ANGLICARE VICTORIA'S OUT-OF-HOME CARE OUTCOMES ASSESSMENT FRAMEWORK: THEORETICAL AND CONCEPTUAL UNDERPINNINGS

Tatiana Corrales
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Introduction

Recent years have witnessed an increased emphasis on evidence-based practice and outcomes measurement in the community services sector. This emphasis reflects a growing acknowledgement by government, service providers and researchers that while much of the work that is done with vulnerable and 'at-risk' children, youth and families is important, evidence to support its efficacy in leading to demonstrable improvements in the lives of our clients is often limited.

An important component of building the evidence base to support our practice is the development of rigorous, theoretically grounded outcomes assessment, or quality assurance, frameworks. These frameworks, when implemented alongside evidence-based programs, allow us to begin articulating the impact of our services and programs on key areas of client wellbeing and functioning.

To this end, the research unit in collaboration with a working group comprised of senior management and key workers across all of our OHC programs began developing an outcomes assessment framework in October 2015. This paper outlines the theoretical and conceptual underpinnings of the assessment framework. It begins with a brief overview of what is currently known regarding the outcomes of children and young people who experience child protection involvement and placement in OHC. Based on this research the core outcome of 'wellbeing' is identified as central to promoting the psychosocial development of children and youth. Three theoretical frameworks, attachment, self-determination theory and resilience theory, are then utilised to draw out the key factors that support psychosocial development and wellbeing. The paper concludes with a presentation of a conceptual map which identifies the mechanisms and outcome indicators that contribute to improved wellbeing for children and youth in OHC.

Outcomes research: What we know about the life-course trajectories of children and young people in care

There is now a large body of literature focussed on the generally poor outcomes that follow experiences of abuse, maltreatment and adversity. This literature can be grouped into two main themes a) the development of sometimes severe psychopathology, and the associated sequela that impact on a broad range of life areas; and b) psychosocial 'deficits' that hinder developmental trajectories. These two broad areas are deeply interrelated, although with a few exceptions, the focus of much research in the child protection field has been on psychopathological outcomes (Collin-Vézina, Coleman, Milne, Sell & Daigneault, 2011; Fernandez, 2008; Murphy, Shevlin, Armour, Elklit & Christofferen, 2014; Neely-Barnes & Whitted, 2011; Schilling, Aseltine & Gore, 2008). A restricted range of psychosocial outcomes, linked predominantly to educational attainment, employment, criminal justice system involvement, welfare dependence, drug and alcohol abuse, early parenthood and homelessness have also been investigated (see for example, Bright & Jonson-Reid, 2015; Courtney & Dworsky, 2006; Hook & Courtney, 2011; Keller, Cusick & Courtney, 2007; Lee, Courtney & Hook, 2012; Shook, Goodkind, Herring, Pohlig, Kolivoski & Kim, 2013; Yampolskaya, Armstrong & McNeish, 2011).

A main conclusion to emerge from the vast scholarship on the profiles and outcomes of children and young people in care is that, on average, they experience significant and long-term disruptions in their developmental trajectories. Specifically, the bulk of research evidence points to significantly elevated levels of emotion and behavioural dysregulation (aggression, violence, post-traumatic stress, anxiety, depression), alongside what appears to be chronic and long-term multiple service system involvement.

The mechanisms that underlie these outcomes are also beginning to receive greater research attention. For example, there is a growing body of literature exploring the multiple impacts of early traumatic experiences. This research includes a focus on the complex interactions between the individual and the environment that effect neurological, physical and psychological development (Moffitt, 1993; O'Connor et al., 2011; Odgers et al., 2008). In the context of childhood abuse and maltreatment, there is evidence of significant and sustained impacts at the neurobiological and psychological levels that help explain the development of psychopathology and related outcomes (Cicchetti, 2013). This research reinforces that healthy development is influenced by a confluence of genetic/dispositional and environmental factors that can be fundamentally undermined during critical stages, including antenatally, during infancy and early childhood, and adolescence. In fact, recent research points to the differential, and potentially more pervasively negative outcomes associated with adolescent, versus childhood maltreatment, further reinforcing the need to incorporate life-course developmental frameworks in understanding the mechanisms and outcomes associated with experiences of abuse, neglect and adversity (Thornberry et al., 2010).

In the context of OHC specifically, there is ongoing debate regarding the *impact* of OHC placement on child and adolescent outcomes. On the one hand, research clearly points to the generally poor outcomes experienced by children and young people who are either in care and who have exited or 'aged out' of care. This is further supported by evidence showing that adults who have experienced childhood maltreatment and adversity but who have not had contact with child protection or OHC systems, also experience a range of negative outcomes, predominantly in their mental health and adjustment (Edwards, Holden, Felitti & Anda, 2003). On the other hand, there is little evidence to support the claim that placement in OHC in itself contributes to poor outcomes. For example, Berzin (2008) drew on data from the National Longitudinal Study of Youth to investigate whether OHC placement made a unique contribution to the outcomes of youth. The study involved matching young people who had been in OHC, to those who had a similar risk profile but had never been placed in care, and to a broader sample of youth in the study. A wide range of demographic and maltreatment history factors were used to match the OHC and 'at risk' groups. The results showed that the foster care, and 'at risk' groups did not differ on a range of outcomes, including welfare dependence, early parenthood, criminal justice system involvement and low educational attainment. However, these two groups did differ from the young people without any risk profiles.

Research focussing specifically on educational outcomes has highlighted the potentially protective role of OHC. Font and Maguire-Jack (2013) investigated the impact of OHC placement on educational engagement and academic performance in a longitudinal study involving over 1130 children and young people. The authors compared children who had never been placed in OHC, with children who had been removed and reunified within a single wave of data collection, those who had been removed during the last stage of data collection only, and those who had been in OHC during two consecutive waves of data collection. The results showed that children who had spent shorter periods in care (removed during later stages of data collection) had better educational engagement, compared to all other groups. No differences were identified based on measures of educational achievement.

Luke, Sinclair and O'Higgins (2015) have recently provided evidence that when appropriate comparison groups are utilised, some children in care outperform their peers on educational outcomes. Drawing on population (administrative) data collected by the Department of Education and the Department of Social Services in the UK, the authors compared the educational progress, engagement and attainment of four groups: those not in care and not in need (i.e., not identified as experiencing chronic financial hardship); those in need but not in care; those who had been in care for less than 12 months; and those who had been in

care for more than 12 months. This last group was further divided into children who had entered care prior to their 10th birthday, and those who had entered care subsequent to their 10th birthday. The study also included a longitudinal component, which tracked the progress and attainment of all children in the data set from Year 2 to Year 11. One of the core findings from this project was that children and young people who had been in care for more than 12 months showed progressive improvement in their educational performance, and across every indicator measured, scored consistently higher than the short-term care group and the 'in need' group. In contrast, the short-term care and 'in need' groups showed a progressive decline in their academic performance, a pattern that was most pronounced for the in-need group. While the long-term care group showed the strongest outcomes, these effects were attenuated when age of entry into care was included in a statistical model. Specifically, age of entry into care (after 10th birthday) and length of time in care (exceeding 10 years) were significant predictors of poorer educational outcomes.

Therefore, the impact of OHC placement is complex, and depends on a range of factors, including age of entry into care and length of stay. It also fundamentally depends on the stability and type of placement. For example, supplementary analyses conducted by Luke et al., (2015) showed that children and young people in residential care had consistently poorer educational outcomes, compared to children and young people in kinship and foster care. This pattern has been observed across multiple studies, including our own analysis of the differential profiles of children and young people in care (Corrales, 2015).

The heterogeneity of children and young people further contributes to an understanding of their differential outcomes. Research has identified a number of profiles or clusters with specific and unique characteristics that can be used to inform differential service system approaches, and to predict pathways through and out of care. In this context, Keller et al., (2007) identified four primary 'clusters' of youth in care in four large Midwest states of the USA, including:

1) Distressed and disconnected (43.3%) – characterised by high levels of instability, placement in residential care, significant behavioural and mental health problems (predominantly substance abuse), high rates of violet victimisation, high levels of delinquency and criminal justice system involvement, educational difficulties (including enrolment in special education classes), social alienation, and significant distrust and antipathy towards the child welfare system
2) Competent and connected (37.8%) – characterised by relatively stable placements predominantly in kinship or foster care. Typically satisfied with their in-care experiences, and showed evidence of social connections and good social support, as well as educational achievement. Little evidence of significant emotional or behavioural problems. No evidence of delinquency or contact with the CJS.
3) Struggling but staying (14.2%) – similar to the 'distressed and disconnected' group, but differentiated by a strong sense of connection to the child welfare system. Most likely to report seeking assistance once they leave care. However, highest rates of educational difficulties and delinquency.
4) Hindered and homebound (4.6%) – small subpopulation, characterised by highest levels of early parenthood and late entry in to the care system. This group was most likely to be in kinship care and showed evidence of positive interpersonal connections and perceived social support, however, also experienced difficulties with education and employment.

Overall, there is strong evidence to support the claim that children and young people in care experience a range of negative outcomes. There is also growing consensus that the impact of OHC is complex, and depends on a broad range of factors including systemic issues that may contribute to instability, as well as the fundamental heterogeneity of the children and young people in the care system.

Despite the breadth and sophistication of current research, the focus remains on outcomes that are often linked to conceptions of life success that may not be shared, or owned, by individuals. Low educational attainment, unemployment, criminal justice system involvement, welfare dependence, mental health difficulties and homelessness, while fundamentally important, can be conceptualised as obstacles that limit, to varying degrees, an individual's ability to be a full, active participant in society. In contrast, *outcomes* are best conceptualised as states of being. Conceptually, outcomes are reflective of broader human needs, drives and potentials which, if fulfilled, allow individuals to reach for, and enact their potential in meaningful and self-determined ways.

The re-emergence of child and adolescent wellbeing

Much of the narrative on outcomes within the child, youth and families sector continues to conflate *mechanisms* with outcomes. Education is a case in point. Existing outcomes frameworks focus on enrolment, attendance, progress and attainment, which all reflect mechanisms, or processes that may lead to an eventual outcome, by virtue of the opportunities opened up to individuals through educational attainment. Put another way, completing Year 12 is an 'outcome' only to the extent that it increases the human capital (i.e., knowledge, skills, expertise) of an individual, compared to someone who has not completed Year 12. Increased human capital can then lead to greater wage earning potentials, better employment opportunities, and greater access to and participation in free market economies. These, in turn, may increase a person's objective quality of life, in that they decrease the *risk* of hardship. However, educational attainment on its own does not necessarily increase a person's social capital - that is, a person's sense of connection to others in his/her life. Without social capital, the value of human capital is diminished.

The current focus on outcomes, therefore, places a great amount of emphasis on providing children and young people in care with the resources they need to increase their social capital. Recently, however, there has been a discernible shift in the outcomes literature, towards a greater emphasis on definitions of outcomes that are centred on the concept of wellbeing. This is consistent with a focus on 'trauma-informed' care, but also reflects a broader acknowledgement that wellbeing is a necessary condition for achieving valued and meaningful goals.

The psychological literature has devoted much attention to the construct of wellbeing, although typically the focus has been on the *absence* of psychopathology. There are, however, a number of theoretical frameworks that position wellbeing as a positive construct, emphasising the importance of self-worth, relatedness and connectedness, autonomy, mastery/competence, and a general sense of purpose and meaning in life (Cummins & Lau, 2005; Ryff & Keyes, 1995). These concepts are well-articulated in much of the social work and social welfare literature, although they do not appear to have been translated to the language of outcomes. This is in part due to the 'fuzziness' of these concepts, which have typically been difficult to operationalise and measure. More importantly, outcome assessment or quality assurance frameworks have traditionally been decontextualized from theory, resulting in broad approaches that selectively draw upon existing knowledge but fail to cogently articulate *how* addressing specific areas will result in demonstrable improvements in the general wellbeing of clients.

Anglicare's OHC Outcomes Assessment Framework: Theoretical underpinnings

To address this gap, Anglicare's outcomes assessment framework is underpinned by three major theoretical perspectives: attachment and trauma, Self-Determination Theory (SDT), and resilience theory. Together, these theories provide a robust and empirically validated model that will allow us to articulate:

a) The rationale for identifying 'wellbeing' as the overarching outcome within our framework
b) The factors that contribute to wellbeing at different stages of development; and
c) How the work we undertake with children and young people can influence their wellbeing.

Attachment and trauma

Attachment theory has a long history, and has undergone substantial elaboration since it was first postulated by John Bowlby in the late 1940s and early 1950s (Ainsworth & Bowlby, 1991). Attachment theory provides a comprehensive and rich framework that underpins much of developmental psychology, thereby providing insights into the conditions that favour 'positive' or healthy human development. At its core, attachment is about human relationships and interactions, specifically those that occur during early stages of development. Based on extensive, and rigorous empirical evidence, it has been established that the *relational* patterns between an infant and his/her primary care-giver (typically a mother, or mother-figure) underpin a range of regulatory systems (emotional, cognitive, behavioural) that influence the way a child understands and respond to others and his/her social world (Ainsworth, 1969; Bowlby, 1982; de Zulueta, 2009; Keyfitz, Lumley, Hennig & Dozois, 2013; Riggs, 2010; Sroufe, 2005).

At its most basic level attachment theory contains a number of core tenets that guide our understanding of some of the emotional, behavioural and interpersonal problems that children and young people in care often exhibit. During infancy and very early stages of childhood there is a strong, evolutionary need for safety and security (Ainsworth & Bowlby, 1991). In the presence of threats (real or perceived) a child will turn to his/her caregiver for safety and comfort. If a caregiver is accessible and responsive to the child's signals of fear and insecurity, a secure attachment system develops. This attachment system is predicated on shared affect and learning. That is, a primary caregiver responds not just with the provision of physical safety, but also with an emotional attunement to the needs of the child. The child in turn, learns to adapt his or her behaviour to the physical and emotional responses of the primary caregiver (Ainsworth, Blehar, Waters & Wall, 1977; Riggs, 2010; Sroufe & Waters, 1977).

This essentially means that children develop internal working models, or cognitive templates, based on the belief that in the presence of a threat there is a secure base that they can retreat to, which will provide protection and nurturance (Ainsworth, 1969). If the provision of a secure base is consistent, a child's rudimentary cognitive template will evolve into a more complex belief system that will frame his/her understanding and orientation towards the social world. If, however, a primary caregiver is inconsistent in the provision of a secure base, or if the caregiver is consistently hostile and threatening, the child will develop a cognitive orientation based on implicit assumptions of threat, malevolence and hostility (Crick & Dodge, 1994; de Zulueta, 2009; Riggs, 2010; Sroufe, 2005). Over time, and through a complex interplay between the environment and the individual, this belief system may become entrenched through chronic activation, leading to a range of information processing biases whereby threat is perceived in seemingly benign or ambiguous situations, and the emotional and behavioural system is activated to respond to these perceived threats (Crick & Dodge, 1994; Hankin, 2005; Sroufe, 2005). In essence, the relational experiences of early childhood provide a context for the hyper-arousal of the fight-flight response.

While the primary focus of attachment has typically been on the mother-infant dyad, there is also an explicit acknowledgement that the broader environment plays an important role in the development of relational styles. There is research, for example, showing that the presence of a secure attachment with a primary care-giver can act as a buffer, or protective factor, against the detrimental effects of a hostile environment (Cashmore & Paxman, 2006; Collin-Vézina et al., 2008; Masten, 2011). There is also increasing evidence that access to

social support from extended family and/or trusted adults can mitigate some of the impacts of disrupted attachment with a primary-carer (Evans, Steel & DiLillo, 2013; Noble-Carr, Barker, McArthur & Woodman, 2014; Salazar, Keller & Courtney, 2011). Moreover, despite early research indicating that once established attachment styles were invariant throughout the life-course, there is now considerable research showing that there is both continuity *and* discontinuity in a person's attachment style (Raby, Steele, Carlson & Sroufe, 2015; Van Ryzin, Carlson & Sroufe, 2011; Weinfield, Sroufe & Egeland, 2000). For example, research has found that there is an intergenerational pattern, whereby mothers who experienced disrupted attachments are also more likely to have disrupted attachments with their own children. Within this pattern of continuity there is also evidence of discontinuity, whereby children exhibit shifts in their attachment styles at different developmental stages and depending on the social context (Sroufe, Coffino & Carslon, 2010). This indicates that while some of the effects of disrupted attachments can be severe and impact multiple areas of psychosocial development, individuals develop multiple internal working models that can be selectively drawn upon to guide emotional, behavioural and social functioning in varying circumstances.

Despite this, current scholarship points to the significant and long-term impacts of severe attachment disruption resulting from abuse, violence and maltreatment. Violence, in its various forms, poses a significant challenge in the context of attachment. For example, based on an extensive review of threat detection among children and adolescents exposed to family violence, Miller (2015) identified that infants as young as three months old are attuned to threat signals in their environment, as evidenced by a differential pattern of gazing directed at threatening versus friendly or neutral faces. Moreover, hypervigilance to threatening cues continues through childhood and into adolescence, and is linked to activation of neural, physiological, cognitive and behavioural systems. Throughout childhood, the chronic activation of these systems can result in a bias towards the selective attention, encoding and interpretation of threatening cues, resulting in a range of negative emotional and behavioural outcomes, including aggression, hostility, anger, anxiety and depression (Dodge, 2006; Fontaine & Dodge, 2009, Miller, 2015).

Attachment theory provides a hypothesised causal mechanism for these effects, in the conflict a child experiences between the need for safety and the experience of fear. Specifically, the instinct to seek security (safety and nurturance) from a primary attachment figure is fundamentally compromised when that figure is the source of fear and insecurity. In these instances, a child 'learns' that their basic needs evoke angry, hostile and/or violent responses, and therefore develops emotional and behavioural strategies to cope with danger and the absence of need fulfilment (Crick & Dodge, 1994; Miller, 2015; Riggs, 2010). The result in very young children tends to be emotional withdrawal and 'stunted' development both physically and psychosocially. If exposure to threatening, hostile and violent environments continues, and there is an absence of consistent access to supportive, alternative caregivers or environments, the adaptive responses of childhood are likely to evolve into 'maladaptive' coping styles (Hankin, 2005; Riggs, 2010; Vansteenkiste & Ryan, 2013; Wright, Crawford & Castillo, 2009). These can include violence, aggression, self-harm, social withdrawal, dissociation, and the development of conduct and personality disorders (Riggs, 2010; Sroufe, 2005; Wright et al., 2009).

There is also emerging evidence that emotional abuse can have equally severe and long-lasting impacts on psychological and psychosocial development (Riggs, 2010). Rather than the hypervigilance to threat associated with exposure to violence, emotional abuse is associated with the development of 'dysfunctional' relational patterns that can persist into adulthood. Specifically, when children's basic need for nurturance is thwarted they may develop internal working models grounded in assumptions of their inherent unworthiness. As a child develops, his/her behaviour is unconsciously structured around these relational schemas and the associated emotional and behavioural responses. For these individuals,

there is evidence that the inherent tension of fearing the primary source of protection, comfort and emotional nurturance can express itself in a range of complex and chaotic 'coping' strategies, often resulting in the development of significant psychopathology (Riggs, 2010). This pattern can be sustained into adult relationships, which act as reinforcers of belief systems and relational styles that 'confirm' a person's view of themselves, their social world and others. Put simply, once relational schemas are internalised, the belief systems that support these schemas are reinforced through selective cognitive biases that predispose an individual towards the encoding and interpretation of social information cues that confirm their existing belief systems.

While attachment theory provides a complex theoretical lens from which to understand some of the difficulties experienced by children and young people in care, it is important to note that attachment disruption occurs within a broader ecological system that is often characterised by a range of additional risk factors. A range of social factors associated with broad indices of hardship, including poverty, low educational attainment of parents, being born to young parents, growing up in low SES and high crime areas, being raised by a single parent (typically a single mother), and having a large number of siblings are all significant risk factors for hardship, adversity and maltreatment. Additional risk factors that have been consistently identified in the literature include parental drug and alcohol use, parental mental illness and parental criminality (Farrington, 2005; Moffitt, 1993; Odgers et al., 2008). The impact of attachment disruption therefore needs to be contextualised against these broader indices of hardship and adversity.

With these caveats in mind, there are a number of 'themes' that can be drawn from the attachment literature to inform an outcomes framework. Attachment is fundamentally about relationships, and directs our attention to the importance of the provision of safety for children. This needs to be understood as a holistic concept that is developmentally grounded. Specifically, the provision of physical safety is paramount, but it cannot be decontextualized from the provision of a 'secure base' from which children and young people can develop positive representations of themselves, others, the nature of the social world, and healthy human relationships. The capacity of the OHC system to provide this type of psychological safety is often compromised, especially in residential care, by the inherent instability associated with these placements. It is further undermined by inadequate staff training, and exacerbated by the various developmental 'assaults' that young people have experienced by the time they reach residential care. Nevertheless, attachment theory highlights the central importance of developing environments where children and young people are provided opportunities to experience positive, nurturing, consistent relationships.

Self-Determination Theory (SDT): Fundamental human needs and psychosocial wellbeing

Self-Determination Theory (SDT) is described as a meta-theory of human nature (Deci & Ryan, 2000) that draws on motivation and personality theories to argue that human behaviour can be fundamentally understood as the intrinsic drive towards growth and integration, both psychological and social. Conceptually and empirically, SDT provides a framework for understanding the multiple pathways to psychological wellbeing.

At the core of the theory is the premise that human behaviour is driven by the fulfilment or thwarting *basic human needs*, which are defined as autonomy, competence and relatedness (Deci & Ryan, 2000; Vansteenkiste & Ryan, 2013). When these needs are fulfilled, individuals experience a range of positive outcomes across various life domains. Conversely, research from within the SDT framework has identified that need frustration is differentially linked with a range of poor psychological and psychosocial outcomes, including anxiety, depression, aggression, eating disorders, alcohol and/or substance abuse, and self-injurious behaviour (Vansteenkiste & Ryan, 2013). While all three needs are conceptualised as central to psychological wellbeing, the SDT literature has tended to prioritise the need for

autonomy. This is evidenced both in the theoretical and empirical work, which has predominantly explored the role of autonomy supportive compared to controlling environments. Based on the available evidence, it can be argued that there is a hierarchy of needs, with autonomy acting as a superordinate construct that supports the need fulfilment associated with competence and relatedness.

According to Deci and Ryan (2000) autonomy provides the foundation for volitional and integrated action, without which a person is not likely to meet his/her need for competence or relatedness. Scholars working within the SDT framework further argue that the three basic needs should be considered as *antecedents* or necessary preconditions to psychological wellbeing, rather than as outcomes per se (Ryan & Deci, 2000). This is an important point in the formulation of an outcomes framework, as it highlights three *mechanisms* that can be measured and have been theoretically and empirically linked to wellbeing across a wide range of populations, both culturally and demographically (see for example, Chen et al., 2015).

Need fulfilment is further posited to occur as the result of interactions between an individual and his/her environment. In this context, SDT postulates that individuals will show a natural tendency to differ in their propensity towards autonomy or control, but these individual differences will be fundamentally influenced by the environment these same individuals are exposed to throughout their development, as well as the contexts in which behaviour occurs through social interactions (Deci & Ryan, 2000; Ryan & Deci, 2000; Ryan, Legage, Niemiec & Deci, 2012). Environments that are supportive of autonomy, competence and relatedness tend to foster greater wellbeing. In contrast, environments that are highly controlling are associated with needs thwarting, which has been linked to psychological ill-health, or at the very least, wellbeing that is not easily sustained over time or across contexts.

To date, SDT does not appear to have been widely utilised in the child welfare and OHC sectors. This is perhaps unsurprising given that it is not an explicitly developmental or trauma-informed framework. However, upon closer reflection there are some clear linkages between SDT and the experiences and outcomes of children and young people in care. For example, there is a developmental undertone through much of the theory, specifically in the centrality that is attributed towards the intrinsic pull towards growth. While specific mechanisms have not been articulated, need fulfilment is important at all stages of human development, which then creates the necessary internal conditions that allow for growth through coherence and integration. More importantly, perhaps, the literature on needs thwarting and needs frustration points directly to the negative impact of early experiences that are analogous of abuse and maltreatment.

Vansteenkiste and Ryan (2013) for example, have posited that the poor outcomes associated with needs frustration likely their have origins in early experiences of highly controlling environments. These environments result in the development of a range of 'compensatory strategies' aimed at attaining a *sense* of need fulfilment. For example, individuals may develop need substitutes, marked by the pursuit of extrinsic goals that act as markers of personal worth. While these strategies may lead to short-term satisfaction, in the long-term they may interfere with the attainment of genuine needs, thereby leading to poorer life outcomes. Alternatively, individuals may develop compensatory behaviours, including risk taking, the development of rigid behavioural patterns, and the development of oppositional defiance. While these are all markers of clinical risk for various emotional and personality disorders, under the SDT framework they serve as strategies whose aim is to provide an individual with a sense of need fulfilment. Importantly, however, SDT posits that hostile, violent and rejecting environments are fundamentally needs thwarting, thereby leading to protective responses which although adaptive, result in non-optimal functioning (Deci & Ryan, 2000).

The emphasis that is placed on 'need-supportive' environments, in combination with the impact of need frustration points to a synergy between the main tenets of SDT and the principles of attachment theory outlined in the previous section. While these links have not been fully elaborated in the literature, there is a strong argument to view attachment as a *context* that can either be need supportive, or need thwarting (La Guardia & Patrick, 2008). From this perspective, the affective and relational bonds that emerge between a child and his/her primary caregiver create a context for need fulfilment. When these bonds are based on caregiver responsiveness, non-contingent love, warmth and nurturance, a child's need for autonomy, competence and relatedness are met. In contrast, when the affective and relational bonds are disrupted, these basic needs are thwarted, resulting in the development of compensatory strategies, including internal working models that may eventually develop into rigid schema and the erosion of a coherent sense of self (La Guardia & Patrick, 2008; Vansteenkiste & Ryan, 2013).

SDT also shares with attachment theory an emphasis on integration. When individuals develop a secure attachment they exhibit greater integration of their internal working models, such that their representations of themselves, others and the world are more adaptable and flexible. This leads to greater 'ego integrity', in that securely attached individuals are more able to withstand challenges to their self-concepts, leading to greater assimilation of incongruent information, and therefore greater adaptability to the social world. In the context of maltreatment, however, a person is more susceptible to develop internal working models that are defined by an 'amotivational' self-representation. In other words, attachment disruptions that occur within the context of abusive, hostile, neglectful and/or violent environments can result in the development of a self-view marked by the belief that one has no volition or control. In the absence of a true sense of volition, autonomy is thwarted resulting in a compromised capacity to meet the need for competence and relatedness.

It should be noted that the above links have been postulated rather than tested. As indicated above, the SDT and attachment literatures have not typically been considered alongside each other, despite the significant theoretical convergence. This convergence is especially apparent in the role that is attributed to autonomy-supportive and controlling environments. Recent research, for example, has begun to articulate the effects of maltreatment on a person's ability to meet his/her basic needs, with a specific focus on the impact of authoritarian parenting styles, and, to a lesser extent, emotional abuse. In the context of emotional abuse, Deci and Ryan (2012, pg. 10) state, "When feedback is negative, the message tends to convey 'incompetence' and decreased autonomous motivation. If the negative feedback is persistent, and especially if it is demeaning, it will tend to result in amotivation." This statement further highlights the synergy between attachment and SDT, which can be crystallised into the following statement:

> Attachment represents the *mechanism* through which exposure to controlling environments impact a child's ability to meet his/her need for autonomy, competence and relatedness. The frustration of these needs has been shown to predict a range of poor psychological and physical wellbeing outcomes at various stages of the life-course.

Importantly, both the attachment and SDT literatures point towards resilience as an important construct in wellbeing, as individuals who are able to fulfil their basic needs are better able to cope with need frustration when it occurs (Vansteenkiste & Ryan, 2013). The role of resilience is therefore covered in the following section.

Resilience and positive youth development

Resilience has experienced a resurgence in the child maltreatment and welfare literature in recent decades. This is in part due to the shift away from deficit-based models that emphasise risk and psychopathology, to more strengths-based models that explicitly recognise children and young people's varied response to, and outcomes following experiences of adversity and maltreatment. In this respect, resilience research explicitly recognises that while risk factors are important, they have limited explanatory potential when the aim is to understand the processes that lead from risk exposure to later outcomes, in a developmental context.

The resilience literature is expansive and increasingly sophisticated, both conceptually and methodologically. While there are a number of debates regarding how best to conceptualise resilience, two dominant models have emerged: the developmental tasks perspective, which is firmly grounded in developmental psychology and psychopathology (see for example, Cicchetti, 2013; Masten, 2001, 2007, 2011; Masten & Coatsworth, 1988; Masten & Obradović, 2006; Rutter, 2006; Sameroff & Rosenblum, 2006) and the cultural model (Ungar et al., 2008). The major point of differentiation between these two perspectives lies in the way a person's positioning within broad ecological systems is presumed to affect his/her ability to meet normative competencies in the face of adversity. Under the developmental tasks model, the emphasis is placed on the interaction between an individual and his/her environment, with a specific focus on proximal 'ecologies' including the family, the school and, to a lesser extent, the community. Resilience from this perspective is focussed almost exclusively at the individual level.

In contrast, proponents of cultural models argue that while internal characteristics are important, 'resilience' itself is culturally-defined, and therefore our understanding of 'normative' development needs to consider that what appears to be normative and valued in one culture may be perceived as abnormal in another. The underlying point is that resilience is dependent on cultural norms and expectations. Culture not only defines what constitutes resilient functioning, but also provides the resources to allow people to achieve wellbeing (Noltemeyer & Bush, 2013; Ungar et al., 2008).

Despite these differences, both perspectives adopt a fluid and deeply contextual understanding of resilience. For this outcomes assessment framework, the developmental tasks model is most pertinent, as it provides significant conceptual and empirical insight into the varied outcomes achieved by children, youth and adults following exposure to severe adversity. Importantly, the developmental psychology literature has also been extremely influential in the positive youth development framework (Phelps et al., 2007; O'Connor et al., 2011), which provides a strengths-based narrative to complement the 'psychopathology' focus of much of the resilience literature. This framework will be discussed in more detail in subsequent sections of this paper.

Resilience

Resilience is broadly defined as "a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development" (Masten, 2001, p. 228). Over the past 40 years, researchers across varied fields have built upon this definition, identifying a number of core 'elements' that constitute resilience. It is now widely accepted that resilience is not a trait, or a fixed characteristic, of a person. Instead, resilience is understood as a dynamic *process* that occurs at multiple levels, across multiple systems, and across various developmental periods. This means that resilience is not fixed or immutable, but rather is dependent on a range of factors that interact in complex ways across the life-course to influence development and adaptation. The mechanisms that have been implicated in resilient functioning range from intricate molecular, hormonal and neural systems all the way through to broad cultural systems and institutions (Cicchetti & Blender, 2006; Masten, 2011; Zolkoski & Bullock, 2012).

The role of ‘systems’ in resilience theory is particularly important. Masten and her colleagues have progressively refined the conceptual framework of resilience theory, starting from the premise that adverse experiences have the potential to fundamentally disrupt normative developmental milestones or tasks that then compromise future development. In this context, the idea of ‘systems’ refers to processes, mechanisms, internal and external states that have been shown to effect psychosocial development and wellbeing (Cicchetti, 2013; Cicchetti & Blender, 2006; Masten, 2001, 2007; Masten & Coatsworth, 1988; Masten & Obradović, 2006). Nine broad systems have been implicated in resilient functioning, across various historical periods and cultural contexts. These are:

1) Learning systems – problem solving, information processing
2) Attachment systems – close and trusting relationships across various developmental periods and contexts, including family, friends, romantic partners and other significant people in a person’s life
3) Mastery and motivation systems – self-efficacy and reward systems related to goal directed behaviour and goal attainment. There are elements of Self-Determination Theory in this system, in that mastery and motivation are central concepts in autonomous behaviour that is guided by intrinsic motivations (see for example, Deci & Ryan, 2012; Ryan et al., 2012)
4) Stress response systems – alarm and recovery responses (i.e., hyperactivation of the amygdala and the consequent arousal of the central nervous system; fight/flight response)
5) Self-regulation systems – emotion regulation, executive functioning, activation and inhibition of attention and behaviour
6) Family systems – parenting, family dynamics including expectations, cohesion, rituals and norms
7) School systems – values, standards and expectations, teaching practices
8) Peer systems – friendship, peer groups, norms and values
9) Cultural and societal systems – religion, traditions, rituals, social values and standards, laws.

These ‘systems’ represent the basic scaffolding that supports development, regardless of whether a child or young person has experienced adversity. They are, in this sense, universal in that everyone depends on the integrity of these systems to achieve positive psychosocial outcomes. Because these systems are interrelated and inform each other in mutually reinforcing ways, disruption in one system is likely to have an effect on other systems.

Adaptability, or resilient functioning, is typically linked to the acquisition of ‘competencies’ that are developmentally grounded and provide the scaffolding for the acquisition of additional, developmentally congruent, competencies (Masten, 2001; Masten & Coatsworth, 1988). This represents a ‘cascading’ effect, whereby resilient functioning at one stage of life in a particular domain has flow-on effects at various levels of the organism, thereby increasing that organism’s ability to develop further competencies. Conversely, disruption of one or more developmental systems also has cascading effects. For example, research has shown that disruptions to the cognitive system as evidence by social information processing biases (i.e., misattribution of hostile intent, positive appraisals of violence/aggression as an appropriate behavioural response to perceived threat) have a cascading effect on self-regulation and peer systems, such that children who exhibit these processing biases are more likely to be rejected by their peers and to show higher levels of aggression in peer interactions (Lansford, Malone, Dodge, Pettit & Bates, 2010). These patterns are observed across time, further highlighting the way disruptions to adaptive systems (i.e., cognitive, relational) influence outcomes across time.

There is, however, substantial heterogeneity in trajectories of resilient functioning (Masten, 2011; Phelps et al., 2007; Rutter, 2006). Research has consistently shown that even in the presence of significant and severe adversity, there is considerable variability in outcomes across various domains. For example, most studies in this area have identified four dominant 'clusters' of children and young people, based on their profiles of risk and protective factors:

1) High adversity and good adaptation (resilience)
2) Low adversity and good adaption (normative development)
3) High adversity and poor adaptation (low resilience)
4) Low adversity and poor adaptation (vulnerability).

On measures of cognitive functioning and academic achievement children and young people in the 'good adaptation' groups do not differ from each other. Therefore, despite significant differences in their exposure to adversity, resilient children and youth are almost indistinguishable from their peers without experiences of adversity. In contrast, there are large and significant differences between 'resilient' and 'maladaptive' groups, despite similarities in their experience of adversity. This implies that it is not the experience of adversity *per se* that influences resilient functioning, but rather how the various systems that support adaption are able to respond to adversity (Masten, 2011). In other words, resilience is a function of interactions between a person's internal resources and the environments that either support or diminish these resources.

The varied outcomes that can be observed for children and young people with experiences of adversity are also influenced by the developmental and contextual nature of resilience. As such, a child can show resilience in one domain at one point in his/her development, but show poor adaptation in other domains, either during the same developmental stage, or at different stages of the life-course (Cicchetti, 2013; Masten & Coatsworth, 1988). This has been highlighted in various studies showing that there is both continuity and discontinuity in maladaptive and resilient functioning. While this seems contradictory, it can be explained in reference to the conceptualisation of resilience as a *process* that occurs within environments. Continuity can be seen when children are exposed to adversity in the absence of any protective factors. Prolonged exposure to multiple environments marked by the presence of risk factors will fundamentally erode multiple systems, thereby leading to a cascading effect resulting in diminished ability to adapt or function within and across other environments. In contrast, discontinuity is apparent when individuals are exposed to adversity but also have access to a range of protective factors, or environments, that allow for the acquisition of competencies in other domains. Again, the concept of 'cascading' effects helps to understand how meeting developmental tasks (i.e., achieving competence) provides a 'scaffold' from which a child or young person can build additional competencies at different stages of development (Lansford et al., 2010; Masten & Obradović, 2006; Sameroff & Rosenblum, 2006).

Underlying these arguments is the theoretical premise that resilience is the norm rather than the exception. As Masten (2001, p. 227) has argued:

> The great surprise of resilience research is the ordinariness of the phenomena. Resilience appears to be a common phenomenon that results in most cases from the operation of basic human adaptational systems. If those systems are protected and in good working order, development is robust even in the face of severe adversity; if these major systems are impaired…then the risk for developmental problems is much greater, particularly if the environmental hazards are prolonged.

In light of this argument, there is consistent evidence of 'recovery', even in the face of significant and chronic adversity. However, this is predicated on a child or young person being provided good psychological and physical care that is experienced as safe, nurturing, consistent and stable. It is through this provision of care that adaptational systems are able

to revert to normative functioning, sometimes at levels that exceed those that were present prior to the adversity (Cicchetti, 2013).

There is also growing evidence that 'recovery' is linked to turning points. In some instances, developmental milestones such as the transition from childhood to adolescence, or adolescence to young adulthood, result in children and young people being exposed to different environments that support their development. At other times, meaningful turning points in life that are not dependent on chronological or symbolic transitions, also provide 'hooks' for change (Laub & Sampson, 2003; Masten, 2011; Sampson & Laub, 2005; Rutter, 2006). Typically, research has tended to focus on major life transitions, including marriage, entry into full-time employment, joining the military, parenthood and moving away from 'risky' environments (Sampson & Laub, 2005). However, 'turning points' broadly conceptualised can also be understood as any event that is perceived as meaningful or salient to an individual in the context of his/her life experiences. It is the recognition of an event or experience as meaningful that defines it as a turning point, and therefore provides a catalyst for change. From this perspective, resilient functioning in adolescence and adulthood can be prompted by experiences that are perceived as emotionally salient, and therefore enable an individual to reassess his/her actions, goals, values and beliefs in an attempt to alter current circumstances. This is not to imply that the inability to adapt or develop 'competencies' reflects some deficit or failure on behalf of the individual. Instead, it further reinforces the interconnectedness of individuals and their environments.

Resilience and maltreatment

Despite the wide ranging evidence in support of resilience as a normative, almost unremarkable process, there are certain situations that fundamentally erode a person's ability to function resiliently. Primary amongst these is the experience of abuse and maltreatment. Research has consistently found that, as a group, children who have experienced maltreatment show significantly less adaptive functioning than children who have experienced financial hardship but no abuse (Cicchetti, 2013). Moreover, while some children in the maltreatment groups show evidence of adaptive functioning, they typically represent a smaller proportion relative to children with no history of maltreatment. These patterns have been consistently replicated across various studies (see for example, Cicchetti, 2013; Masten & Obradović, 2006).

Importantly, however, there is evidence that a small but nontrivial proportion of maltreated children do not develop competencies across multiple domains and over time. In other words, these children do not develop resilience. For example, in a review of resilience research, Cicchetti (2013) found that across studies, between 10% and 21% of maltreated children scored 0 on a composite measures of resilience, compared to between 1% and 11% of children in non-maltreated, low SES comparison groups. These differences were statistically significant and provide some evidence that in the face of chronic exposure to maltreatment, some children do not meet fundamental developmental milestones that serve as markers of psychosocial functioning.

Theoretical integration: Attachment, self-determination and resilience

The theoretical perspectives discussed in the preceding sections, despite some slight differences, all converge on their conceptualisation of positive, healthy and 'adaptive' or 'normative' human development. Underlying all perspectives is the explicit understanding that growth, whether physical, emotional or psychological, is fundamentally predicated on the experience of nurturing and supportive environments. Within these environments *relationships* emerge as one of the centrally defining components of healthy development. As articulated in the attachment literature, early affective bonds between an infant and his/her primary caregiver set a foundation for a range of 'competencies' or skills that have

been shown to be fundamental for growth and development throughout the life-course. When these environments are hostile, violent or threatening, the relational and affective bond between an infant and care-giver takes on increased importance. If this relational bond is also disrupted – as is often the case in violent, hostile and threatening environments – a child's development can become compromised.

The resilience literature points to the attachment system as one of the core adaptive systems in human development. According to Masten and Coatsworth (1988) the attachment system is critical to healthy development as it provides a child with a range of tools that are essential for survival and adaptation. Beyond the provision of safety (physical, emotional and psychological) and nurturance, the attachment system also functions to regulate emotions. During very early stages of development, infants do not have the capacity to self-regulate – that is, to module their emotions and behaviours in response to stimuli. The attachment system therefore acts as a 'regulator' through the primary care-giver's responses to an infant's needs. Progressively, this affective and behavioural responding also acts as a model or template of self-regulation that a child internalises. This occurs through the mechanisms of authoritative parenting, whereby parents or primary care-givers modulate a child's behaviour through the provision of boundaries, within the context of warm and supportive relationships.

From a resilience theory perspective, self-regulation is a core competency, or developmental task in early childhood, and sets the foundation for the development of additional and progressively more complex competencies through the life-course. For example, self-regulation has been linked to social competence and academic achievement, by increasing children's socialisation skills and positive peer relationships, as well as compliance with rule-governed behaviour (Ainsworth, 1969; Cicchetti, 2013; Constantine, Benard & Diaz, 1999; de Zulueta, 2009; Keyfitz et al., 2013' Lansford et al., 2010; Masten & Coatsworth, 1988; Masten & Obradović, 2006; Sroufe, 2005; Zolkoski & Bullock, 2012). Conversely, the dysregulation of emotion and behaviour has been linked to a range of 'maladaptive' outcomes, including antisocial behaviour, peer rejection, poor concentration, academic disengagement and poor academic performance (Lansford et al., 2010; Obradović, 2006; Zolkoski & Bullock, 2012).

The attachment system has also been linked, both theoretically and empirically, to the development of schemas that have the potential to exert a strong influence on development through all stages of the human life-course. For example, a number of factors have been identified as empirically robust correlates of resilience, including the presence of positive and reciprocal relationships with peers and the presence of positive relationships with adults (Cicchetti, 2013; Constantine et al., 1999; Lansford et al., 2010). Interestingly, the relationship between positive relationships and resilient functioning appears to be stronger among non-maltreated low SES youth, than among their maltreated counterparts (Cicchetti, 2013). This may be a function of the pervasive effects of disrupted attachment on relational schemas, such that children who experience maltreatment find it more difficult to form trusting relationships with adults due to their experience of violence, abuse and/or neglect during early stages of development. For these children and young people, positive relationships with adults may be important, but less so than feeling self-reliant.

All individuals attach meaning to their life experiences, and this meaning frames and informs self-definitions. Meaning-making relies on broader social-cultural meta-narratives that frame how we understand what is 'normal', desired and desirable (Bruner, 1990). The process is no different for children and young people who have been placed in OHC. In a study exploring how youth who had transitioned from the care system made sense of their experiences, Samuels and Pryce (2008) found that youth constructed identities reflecting 'survivalist self-reliance'. This identity helped the youth make sense of their life experiences, including pre-care, in care and during the transition from care. Importantly, the 'self-reliant

survivalist' trope reflected broader culturally valued and shared beliefs about self-reliance as a sign of emotional strength and fortitude. For the youth in this study, their self-construction was inextricably tied to their experiences of 'growing up young', including experiences of being rejected, abandoned, abused and removed from their biological families, and the concomitant psychological assault of losing a sense of place and security. Their experiences in care served to reinforce this emerging internal narrative. As the youth matured and prepared to leave the OHC system, their internal narrative was further reinforced by beliefs that support, in whatever form, was not forthcoming. As such, self-reliance was perceived as necessary for survival. This in turn led to the belief that interpersonal connections, as the foundation of emotional support, were undesirable, providing a false safety net that challenged their self-concept as strong, independent and autonomous. For these young people, being able to take care of themselves *in spite of* or in the face of adversity was a source of pride and the basis of their identity. According to Samuels and Pryce (2008), these self-constructions were most clearly exemplified by the young people's hypervigilance to any form of emotional connection and interpersonal ties, especially in the context of seeking help or assistance from services, family or friends.

More recently, Keyfitz et al., (2013) have argued that cognitive templates reflecting internal beliefs about self-efficacy and coping, success, trust, optimism, and worthiness, which they refer to as positive schema, may play an important role in the process of resilient functioning. Specifically, these authors tested the differential impact of positive schema, beyond the impact of negative schema, on two indices of psychopathology, namely depression and anxiety, as well as on an index of resilience. The results confirmed that positive schema, both globally defined and in reference to the specific themes of self-efficacy, success, trust, optimism and worthiness were statistically significant and strong predictors of resilience, with self-efficacy emerging as the strongest predictor.

Conclusion

Collectively, there is strong evidence in support of attachment mechanisms as important antecedents to psychological wellbeing and resilient functioning. Moreover, the 'cascading effects' that flow from early disruptions to attachment have been shown to extend across multiple domains of functioning, including social relationships, antisocial or aggressive behaviour, academic engagement, performance and attainment, anxiety and depression, and in some cases the development of more severe personality disorders (Cicchetti, 2013; Lansford et al., 2010; Miller, 2015; Phelps et al., 2007; Riggs, 2010). Attachment is by no means the only mechanism that can explain the psychosocial difficulties evidenced by children and young people with experiences of abuse, neglect and maltreatment. However, as both the attachment and the resilience literature highlight, 'system' disruptions occur within a broader social ecology. That is, a child who experiences threats to his/her attachment system is also likely to experience threats to multiple other systems, as these threats are typically contained within the environment.

There is also conceptual overlap and synergy between the core concepts of resilience and self-determination. A number of key indices of resilient function across all stages of development relate specifically to autonomy and mastery. In addition, underlying much of the resilience and attachment literature is the importance of relatedness. As discussed in previous sections, proponents of Self-Determination Theory (SDT) have argued that these three constructs are central to understanding trajectories to wellbeing. Autonomy-supportive environments have been found to be predictive of a range of wellbeing markers, including greater self-worth reflected in increased sense of mastery or competence, and increase sense of social and interpersonal connectedness (Chen et al., 2015).

When viewed from the mutually informing perspectives of attachment, resilience and SDT the following core issues emerge:

>> Exposure to hostile, threatening, violent and neglectful environments can fundamentally compromise multiple adaptive systems that support human development and growth
>> An important mechanism to understand the impact of early adversity is the attachment system. The affective and relational bonds between an infant and his/her primary caregiver is universal and underpins the development of a range of competencies, or developmental tasks, that are necessary for healthy development
>> Environments that do not support autonomy (self-directed action motivated by internal drives that are perceived as meaningful) result in a reduced capacity to achieve competence and mastery, which are important elements of resilient functioning
>> These same environments tend to be characterised by disruptions across multiple systems, including relational systems that support connectedness and a sense of belonging
>> Over time, individuals begin to develop and internalise cognitive representations about themselves, their social worlds and other people, that are based on assumptions of inherent unworthiness and unloveability, the untrustworthiness of others, and a perception of the world as malevolent and inherently hostile
>> These cognitive templates, or schemas, begin to influence the way information is processed and the way behaviour is modulated. In essence, individuals begin to develop cognitive biases that influence the way information is interpreted, and the behavioural responses that are perceived as appropriate given the biased interpretation
>> Disruptions to the attachment system also influence the way individuals relate to others; typically, children and youth who have experienced adversity exhibit considerable difficulties in their social interactions with peers and with adults
>> Exposure to adverse environments also disrupts a range of other 'systems' linked to cognitive functioning, brain development, and hyperarousal
>> The inability to effectively regulate emotions is particularly important, and is again linked to early experiences of attachment disruption
>> Poor emotion regulation has flow-on effects, including on academic engagement and performance, as well as on social interactions
>> As individuals experience difficulties across these various domains of life, their sense of autonomy, competence and relatedness continues to be eroded, thereby decreasing their subjective sense of wellbeing, and potentially resulting in a range of psychosocial markers of distress and dysfunction.

In view of these theoretical and empirical linkages, the following emerge as key themes for the development of an outcomes framework:

1) Wellbeing should be a central outcome of interest. It is a positive outcome in that it reflects more than just the absence of psychological distress or psychopathology, although this is also an important outcome. Instead, it refers to a person's capacity to effectively adapt to his/her social environment; to perceive a good quality of life; to form meaningful and valued interpersonal relationships; to feel a sense of mastery over his/her environment; to feel a sense of achievement and competence in areas that are personally meaningful and satisfying; and to feel a sense of ownership and control over his/her life.
2) Resilience can be seen as a component of wellbeing. While the term has been most notably used to describe a process, *resilient functioning* is more closely aligned with contemporary definitions of wellbeing. In this respect, resilient functioning is assessed through the various resources (both internal and external) that individuals can draw upon to assist in their adaptation and development.
3) Autonomy, competence and mastery are underlying factors that promote wellbeing, through their links with resilient functioning and adaptation. These three

concepts can be seen as ‘pre-requisites’ in that their absence has been shown to diminish wellbeing across the life-course.

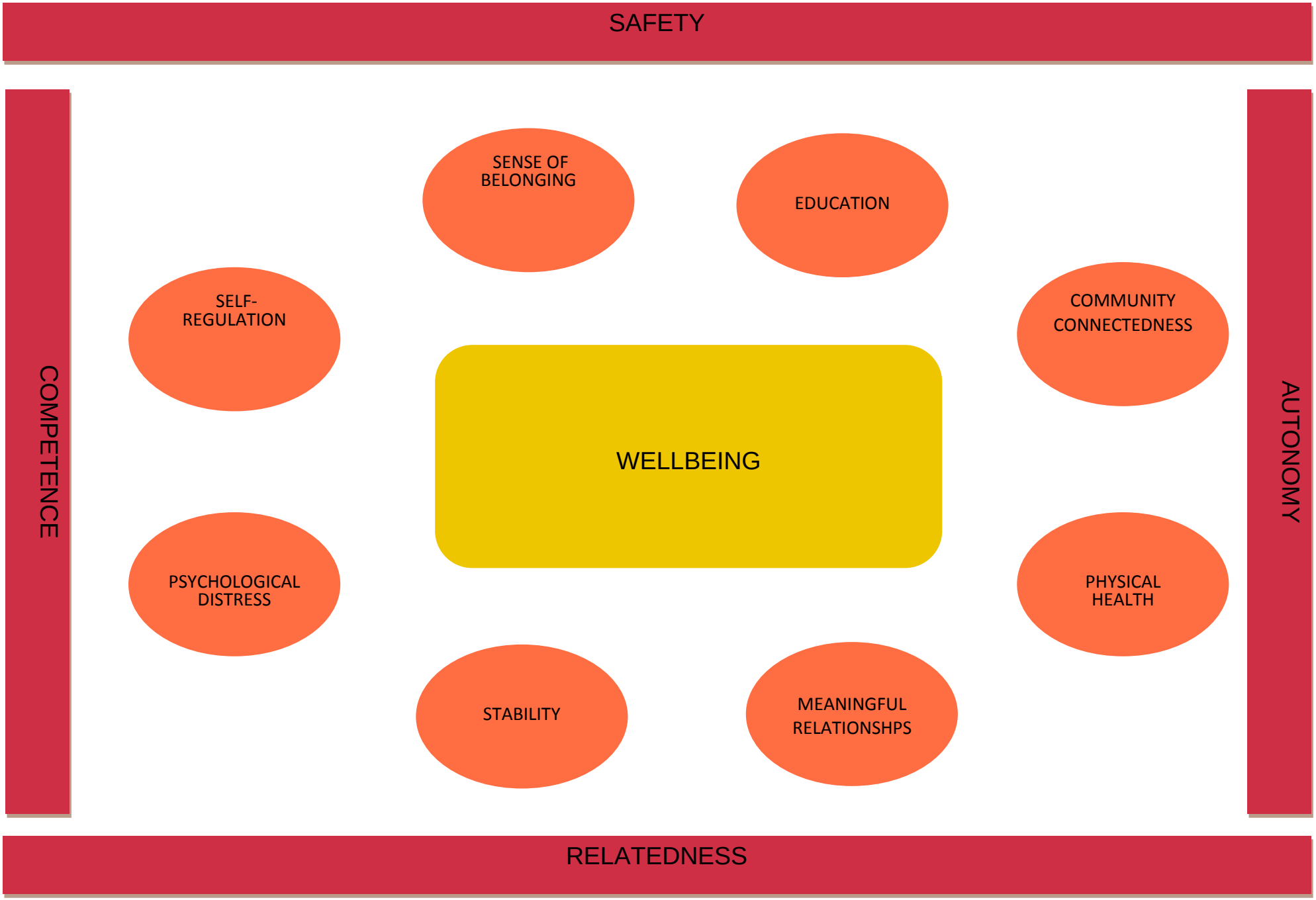
In addition to these three themes, there are clearly a wide range of psychosocial developmental tasks that are central to understanding the outcomes of children and young people in care. These include:

- Self-regulation of affect and behaviour
- Educational engagement, progress and attainment
- Meaningful and positive relationships with peers and adults
- Sense of belonging and connection
- Community participation and engagement
- Stability
- Physical development and health

Based on the literature reviewed throughout this paper, and the key themes identified above, a proposed ‘conceptual map’ for Anglicare’s outcomes framework is presented in the diagram below. The concept of wellbeing is placed at the centre of the framework, indicating that it is the central outcome of interest. This links not only with the literature, but also much of our core practice, which is fundamentally geared towards ensuring the wellbeing of all children and young people in OHC.

The concepts of safety, autonomy, competence and relatedness provide a structure around the outcome of wellbeing, and also the psychosocial tasks that are associated with wellbeing. This ‘framing’ represents the theoretical premise that in order to achieve positive psychosocial functioning, children and young people need to experience environments that are safe (physically, psychologically, emotionally), that promote autonomy and therefore allow for the development of competence and a sense of relatedness. The provision of these environments is predicated on the presence of trusting, supportive and nurturing relationships, specifically with adults.

Collectively, the psychosocial tasks positioned around the concept of wellbeing reflect contemporary scholarship on the factors that not only improve wellbeing, but importantly, are linked to healthy and positive development through childhood and adolescence. In this respect they are inherently developmentally grounded. Moreover, they allow for the capture of a broad range of indicators that can speak to our ability to positively influence the developmental trajectories of children and young people in care.


SAFETY
COMPETENCE
AUTONOMY
RELATEDNESS
SENSE OF BELONGING
EDUCATION
SELF-REGULATION
COMMUNITY CONNECTEDNESS
WELLBEING
PSYCHOLOGICAL DISTRESS
PHYSICAL HEALTH
STABILITY
MEANINGFUL RELATIONSHPS

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