

“Kien hemm hafna support min naha tax-xogħol għax kelli anke problemi jiġifieri b’dawn il-problemi qatt ma taħdem żgur... Issapportjani hafna jiġifieri...għadu s’issa.” (ll. 690-1)

Some participants, though not all, were also hopeful about their future life chances:

“It’s good that you do not get discouraged...That you do not lose...in the sense that...there is a chance that you will make it in life. There is a possibility that you will be better than your parents. There is that possibility too and you have to work hard for it, but let’s hope for the best.” (ll. 781-4)

“Tajjeb li ma taqtagħx qalbek...Li ma titlifx...fis-sens li isma’, hemm possibilita’ li tagħmilha f’din il-ħajja. Hemm possibilita’ li tkun hafna aħjar mill-ġenituri tiegħek. Hemm dik il-possibilita’ ukoll, li trid taħdem għaliha imma, ejja nisperaw fit-tajjeb” (ll.781-4)

5.12 Proposing A Way Forward

The themes that emerged within this superordinate theme can be broadly divided into recommendations for ‘life in care’ and those related to ‘leaving out-of-home care’.

Some participants voiced their criticism regarding the enormous buildings housing the residential homes. Benjamin criticised the lack of privacy due to living arrangements in dormitories coupled with the lack of shower units whilst his brother criticised the overall ambience which needed considerable refurbishment.

Simon spoke about the need for more flexibility, which would counteract the rigidity of an institutional structure, and advocated the need of responsible adults who would be available to them. Luke stressed that children should be given the opportunity to keep in touch and express their feelings with members of their family of origin. Daniel also made a very interesting suggestion in terms of mentoring and positive role modelling by ex-residents.

Becky expressed her dissatisfaction and anger at the system that regulates social contacts and stressed on the fact that children need to be protected from yet another rejection or inconsistency. In terms of this need for more protection, Luke proposed looking at other alternatives to institutional care such as kinship fostering and fostering, where he feels children stand a better chance of getting more individual attention.

Daniel shifts our attention towards the need to deal with the children's inner reality. He adds that whilst living in residential care he went to see a psychologist. Though these visits started off as an escape from school, they developed into something meaningful to him.

Simon also spoke about the need for an adult to offer therapeutic assistance. Whilst one recognises the need for the formal one hour therapy session, one also perceives the value of adopting a broader therapeutic stance spanning the other hours spent in residential care.

Luke spoke about the effect on parents when their children are taken into care:

“When you take away their children, the only person that maybe keeps them back from doing certain things, then these persons will have nothing to lose and they will not care. ‘You took away my children. You took away everything.’” (ll. 216-8)

“Meta ħadtilhom lil uliedhom, l-unika persuna li forsi żżomhom lura minn ċerti affarijiet...Tajjeb? Mela dawn ġew I don’t care. ‘Ħadtli lil uliedi, ħadtli kollox’” (Il. 216-8)

Samuel talks about the need to support members of the family of origin. It seems that in preserving fond feelings towards his father, he constructs a narrative which supports the possibility that his father could have been helped, had such help been available. Yet, on another level, his statement also draws our attention towards how easy it is for our society to construct a narrative of judgment and abomination towards persons who are not able to take care of their children.

Whilst being passionate and critical in making suggestions regarding desired changes, Luke recognised recent improvements in the care system. He acknowledges that nowadays children in care have a greater voice through the work of external social workers and what he perceived as changes in the legislature. He also spoke about care institutions nowadays being much more open to scrutiny by external authorities.

Within the second group of recommendations, that is, those pertaining to aftercare, we encounter two themes: the need for a 16 + house, and the need for personalised after care and follow-up after leaving. It is important to remark that most of our participants had to face the harsh reality of no adequate placements beyond the age of sixteen.

One participant remarked that if no adequate placement exists for sixteen year olds who were removed from their homes:

“So you might as well have left them where they were...so why did you take them away if you were trying to help them, if you are supplying them with the same poison they were feeding on before...so you tried to help this boy for nothing.” (Il. 645-7)

“Allura stajt ma hadthom xejn...mela inti x’hadthom jagħmlu jekk inti ppruvajt tgħinhom u mbagħad tajthom l-istess velenu li kienu ħadu qabel. Mela inti għalxejn ippruvajt tgħinu dan it-tifel” (ll. 645-7)

These findings throw light on the long term consequences of living in out-of-home care, especially, since our system is ready to provide out-of-home care for children till the age of 16 or 18, and then, at times, expects them to settle back with an available relative.

Daniel and Becky strongly believed that a system of follow-up of care leavers was helpful because not all ex-residents seek help even if they would need it.

We conclude this section with Abigail’s address to children who are presently going through the experience of residential care:

“They should appreciate those people who care for them, that they are grateful to the nuns and what they tell them, and they stay there till they come of age, they do not leave prematurely because they end up facing huge problems, what the nuns tell you is for your own good ...” (ll. 393-407)

“Japprezzaw dawk in-nies li jieħdu hsiebhom, japprezzaw kull kelma li jgħidulhom is-sisters u jibqgħu sakemm jagħlqu ż-żmien tagħhom, ma jgħaġġlux għax jispiċċaw bi problemi kbar, ah imbagħad, għax huma li jgħidulek is-sisters għall-ġid tiegħek għax kieku mhux għall-ġid tiegħek...” (ll. 393-407)

6.0 Discussion of Findings

The study highlights the vulnerability of the care leavers. Four participants spoke about difficulties they encountered in finding accommodation following their departure from residential care, which resulted in frequent changes in living arrangements and inadequate shelters. All participants spoke about insurmountable difficulties in finding a stable job. Some of the participants in our study, women in particular, tended to rely heavily on social assistance and this pushed them to live in poverty, on the margins of

society. Moreover many of the women interviewed became parents at a very young age. Pregnancy soon after care emerges as a salient issue in a number of studies, for example, Wertheimer (2002), Maunders et al. (1999) and Cashmore and Paxman's longitudinal research (1996). Whilst all out-of-home care leavers are at risk of poverty, females leaving residential care emerge as a most vulnerable subgroup that necessitates specially focused attention in terms of skills in the area of relationships and the development of their personal identity.

In terms of formal education, none of the participants in this research were able to continue post-secondary education on a full-time basis. Though other factors need to be taken in consideration, the fact that participants left care so early did not help them continue with their schooling. This seriously limited the participants' life chances and is even more alarming when evaluated against a local context where education policy is aiming towards increasing the number of adolescents who continue with post-secondary education (Ministry of Education, 2005). Ensuring a positive school experience for children in out-of-home care needs to be seen as a priority even in the light of research (Rutter et al., 1998; Newman & Blackburn, 2002; Sinclair et al., 2005). While we need data which would enable us to quantify the problem, findings in this research point towards an alarming situation that requires an immediate response.

The majority of participants stressed that building and sustaining long-term relationships was and still is a challenge for them. Participants' difficulties, in this area, point towards the impact of complex trauma (Cook et al., 2005) and the effects of institutional care on attachment patterns (Ainsworth et al., 1978). The impact of difficulty in sustaining relationships is far reaching, as it crucially hinders the person's ability to be with others and reap the benefits of such interactions.

Except for Simon, the research participants were, to various extents, disarmed to face the challenges of adulthood when they left care between the age of 16 and 18. This is in line with research by McDonald, Allen, Westerfelt & Piliavin (1996) which shows that youths who leave the care system, do so in an accelerated manner and at a relatively young age. Stein (2004) showed that this accelerated process has damaging effects on the youths' resilience whilst research by Del Valle, Bravo, Alvarez & Fernanz (2008) shows that youths leaving care at an older age fare much better in life.

It appears that institutions and state agencies were aware of the risks, yet felt powerless and lacking in terms of resources to provide an alternative. When listening to the young people's stories, it is evident that state authorities, and religious institutions needed to be more in tune with these young people's needs.

The exploration of the psychosocial well-being of participants showed that developing self-regulation was a developmental challenge for our participants. The care system seems to have been unable to deal with this acting out and rebellious behaviour and this may have led to premature departures. Findings suggest that residential care settings seem to have repeated the initial cycle of rejection once these children reached 16 years of age. This rejection could have confirmed the negative narratives the participants held about themselves.

When making recommendations regarding changes that they perceived as supportive, research participants highlighted two factors: they spoke of the need for placements beyond the age of 16, alongside the need for personalised after care and follow-up after care. The evaluation of specialised schemes in other countries (Biehal et. al, 1995) coupled with the recommendations made by our research participants stress the need for residential homes to continue caring for the children in their custody beyond the age of 16

Findings indicate that risks can be reduced by strengthening the individual child. This can be achieved through supporting the families of children in need of out-of-home care alongside measures intended to promote resilience. Our quantitative research project (Abela, Abdilla, Abela, Camilleri, Mercieca, D., & Mercieca, G., 2011) and that by Galea-Seychell, (2005) indicate that parenting difficulties and parental issues feature as prominent reasons for admission into out-of-home care. Moreover, the theme of longing for one's family of origin and the desire to belong to a family emerged very strongly from the findings. This calls for stepping up efforts to intervene with the families of these children in order to try and prevent resorting to out-of-home care in the first place, especially long-term residential care.

In this study, self-reliance emerged as a dominant coping mechanism, as participants faced abandonment and the mistrust it generated. We can hypothesise that following rejection and abandonment by significant others, a lack of trust in others led to a self-concept based around the belief that one can only rely on oneself. This principle goes against the body of knowledge on resilience which shows that resilience can best be bolstered in a relationship context with significant others in one's own family and in the wider community (Walsh 2006). Other factors seem to have impacted the participants' self-concept and the manner in which they coped with abandonment. Raymond, Alexia, Becky and Luke sought to transform their predicament by becoming parents. This seems to have contributed to a sense of a renewed self-concept, which seems to have empowered some of the participants to break the cycle of rejection, and be motivated to parent their own children amidst financial and other difficulties.

Within this study, participants struggled to make sense of the fragmented stories they lived, which is in line with research by Biehal et al., 1995 (in Stein, 2005). This fragmentation also featured as a symptomatic consequence of trauma characterised by memory loss about the difficult experiences they had gone through. The extent to which participants managed to reclaim their story, and be coherent in their narrative seems to have heavily impacted the manner in which they make sense of their present and future life experiences.

As they spoke about their lived experience, participants acknowledged that the trauma of abandonment led towards a negative self-concept. They may have been more prone to unconsciously repeat their stories of failure and rejection. A critical feature in enhancing resilience is the presence of someone who is willing to hold on to an alternative narrative (White & Epston, 1999) and believe in the children's potential. The above discussion highlights the crucial impact of stable, long lasting, genuine and caring relationships.

Participants' narratives generated both negative and positive characteristics of out-of-home care. Findings suggest that most participants in this research felt inferior to peers and that the phenomenon of "homes" "*istituti*" in Malta has negative connotations. Any improvement in the overall care environment needs to reduce rather than increase

such perception of inferiority, by enhancing the integration rather than contributing towards the stigmatisation of these children.

Whilst describing positive practices within the homes, participants spoke about the need for affirmation, the importance of containment, and the significance of carers, acting as role models, with whom they could identify. Moreover, participants highlighted the need to know that they are being held in high regard by adult carers who manage to make them feel special. The feature of genuine concern emerged, most significantly, when participants spoke about how they perceived particular carers as going out of their way to support them. Research consistently points towards the need for the cultivation of a reparative adult child relationship, highlighting connectedness and genuine care (Rutter, Giller & Hagell, 1998; Resnick, Harris & Blum, 1993; Twedde, 2005).

The limited availability of carers and the severance of significant relationships due to transitions in care point towards the limitations of group care settings. Even if we manage to get rid of the institutional trimmings and advocate for small scale family-like settings, we still have to contend with limitations which will be taken into consideration in the recommendations section.

Some of the reparative relationships experienced by participants were possible only because they existed outside the confines of the residential organisations and continued beyond the transitions in care. This seems to be in line with research by Cashmore & Paxman (2006) who noted that *felt security* (our emphasis), continuity and social support beyond care were the most significant predictors of young people's outcomes, four to five years after leaving care. Such findings suggest that we need to link the issue of fostering high quality care through significant relationships with the concept of continuity and stability.

Findings help us appreciate the damaging impact of significant relationships built within one setting, being severed with each transition in care. In our local context, working towards the preservation of such relationships that ensure stability and continuity may be even more possible due to the relatively shorter geographical distances. Limiting transitions in care will ensure continuity and stability. The current local context, where a

set of homes cater for children aged 5-9 while other homes care for pubescents and adolescents, renders transitions in care almost inevitable.

Findings also indicate that some carers were not always in tune with the children's pain. Whilst this research was not designed with an investigative purpose in mind, there were instances when participants alluded to carers and professionals behaving in inappropriate ways. This calls for more protection and an evaluation of what goes on in residential homes. Carers and professionals who transgress need to be held responsible for their actions. At the same time, we need to increase our understanding as to why carers in such instances were not coping.

In terms of challenging behaviour, findings suggest that the manner in which the out-of-home care system has responded to the challenging behaviour of a number of children in this study has not met their needs and so requires evaluation. Resorting to psychiatric hospitalisation and medication resulted in further stigmatisation whilst core issues remained under-addressed. Findings suggest that we need to go beyond observed behaviour and look at the factors which might have contributed to such challenging conduct. Complex trauma (Cook et al., 2005), neglect (De Bellis, 2005) and institutionalisation in the early years of life (Johnson, Browne & Hamilton-Giachritsis, 2006) adversely impact self-regulation and attachment. These factors seem to have impacted some of our participants, rendering them more vulnerable to rebellious behaviour.

Negative practices within the homes, seem to have impacted on the psychological development of some of our participants. This is in line with research which shows that group care settings, as opposed to a family-foster placement, have been linked to more negative outcomes namely problems in parenting and intimate and social relationships in adulthood (McDonald, Allen, Westerfelt & Piliavin, 1996). Moreover, these negative experiences in care could have led the research participants to want to leave care as early as possible. Research participants often went through the pain of rejection negatively impacting their identity, possibly thinking of themselves as deserving rejection, and thus more prone to provoke a rejecting response from others.

Research suggests that the lack of responses to problem behaviour amongst children living in out-of-home care contributes towards negative outcomes (Zimmerman 1982; Department of Health 1998; Stein 2005). Unresolved anger amongst our participants further emphasises the need for an overall therapeutic set-up that allows children to work through such anger.

Although it is important to note that trauma and early institutionalisation adversely impact the brain and contribute to rebellious behaviour, it is also crucial to point out that this impact is not irreversible because the structure of the brain can still change, particularly in the early years of life. Early interventions based on attachment and biobehavioural feedback have been shown to yield positive results (Dozier et. al in Minnis et. al., 2010). This highlights again the need for early intervention.

A multi-systemic or multi-modal approach (Gonzi et al 2006; Vostanis, 2010) is being proposed as a response to the challenge of rebellious behaviour. Such an approach means that carers and professionals need to value interconnectedness and communication and strive towards attaining a sense of synergy between them. In a number of situations described in the findings, lack of inter-agency collaboration and resources seem to have led to children being sent back to unsafe situations, thus facing bleak periods of intense loneliness and extensive isolation.

7.0 Recommendations for Policy

This study highlights the need for a number of changes with regards to residential care services namely:

- a. ***The age of leaving care needs to be seriously reconsidered.*** Research amply suggests that semi-independent residential facilities, which support care leavers at least until the age of 21, need to be urgently put in place. This setup should be coordinated by the relevant authorities including *Aġenzija APPOĠĠ* and the Department of Social Welfare Standards. Such community placements should serve as a temporary and transition placement where youngsters are empowered and provided with skills necessary for responsible autonomy and self-care once in adult life.

- b. ***Care leavers in transition need to be provided with personal support, accommodation, financial assistance and career guidance.*** Such support is associated with promoting resilience (Stein, 2005).
- c. ***Care-leavers also need specific skills training, by specially trained personnel, in the areas of development of personal identity, human relationships, love relationships and sexual education and health.*** Their experiences indicate a lacuna in knowledge and in the possession of important skills in this regard.
- d. ***The need for a positive school experience for children in out-of-home care. All possible resources need to be mobilised so as to support and promote children's and youngster's educational achievements to the full. Service provision needs to be integrated.*** Access to post-secondary and further education opportunities also emerged as a major gap in the experiences of the care leavers that were interviewed. The importance of interagency work between educational authorities, social care and mental health agencies is of utmost importance, if we are to meet the needs of the children and their families. As far as possible placement moves are to be reduced, thus aiming at continuity and stability in the placement
- e. ***Care policies need to be put into place in the area of children in out-of-home care with a special focus on priority areas.*** In the first instance, as has already been pointed out in the Annual Report of 2010 of the Commissioner for Children, the Standards for Out-of-Home Care, set up in 2009, need to have the necessary legal framework to monitor standards and practices effectively as well as oversee service delivery. Within this legal framework, residential care settings need to have a Child Protection policy. Such a policy needs to be child friendly, and children in out-of-home care need to know and have direct and easy access to the appointed person who would be specifically tasked to receive complaints, by children and/or adults in the home, related to negative experiences whilst in care.

- f. ***The concept of residential care in Malta, as it is understood today, needs to be revised and re-constructed.*** Given the negative impact on children of living in big institutions there is a need to invest more in smaller community-based homes such as the one launched in 2008 by the Salesians (Don Bosco House in Balzan) as an alternative to St Patrick's.

- g. ***A residential care plan with a limited time frame, and policies regarding decisions for permanence need to be established.*** One of the major objectives of such care plans needs to focus on maintaining stability throughout long-term care placements, limiting unnecessary transitions between "homes".

- h. ***Care workers in this field need to be properly selected, trained, supervised and also adequately well-paid.*** This is because the occupation of a care worker is complex and challenging and must be regarded to be at par with the work of other helping professionals.

- i. ***Therapeutic work needs to take place in the context of team work which is to be carried out by a transdisciplinary team of professionals.*** Some of interviewees admitted that they needed their carers to attend to them in an intense therapeutic way in order for them to be able to process raw feelings of anger. This should be regularly evaluated in terms of its effectiveness, with the required professional supervision practices together with supervision of supervision.

- j. ***Valid alternatives to hospitalisation placements, such as YPU and Mount Carmel hospital, also need to be actively explored.*** Children and youngsters, who present with challenging behaviour, can still be housed and therapeutically supported without being removed from the environment of the residential facility.

- k. The necessity of a multi-systemic approach with the family and exploring potential routes leading to family restoration are to be considered paramount.* This involves the need to intervene in terms of systematic life story work, and to sustain all of the work carried out over the years by competent caring professionals such as family therapists. Some of our existing residential facilities might actually specialise in this form of intervention and provide support to youths in care and their families.

- l. Quality relationships with significant others and lasting supportive social contacts need to be actively sought while youngsters are still in out-of-home care.* When and where residential care seems to be the only other alternative, we feel it is of vital importance to preserve links with persons who, while standing on the periphery of or even outside care organisations, may be really significant to the children and may be able to accompany them across transitions from out-of-home care and beyond.

- m. Relationships built should be preserved. It is to be acknowledged that a relational base is a crucial aspect that can be restorative and therapeutic, and should be integrated within standards of care practices.* Stein (2005) advocates for “returning after care to the caregivers themselves” (pg. 25) thus extending and nurturing the relationship that care leavers would have already built with their carers. In this respect, it is also necessary that long-term social contacts are trained to handle the challenges that such intense relationships with people who have been emotionally challenged, almost inevitably, bring with them.

8.0 Suggestions for Further Research

This research project involved in-depth qualitative research where we chose to give a voice to the care leavers themselves. Some of the findings however merit further investigation, as part of a research agenda, around the topic of out-of-home care in Malta:

- a. More research is warranted to help us understand the quality of life that persons, formerly in residential out-of-home care, have as adult persons. Therefore a large-scale quantitative research study which would investigate the long-term outcomes of children in care is recommended.
- b. An in-depth longitudinal study, which would follow youngsters currently in care and through the process of transition and after care, would also be useful in helping us understand further the complexities of this process. It will also shed light on the human and support resources required to achieve successful outcomes
- c. A qualitative and more robust study, which also takes into consideration the views of carers, social workers, care workers and other professionals regarding the issues of transition into after care, will help shed further important light on this issue and the challenges involved.
- d. Finally, we think it is worth studying the effectiveness of after-care specialist schemes that have been set up recently.

9.0 Conclusion

The care leavers, who participated in this study, could have had various motivations to do so. For example, it is possible that those who chose to participate were more resilient, or had something to say, or were possibly not shamed by their experiences, or had taken something positive from being in care. On the other hand, it is also possible that those who accepted perceived the research as a unique opportunity to vent out their anger and recount their negative experiences. As a research team working on this project, we believe that we have the responsibility to satisfy these persons' desire to make their voices heard within a context where the relevant policy-makers and stakeholders are in a position to actively listen to their experiences and concerns.

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Appendix A

One Sample t-tests comparing M & SD's obtained on CBCL scales among younger and older boys and girls in out-of-home care with CBCL norms for a non-referred sample

Table A 1: *One Sample t-test comparing M & SD's obtained on CBCL scales among 6-11 year old boys in out-of-home care with CBCL norms for a non-referred sample*

	CBCL norms for non-referred sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	24.6	4	17.8	5.4	t (66) = 10.21, p < 0.001
'Total Internalising'	5.1	4.8	10.5	7.1	t (67) = 6.34, p < 0.001
'Total Externalising'	6.6	6	18.7	12.1	t (67) = 8.21, p < 0.001
'Total Syndrome'	23.4	16.9	54.2	31.7	t (67) = 8, p < 0.001

Table A 2: *One Sample t-test comparing M & SD's obtained on CBCL scales among 12-18 year old boys in out-of-home care with CBCL norms for a non-referred sample*

	CBCL norms for non-referred sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	25	4.3	17.4	5.6	t (37) = 8.35, p < 0.001
'Total Internalising'	5.6	5.3	11.8	9.2	t (44) = 4.53, p < 0.001
'Total Externalising'	7.5	7.5	16.5	10.8	t (44) = 5.61, p < 0.001
'Total Syndrome'	23.7	19	52.7	36.1	t (44) = 5.39, p < 0.001

Table A 3: *One Sample t-test comparing M & SD's obtained on CBCL scales among 6-11 year old girls in out-of-home care with CBCL norms for a non-referred sample*

	CBCL norms for non-referred sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	24.9	4.2	20.5	4.7	t (53) = 6.9, p < 0.001
'Total Internalising'	6	5	10.3	7.6	t (53) = 4.19, p < 0.001
'Total Externalising'	6.1	5.6	14.6	10.5	t (53) = 5.9, p < 0.001
'Total Syndrome'	22.9	16.6	42.3	26.2	t (52) = 5.37, p < 0.001

Table A 4: *One Sample t-test comparing M & SD's obtained on CBCL scales among 12-18 year old girls in out-of-home care with CBCL norms for a non-referred sample*

	CBCL norms for non-referred sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	24.8	4.4	17.5	5.2	t (34) = 8.22, p < 0.001
'Total Internalising'	6.5	5.7	12.8	10.7	t (42) = 3.85, p < 0.001
'Total Externalising'	6.6	7	13.4	11.7	t (42) = 3.84, p < 0.001
'Total Syndrome'	22	18.2	42.2	31.9	t (41) = 4.11, p < 0.001

Appendix B

One Sample t-tests comparing M & SD's obtained on CBCL scales among older and younger boys and girls in out-of-home care with an American clinical sample attending mental health, substance abuse or special educational services

Table B 1: *One Sample t-test comparing M & SD's obtained on CBCL scales among 6-11 year old boys in out-of-home care with an American clinical sample attending mental health, substance abuse or special educational services*

	Clinical sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	17.7	5	17.8	5.4	t (66) = 0.15, p = 0.88
'Total Internalising'	14.3	9.6	10.5	7.1	t (67) = 4.38, p < 0.001
'Total Externalising'	23.8	12	18.7	12.1	t (67) = 3.48, p = 0.001
'Total Syndrome'	68.2	32.2	54.2	31.7	t (67) = 3.63, p = 0.001

Table B 2: *One Sample t-test comparing M & SD's obtained on CBCL scales among 12-18 year old boys in out-of-home care with an American clinical sample attending mental health, substance abuse or special educational services*

	Clinical sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	17	5	17.4	5.6	t (37) = 0.45, p = 0.66
'Total Internalising'	14.5	9.1	11.8	9.2	t (44) = 1.93, p = 0.06
'Total Externalising'	22.9	13	16.5	10.8	t (44) = 3.98, p < 0.001
'Total Syndrome'	63.5	30.9	52.7	36.1	t (44) = 2, p = 0.051

Table B 3: *One Sample t-test comparing M & SD's obtained on CBCL scales among 6-11 year old girls in out-of-home care with an American clinical sample attending mental health, substance abuse or special educational services*

	Clinical sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	18	5.2	20.5	4.7	t (53) = 3.83, p < 0.001
'Total Internalising'	13.4	9.4	10.3	7.6	t (53) = 2.94, p = 0.005
'Total Externalising'	19.8	12.6	14.6	10.5	t (53) = 3.61, p = 0.001
'Total Syndrome'	58.5	32	42.3	26.2	t (52) = 4.51, p < 0.001

Table B 4: *One Sample t-test comparing M & SD's obtained on CBCL scales among 12-18 year old girls in out-of-home care with an American clinical sample attending mental health, substance abuse or special educational services*

	Clinical sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
'Total Competence'	17	5.6	17.5	5.2	t (34) = 0.61, p = 0.54
'Total Internalising'	18.3	10.5	12.8	10.7	t (42) = 3.4, p = 0.001
'Total Externalising'	20.8	13.3	13.4	11.7	t (42) = 4.13, p < 0.001
'Total Syndrome'	63.4	32.7	42.2	31.9	t (41) = 4.29, p < 0.001

Appendix C

One Sample t-test comparing M & SD's obtained on SDQ scales self, teacher and carer version, among girls and boys in out-of-home care with a normative sample of Maltese females and males

Table C 1: *One Sample t-test comparing M & SD's obtained on SDQ scales self-informant version, among girls in out-of-home care with a normative sample of Maltese females.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	3.26	2.12	4.62	2.72	$t(46) = 3.42, p = 0.001$
Conduct Problems	2	1.53	2.83	1.76	$t(46) = 3.23, p < 0.005$
Hyperactivity	3.42	2.03	4.17	2.49	$t(46) = 2.07, p < 0.05$
Peer Problems	2.01	1.45	3.17	2.36	$t(46) = 3.37, p < 0.005$
Total Difficulties	10.68	4.66	14.79	6.73	$t(46) = 4.18, p < 0.0005$
Pro-social behaviour	8.61	1.54	8.66	1.56	$t(46) = 0.22, p = 0.83$

Table C 2: *One Sample t-test comparing M & SD's obtained on SDQ scales teacher version, among girls in out-of-home care with a normative sample of Maltese females.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	1.93	2.11	2.46	2.17	$t(101) = 2.47, p < 0.05$
Conduct Problems	1.66	2.12	3.35	2.52	$t(101) = 6.77, p < 0.0005$
Hyperactivity	3.99	3.07	5.89	3.21	$t(101) = 5.99, p < 0.0005$
Peer Problems	2.01	1.89	3.18	2.24	$t(101) = 5.26, p < 0.0005$
Total Difficulties	9.6	6.44	14.87	7.42	$t(101) = 7.17, p < 0.0005$
Pro-social behaviour	6.87	2.63	6.52	3.03	$t(101) = 1.17, p = 0.25$

Table C 3: *One Sample t-test comparing M & SD's obtained on SDQ scales carer version, among girls in out-of-home care with a normative sample of Maltese females.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	2.93	2.38	4.04	2.9	$t(98) = 3.81, p < 0.0005$
Conduct Problems	1.75	1.59	3.41	2.67	$t(98) = 6.2, p < 0.0005$
Hyperactivity	4	2.47	4.68	2.87	$t(98) = 2.35, p < 0.05$
Peer Problems	1.93	1.72	2.94	2.2	$t(98) = 4.57, p < 0.0005$
Total Difficulties	10.61	5.65	14.99	7.64	$t(98) = 5.7, p < 0.0005$
Pro-social behaviour	8.79	1.51	7.86	2.36	$t(98) = 3.93, p < 0.0005$

Table C 4: *One Sample t-test comparing M & SD's obtained on SDQ scales self-informant version, among boys in out-of-home care with a normative sample of Maltese males.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	2.06	2.2	2.91	2.31	$t(84) = 3.38, p = 0.001$
Conduct Problems	1.21	1.85	3.02	2.51	$t(84) = 6.67, p < 0.0005$
Hyperactivity	2.84	2.72	4.71	2.97	$t(84) = 5.79, p < 0.0005$
Peer Problems	1.71	1.72	2.41	1.87	$t(82) = 3.4, p = 0.001$
Total Difficulties	7.81	6.04	13.06	7.22	$t(83) = 6.67, p < 0.0005$
Pro-social behaviour	7.9	2.28	7.5	2.6	$t(83) = 1.41, p = 0.16$

Table C 5: *One Sample t-test comparing M & SD's obtained on SDQ scales teacher version, among boys in out-of-home care with a normative sample of Maltese males.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	2.56	2.15	3.33	2.59	$t(117) = 3.22, p < 0.005$
Conduct Problems	1.85	1.66	3.78	2.6	$t(117) = 8.05, p < 0.0005$
Hyperactivity	4.47	2.68	5.86	2.8	$t(117) = 5.37, p < 0.0005$
Peer Problems	1.93	1.76	3.73	2.42	$t(117) = 8.1, p < 0.0005$
Total Difficulties	10.81	5.66	16.62	7.3	$t(117) = 8.64, p < 0.0005$
Pro-social behaviour	8.25	1.73	7.05	2.69	$t(117) = 4.84, p < 0.0005$

Table C 6: *One Sample t-test comparing M & SD's obtained on SDQ scales carer version, among boys in out-of-home care with a normative sample of Maltese males.*

	Normative Maltese sample		M & SD's for this study		One Sample t-test
	M	SD	M	SD	
Emotional symptoms	2.63	1.97	3.96	2.54	$t(54) = 3.9, p < 0.0005$
Conduct Problems	2.5	1.76	3.38	1.7	$t(54) = 3.84, p < 0.0005$
Hyperactivity	3.81	2.11	5.24	2.48	$t(54) = 4.27, p < 0.0005$
Peer Problems	2.4	1.73	3.65	2.15	$t(54) = 4.34, p < 0.0005$
Total Difficulties	11.33	5	16.24	6.19	$t(54) = 5.88, p < 0.0005$
Pro-social behaviour	7.5	1.96	8.07	2.14	$t(54) = 1.98, p = 0.052$