13 May 2011

The Honourable Philip Cummins
Chair
Protecting Victoria's Vulnerable Children Inquiry
GPO Box 4708
MELBOURNE VIC 3001

Via email: childprotectioninquiry@cpi.vic.gov.au

Dear Mr Cummins

Submission *Protecting Victoria's Vulnerable Children Inquiry*

The Royal Australasian College of Physicians (RACP) would like to thank the Victorian Government and the Inquiry Panel for the opportunity to respond to the *Protecting Victoria's Vulnerable Children Inquiry* (the Inquiry).

Introduction

The RACP welcomes the intention to work towards reducing the incidence and negative impact of child neglect and abuse in Victoria. The very broad range of issues addressed in the Inquiry's Terms of Reference is noted.

Paediatricians and the RACP have a holistic view of children and childhood, seeing the child's environment including their system of social supports being integral to the maintenance of individual health, the fulfilment of potential and the future wellbeing of society. The RACP recognises that the systems that oversee children's health and wellbeing play important roles in determining outcomes for many children.

The RACP provides the following comments for consideration by the Inquiry Panel.

General comments to the Inquiry

1. Recognising the issues

In many cases of child abuse and neglect the harm is already severe by the time Protective Services becomes involved. In some instances there is already a high likelihood that any future children of the child currently experiencing neglect, physical, or sexual abuse will also be at very high risk of requiring the same interventions in the next generation[1].

The RACP supports strategies that work towards breaking this cycle of inter-generational trauma. The best long-term situation for the child should be the priority, and consideration given to the earlier use of stable long-term fostering or adoption arrangements for abused or neglected children.

There is significant evidence of the long-term, life impacts of any form of child abuse[2]. Among the many outcomes, there is evidence of the significant effects on subsequent parenting and the experience of motherhood and breast-feeding[3]. The RACP supports ongoing research to better understand the genesis of these effects and encourages government to invest in screening and treatment/support programmes that extend into adult life for the victims of child abuse.

2. The role of paediatricians

Paediatricians have expertise in the developmental needs of children and play an important role in the lives of children at risk of, or being abused.

As outlined by the Victorian Department of Health in the *Strategic framework for paediatric health services in Victoria*[4] paediatricians are well placed to:

- Proactively identify children where there is developmental, social, psychological or environmental risk to achieving their developmental potential.

- Identify where a parent or carer's capacity may be diminished; or their ability to meet the needs of their children may be compromised and they may require additional support or intervention.

- Build parents' and families' understanding of their child's health and how they can manage their child's condition, including the emotional and psychological impact on other siblings, relationships with friends, school and general participation in normal activities.

Furthermore, a considerable number of the RACP paediatric workforce is skilled to recognise and respond to vulnerable children. The RACP supervises the training and education that ensures paediatricians are well placed to assist children and help parents better perform the tasks of parenting.

Due to their unique relationship with families[5], paediatricians are in a good position to:

- Oversee intervention strategies to minimise the progression of risk of ongoing abuse or neglect

- Facilitate patterns of parenting behaviour which foster healthy development and which reduce the longer-term impact of abuse and neglect in the child's life and in the lives of the next generation

- Advocate for a stable pattern of parenting, if necessary by permanent foster placement or adoption.

Due to the complex nature of child abuse and problems within families, effective prevention of child abuse and enhanced child protection will be best achieved by key professions and agencies working collaboratively and in partnership. This includes education and non-government organisation service providers. The RACP believes that paediatricians, because of their broad training and experience should be, wherever possible, part of the response to vulnerable children.

Comments to the Terms of Reference (ToR)

ToR 2. Strategies to enhance early identification of, and intervention targeted at, children and families at risk and targeted child and /or family services.

Prevention and intervention strategies

The RACP supports a systematic public health approach to protecting vulnerable children. The development of a National framework, *Protecting Children is Everyone's Business – National Framework for Protecting Australia's Children 2009–2020*[6], indicates that progress has been made to establish a Public Health model approach to child protection. The RACP encourages government to build on these frameworks.

- Preventative and intervention strategies should include health professionals screening for adversity at the pregnancy and post-natal depression stages with services implemented to manage and monitor indicators of adversity[7]. The specialist medical workforce is skilled and trained to work with families and children that are at particularly high risk. Children at high risk require targeted attention due to their adverse living circumstances, or because parental factors place them at risk of abuse or neglect.

- Preventative strategies also need to be focused on supporting vulnerable children and families via community health structures.

- Strategies centred on extended home visitation services (by mothercraft nurses and/or social workers) would benefit new parents and should be made available for as long as required.[8]

- Better access to ongoing high quality mental health services is also recommended. Ongoing assessment of mental health, particularly the assessment of families (given the complexity and severity of multi-generational family dysfunction often encountered; the high prevalence of mental health disorders affecting family members; and the ongoing management of the patient), will act to minimise the harm caused by the initial abuse.

- Further support via free universal childcare programs (full-time, 5 days a week) would be invaluable to parents in need. Services such as early childhood services, disability services and government agencies would be in a good position to evaluate the needs of these families. Seamless communication between government organisations is paramount to achieving the best outcomes for the child and family.

- The RACP encourages an increase of support to the paediatric medical workforce to improve the collaboration with tertiary level Child Protection professionals. Particularly paediatricians that work with the Victorian Forensic Paediatric Medical Service (VFPMS) and specialise in forensic evaluation, prevention of re-abuse and work closely with families to break the cycle of intergenerational neglect and abuse.

ToR 4. The interaction of departments and agencies, the courts and service providers and how they can better work together to support at-risk families and children.

Medical expert witnesses and forensic reports

- The RACP supports the code of conduct and responsibilities outlined by the Coroner's Court of Victoria[9] for all expert witnesses. In all legal instances it is imperative expert witnesses remain neutral and provide impartial advice.

- The importance of accurate preparation and documenting of forensic reports should also be emphasised. Forensic reports are often utilised in the legal process and paediatricians who specialise in this area need to be supported and recognised as key contributors to the legal system.

Conclusion
The members of the RACP are well motivated to provide valuable advice regarding strategies to improve the health, growth and developmental needs of infants and young children. The RACP encourages greater collaboration between child health professionals and Child Protection agencies/ChildFIRST in all stages of the statutory agencies' engagement with families and children. This includes collaboration on case-based decision making and recommendations for a child's ongoing care (under a Public Health model).

The RACP encourages the Inquiry to involve specialist clinicians, trained in the areas of child protection, to join the reference group and be involved in future consultations regarding the protection of vulnerable children.

In conjunction with this response, we would like to draw your attention to the following policies of the RACP that provide further detail to this document, these being: *Protecting Children is Everybody's Business: Paediatricians Responding to the Challenge of Child Abuse* and *Health of Children in "out of home" care.*

Yours sincerely

Dr Andrew Lovett
Deputy Chairperson (Paediatrics)
Victorian State Committee

John Kolbe
President

Enclosure
Appendix 1: *Protecting Children is Everybody's Business: Paediatricians Responding to the Challenge of Child Abuse*
Appendix 2: *Health of Children in "Out of Home" Care*

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http://www.health.vic.gov.au/childrenatrisk/documents/paediatric_framework.pdf

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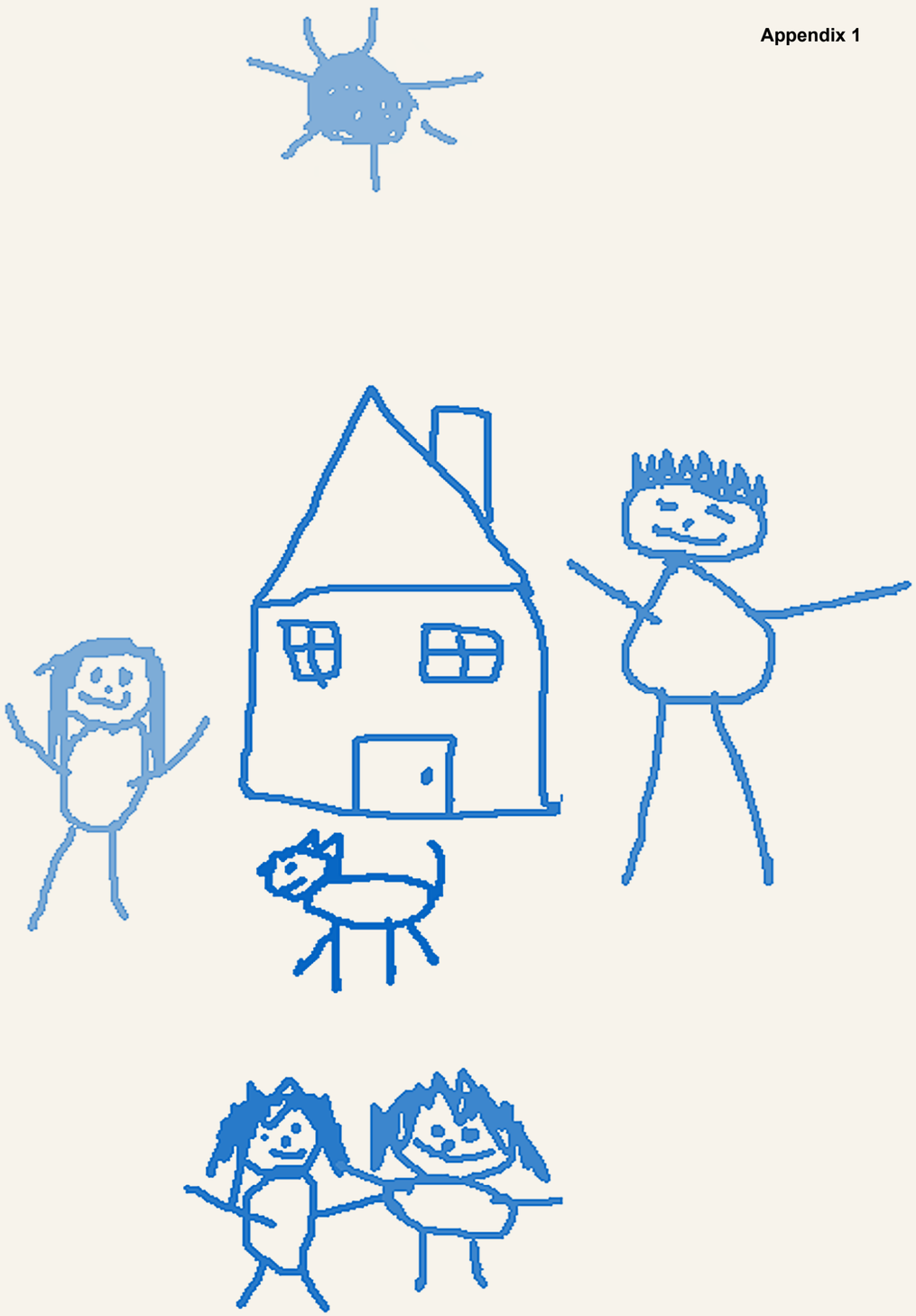

Protecting Children is Everybody's Business:

Paediatricians Responding to the Challenge of Child Abuse

Paediatrics and Child Health Division
Royal Australasian College of Physicians
Health Policy Unit

This publication has been compiled by the Paediatrics and Child Health Division, Royal Australasian College of Physicians for use by members of the community and health professionals. The information and advice is based on current medical knowledge and practice as at the date of publication. It is intended as a general guide only, and where relevant, not as a substitute for individual medical advice. The Royal Australasian College of Physicians and its employees accept no responsibility for any consequences arising from relying upon the information contained in this publication.

The Royal Australasian College of Physicians believes in open dialogue with other professional organisations and the community to ensure sustainable solutions are found to the many challenges identified in the health sector. The Royal Australasian College of Physicians developed a formal collaborative relationship with the organisations listed below to produce this policy statement. This broad coalition will continue to work together in this area to improve outcomes for children.

NAPCAN
HELPING PARENTS – HELPING CHILDREN
www.napcan.org.au

NAPCAN is an Australian non-government funded, non profit, volunteer-based organisation founded in 1987. NAPCAN's vision is "a national commitment to the nurturing and protection of children by supporting parents and communities for the prevention of child abuse in all its forms."

CHILDREN'S ISSUES CENTRE

The Children's Issues Centre is an interdisciplinary research and teaching centre at the University of Otago, concerned with promoting children and young people's rights and well-being in New Zealand.

Australian Consumers' Association

ACA
Australian Consumers' Association

The Australian Consumers' Association has been working for over 35 years providing information to enable consumers to make better health care choices, while representing and advancing consumer interests in the health care reform and health financing debates.

Health Issues Centre

HEALTH ISSUES CENTRE

The Health Issues Centre is an independent policy analysis group which conducts research on health issues from a consumer perspective. The Centre's overall aim is to help create a more equitable health care system which is more responsive to users, particularly those who are disadvantaged by current arrangements.

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Health Policy Unit, RACP, Level 6, AME House, 352 Kent Street,
Sydney NSW 2000.
Tel (02) 9290 6500, Fax (02) 9299 6626,
Email: hpu@racp.edu.au, website: www.racp.edu.au.

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ACKNOWLEDGEMENTS

Working Group:
Dr Sue Packer (Chair)
Prof John Boulton
Dr Terry Donald
Dr Margaret Gibson
Dr Catherine Marraffa
Dr Michael Ryan
Dr Ann Smith

Research Officer:
Ms Victoria Toulkidis, Health Policy Unit

Contributions by:
Dr Alison Blaiklock
Dr Sharon Goldfeld
Dr Patrick Kelly
Dr Victor Nossar
Prof Kim Oates
Mr Craig Glenroy Patterson, Director, Health Policy Unit
Dr Ralph Pinnock
Dr Nigel Stewart
Dr Peter Watson
Dr Mike Watt
Dr Russell Wills

Paediatric Policy Committee, Paediatrics and Child Health Division
Dr Elisabeth Murphy (Chair)
Dr Ion Alexander
Dr Carolyn Cooper
Prof Brian Darlow
Dr Peter Eastaugh
Dr Peter Goss
Prof David Henderson-Smart
Prof Richard Henry
Prof Frank Oberklaid
Dr Jill Sewell

EXECUTIVE SUMMARY

Child physical and sexual abuse is the focus of much attention in contemporary society. Whilst the existence of such abuse is of grave concern and requires action to protect children, other forms of abuse such as emotional abuse and neglect also occur frequently in our society and have just as serious an impact on the health and development of children. A child may suffer more than one form of abuse.

Children from all cultural and socio-economic backgrounds can be victims of child abuse; however, evidence suggests that some children are more at risk of some forms of abuse than others. This includes children who live in families with low incomes, unstable housing and where domestic violence occurs. Children with disabilities are also at high risk of being abused.

Child abuse does not occur in isolation – it occurs within a family and broader social environment. The various factors that lead to, and are associated with child abuse must be acknowledged and addressed in order to improve health outcomes for children. These include poverty, family structure, employment issues (eg work place policies are not very supportive of certain family structures), gender (eg the male stereotype which encourages men to be aggressive and dominant) and violence (in particular domestic violence). Over the past few decades, the economies of both Australia and New Zealand have moved towards a 'free market' approach. This has led to social policy being developed within a context of cost-effectiveness and efficiency criteria which is not always an appropriate context for policy relating to child abuse and the problems outlined above.

All forms of child abuse can damage the development, health and well being of children and the impact can be significant – both in the short and long term. The immediate impact of abuse on children may include very low self esteem, mistrust of others, lack of interpersonal skills which are required for optimal function in society, extreme attention seeking behaviour, delay in developmental milestones, non-organic failure to thrive during infancy, psychosocial growth failure in older children and eating disorders.

In the longer-term children who are physically abused or maltreated are up to three times more likely than non-abused children to be violent, commit crimes, attempt suicide and suffer from anxiety disorders when they are teenagers.

The impact of abuse can be particularly devastating if the abuse occurs during the early years of life. The wealth of recent theoretical and practical research on early life experiences and neurophysiological development highlights the importance of this period in the wellbeing of the child. Evidence suggests that the experiences (social and physical) in the early years of life (from conception to age six) affect the way the brain develops, and this in turn affects learning, behaviour and health throughout life.

In addition to the negative impact on children, the long-term consequences of child abuse are a serious problem for society at large. As outlined above, children who are abused are at high risk of becoming adults with mental health and behavioural problems. If these adults do not receive the assistance they need to overcome the abuse, they are likely to continue the cycle of abuse with their own children. Consequently, child abuse may be passed through the generations creating more and more entrenched social problems.

Child abuse is a significant problem in both Australia and New Zealand. Approximately 4.3 per 1,000 children aged 0-16 years were the subject of a substantiation† in Australia 1998-99.[1] In New Zealand, 0.23 per 1,000 children were hospitalised as a result of child abuse in 1995.[2] The incidence of child abuse in indigenous communities is much higher in Australia and New Zealand than for non-indigenous communities. Approximately 13.7 indigenous Australian children per 1,000 have been abused or neglected – compared with 4.3 per 1,000 for non-indigenous children.[1] The hospitalisation rates for Maori children (0.62 per 1,000 children) as a result of child abuse are 3.7 times greater than for non-Maori (0.17 per 1,000 children).[3]

Statistical information about child abuse in Australia and New Zealand is probably an underestimate. The data are collected by several agencies, and each agency or State/Territory defines 'abuse' and collects information in different ways. Therefore it is difficult to use the data to interpret long-term and national trends. In New Zealand, the most useful sets of data are the hospitalisation rates for children as a result of 'homicide and injury purposely inflicted by other persons'. However, this data does not include cases of abuse which may occur but do not lead to hospitalisation.

† 'Substantiated abuse' means that after investigation, it is concluded that the child has been, is being, or is likely to be abused or neglected or otherwise harmed.

The issues relating to child abuse are complex, and so are the solutions. Simplistic models which focus only on the prevention, identification and treatment of child abuse can fail to take into account the broader social and structural factors associated with child abuse.

The best strategy to protect children is to prevent child abuse from occurring; however, when a child is at risk of or is being abused, action must be taken quickly and intensively.

Effective child abuse prevention and management strategies must be based on the following:

- a systems approach to ensure that:
  - policies and data collection methods are consistent;
  - early intervention programs (which focus on families with young children) are used to reduce risk factors and increase protective factors; and,
  - social policies are evaluated and reviewed to improve outcomes for children (for example, in relation to social justice, violence, physical punishment and child care);
- appropriate training for the various professions involved with children; and,
- paediatricians playing a key role in child protection.

Due to the complex nature of child abuse and problems within families, effective prevention of child abuse and child protection can only be achieved if the various professions and agencies work in partnership.

INTRODUCTION

This booklet has been designed as a tool to provide guidance to professionals concerned with children about how we should respond to child abuse.

Child abuse encompasses a broad spectrum of behaviours towards children, including those which are considered less damaging and which may not be considered 'abuse' by some communities or cultures. **Readers are encouraged to view all aspects of child abuse as damaging and therefore requiring immediate action by all those involved in the life of the child.**

The College supports initiatives in relation to children which support the following principles of the United Nations Convention on the Rights of the Child[4]:

- the best interests of the child should be the primary consideration in all actions concerning children;
- children have the right to life, survival and development and therefore measures must be taken to increase life expectancy, lower infant/child mortality, ensure access to adequate housing, nutrition, health services and education;
- children have a right to express their views in all matters affecting them and their views must be given due consideration according to their age and maturity; and,
- all children, regardless of gender, age and socio-economic status should enjoy the rights recognised by the Convention.

THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

The Paediatrics and Child Health Division (the Division) is the part of the Royal Australasian College of Physicians (the College) which includes the majority of consultant paediatricians in Australia and New Zealand. Included within the Division is the Chapter of Community Child Health, which is a group of consultant paediatricians and other medical professionals with a particular commitment to community child health and welfare.

The College comprises a fellowship of medical specialists who are committed to providing the highest quality of care in internal medicine, paediatrics and sub-specialties to all people in Australia and New Zealand. Core functions of the College include training, accreditation and the maintenance of professional standards, as well as research and policy development in areas such as workforce, public health, health financing and systems development.

WHY ARE WE INVOLVED?

The Division acknowledges the key role that paediatricians in Australia, New Zealand and overseas have played, and continue to play, in identifying and bringing to public attention the frequent occurrence of child abuse in our communities and ways forward in the prevention and management of child abuse.

The practice of paediatrics is committed to promoting health for all children as defined by the World Health Organisation[5]:

> *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*

In this context, paediatricians need to be constantly vigilant to the impact of our changing society on the health and well-being of our children, particularly changes which increase their vulnerability.

1. CHILD ABUSE: THE ISSUES

1.1 What Is Child Abuse?

Child abuse may be defined as:

> *"…the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect, or deprivation of any child or young person."*[6]

There are various forms of abuse, some of which are more difficult to define than others. Emotional abuse includes rejection, not responding emotionally, degrading children, and causing fear, stress and humiliation.[7]

Emotional neglect is a form of abuse and can be distinguished from emotional abuse in that it occurs when "meaningful adults are unable to provide necessary nurturance, stimulation, encouragement, and protection to the child at various stages of development, which inhibits…optimal functioning."[8] This can occur for many reasons, for example, if parents are emotionally unable to respond to their children's needs from adverse circumstances which cause significant mental illness, substance abuse and intellectual developmental delay. In these situations parents may not provide a sufficiently stimulating environment, failing to interact with their children or encouraging them to learn or play.

Sexual abuse involves exposing children to unwanted and potentially harmful sexual experiences, and can range from one episode to ongoing long-term abuse.

Physical abuse includes physical violence or excessive punishment such as belting, beating, shaking or burning.

Neglect is defined as any situation in which the basic needs of children are not met with respect to nutrition, hygiene, clothing and shelter. It also comprises the failure to provide access to adequate physical and mental health care and educational needs.

Domestic violence in the home can lead to physical abuse, emotional neglect and emotional abuse of children. Evidence suggests that there is a strong correlation between

domestic violence and child abuse[9], and that children who witness domestic violence are more likely to have emotional and behavioural problems than other children.[10, 11]

Fabricated illness is an insidious but important form of child abuse. Fabricated illness may express itself as under or over-reporting child illness by a caregiver to the point that specific medical intervention is administered to the child, including unnecessary investigations and treatments. The most severe form of fabricated illness is the actual procurement of signs and symptoms in the child by physical harm generated by a caregiver (Munchausen Syndrome By Proxy).

1.2 Children At Risk

Children from all cultural and socio-economic backgrounds are vulnerable to abuse because:

- of their dependence on adults and the power dynamics between adult and child;
- they are not able or may not have the opportunity to stand up to adults and speak for themselves;
- are placed in the care of various people at different times (such as parents, teachers, sports coaches, baby sitters, family etc) where there is the potential for abuse to occur; and,
- society generally promotes the notion that children 'belong' to their parents, and therefore parents' rights outweigh children's rights.

Evidence suggests that some children are more at risk of some forms of abuse than others (see Appendix 1 and Section 1.3). However, it is important to consider that such data primarily refers to cases of physical and sexual abuse and may not include children who are at risk of other forms of abuse such as emotional abuse and neglect.

Professionals who come into contact with children, particularly those involved in child health and welfare, must consider the needs of each and every child – *regardless of the child's background and socioeconomic status.*

child abuse: the issues

It is now well recognised that the abuse of children with disabilities is far more frequent than for other children.[12, 13] These children are particularly vulnerable because of their prolonged dependency and high incidence of communication problems.

Deaf children and those who are severely physically disabled have been identified as being at particular risk.[14] This becomes especially problematic if the child's "interpreter" or carer is also the abuser.

There is an immediate need for trained, skilled communicators available for investigation of abuse and accurate assessment of care situations for these children. Paediatricians are in a unique position to monitor these children and advocate for them when the need arises.

1.3 Social/Structural Factors Associated with Child Abuse

Child abuse does not occur in isolation – it occurs within a family and social/structural environment. There are many factors that lead to, and are associated with child abuse and these must be acknowledged and addressed in order to improve health outcomes for children.

A discussion paper[15] commissioned by the NSW Child Protection Council† highlights the various social/structural forces that cause harm to children and act as barriers to the effective prevention of child abuse, as follows:

- Poverty
  - Child abuse, particularly neglect, is more likely to occur to children who live in poverty than to other children (though it is by no means inevitable). One US study shows a consistent link between low family income and child abuse and neglect.[16]
- Family structure
  - Certain family structures in particular circumstances, such as single parenthood, are associated with higher rates of child abuse.

† The NSW Child Protection Council ceased to function in 1999 and most of its role has been taken on by the NSWCommission for Children and Young People.

- Links between poverty and family structure
  - Risk of child abuse increases in single parent families on low incomes.
- Work and families
  - Workplace policies are not very supportive of certain family structures (eg both parents working, women working part-time/casual or being the primary income earners for the family) and this can have an impact on the social status and well being of all family members.
- Gender
  - Male and female stereotypes (which encourage men to be aggressive and dominant) can be a contributing factor to violence in society and in the home.
- Violence
  - There is a strong correlation between domestic violence and child abuse. Studies indicate that children from families in which domestic violence is occurring are more likely to be abused (either emotionally, physically or sexually).[17] Children in families with domestic violence are 15 times more at risk than other children of being abused, either by the aggressor or the victim in the family.[18] One study found that the presence of domestic violence limited the effectiveness of a nurse home visiting program in reducing the incidence of child abuse and neglect.[19]
  - The use of physical force (whether it be violence in the community or physical punishment in the home) must be challenged.

Over the past few decades, the economies of both Australia and New Zealand have moved towards a 'free market' approach. This has led to social policy being developed within a context of cost-effectiveness and efficiency criteria, which is not always an appropriate context for policy relating to child abuse and the problems outlined above. It has also led to an increase in user pays systems for many services, which often result in families and communities having to manage their own needs.

Further information about the social determinants of health is available in the College's policy papers 'For Richer for Poorer, in Sickness and in Health'[20] and 'The Impact of Adversity on Child Health'.[21]

1.4 Impact of Abuse on Children

Child abuse is damaging to children – both in the short and long term.

Children have certain needs which must be met in order for them to develop physically, intellectually, emotionally and socially. These include:

- physical needs – being safe, well fed and adequately housed;
- emotional and behavioural needs – children need to feel approval and acceptance, and experience consistency in behaviour from their carers and those around them; and,
- social needs – children need to learn to socialise within the family and in the outside world – childcare, school and the neighbourhood.

Child abuse often results from the failure of one or more of the needs being met. This can have a major negative impact on a child's physical, developmental and psychological well being, and the consequences can continue well into adolescence and adulthood.

The immediate impact of abuse on children may include the following:

- very low self esteem;
- mistrust of others;
- lack of interpersonal skills required to function in society;
- extreme attention seeking behaviour;
- other behavioural disorders eg disruptiveness, bullying and defiance;
- delay in developmental milestones;
- non-organic failure to thrive during infancy;
- psychosocial growth failure in older children; and,
- anorexia, overeating or bizarre patterns of eating or drinking.

Australian follow-up studies[22, 23] into the consequences of physical abuse have shown that, compared with matched controls, abused children have delays in reading and language ability, more behaviour problems, lower self-esteem and do less well on measures of intellectual performance.

Emotional abuse is a component of any other form of abuse and its impact can be difficult to determine. The cumulative effects of repeated acts of emotional abuse can be damaging[24] and can lead to any of the problems outlined above. One study[25] compared the outcomes of children who had been diagnosed as sexually abused eight years earlier, with children who had not been diagnosed as sexually abused. The study found that the abused children were more likely than non-abused children to have:

- been removed from their home;
- changed home address at a higher rate;
- changed schools at a higher rate;
- been further abused;
- adverse behaviours;
- educational problems;
- chronic health problems; and
- involvement in mental health services.

In the longer-term, studies[2] show that:

- children who are physically abused or maltreated are
  - up to three times more likely than non-abused children to be violent, commit crimes, attempt suicide and suffer from anxiety disorders when they are teenagers; and,
  - more likely to be victims of violent assault.
- women who report to have been sexually abused as children, especially if they have been subjected to more intrusive forms of sexual abuse such as sexual intercourse, are more likely than non-abused women to:
  - become pregnant before the age of 19 years;
  - harm themselves deliberately;
  - have post-traumatic stress disorder and other associated mental health problems; and
  - enter into prostitution.[26]

- teenagers who report to have been sexually abused as children are more likely than non-abused teenagers to:
  - suffer from higher rates of major depression, anxiety disorder, conduct disorder, substance abuse disorder;
  - attempt suicide;
  - be homeless;
  - engage in sexual activity at a younger age; and
  - engage in sexual risk-taking.

Sexually abused children followed prospectively for 5 years have been found to have a higher degree of depression, lower self-esteem, disturbed behaviour, self injury, suicide attempts and actual suicides compared with controls.[27] Many of these problems continued at a 9-year follow-up.[28]

1.4.1 First Years of Life

The impact of abuse is particularly devastating if the abuse occurs during the early years of life. The wealth of recent theoretical and practical research on early life experiences and neurophysiological development highlights the importance of this period in the wellbeing of the child.[29]

A review[30] of early childhood literature highlights powerful new evidence that the experiences (social and physical) in the early years of life (from conception to age six) affect the way the brain develops, and this in turn affects learning, behaviour and health throughout life. The review found that:

- "nurturing by parents in the early years has a decisive and long-lasting impact on how people develop, their capacity to learn, their behaviour and ability to regulate their emotions and their risks for disease in later life; and,
- negative experiences in the early years, including severe neglect or absence of appropriate stimulation, are likely to have decisive and sustained effects."

Children facing ongoing abuse, in particular violence, must learn and grow despite feeling

constant threat. Perry[31] states that:

> *"Persisting fear and the neurophysiological adaptations to this fear can alter the development of the child's brain, resulting in changes in physiological, emotional, behavioural, cognitive and social functioning."*

Research[31] shows that children who are abused and exposed to constant threat, process information from the world differently than other children and therefore respond in a different way. For example[31] children in a state of fear:

- have a shortened sense of future – immediate reward is gratifying, delayed gratification is impossible and reflection on their behaviour (and its consequences) is not possible;
- are less able to process and store verbal information – therefore, are less likely to perform well at school and are often thought to have learning disabilities; and,
- focus more on non-verbal information than verbal – this can lead to exaggeration of perceived threats which are acted upon aggressively.

These problems are more likely to occur if the abuse is severe and chronic, and the children are abused early in life.

Research about the impact of early life experiences implies that most children who have experienced mild to moderate forms of neglect can (in a strong supportive environment) improve their developmental capacity if intervention occurs early.

Children with disabilities are more at risk of having negative early life experiences because of their increased dependence on their parents or carers, and the stress and frustration of the parents who often have difficulty in accessing the services they require.[13]

1.5 Child Abuse In Australia

Mandatory notification of child abuse is required by law throughout Australia, except in Western Australia where referral protocols are in place.

The various State and Federal systems of law in Australia are an impediment to the

successful protection of our children. Most child protection laws are not transferable across State/Territory borders. This increases the likelihood of at risk children being lost to follow up. Difficulties in developing inter-agency collaboration are further barriers to the protection of children.

The statistics arising from notifications of child abuse are a useful yardstick, but the abuse recognised, investigated and substantiated is an underestimate. There are several reasons for this[1]:

- cases which are not recognised within the welfare system are generally not included in these statistics;
- there are significant differences and inconsistencies in the way that each State/Territory defines child abuse and collects data; and,
- physical, sexual and emotional abuse are separately categorised, whereas, in reality, the situation is far more complex and emotional abuse is a significant factor in most abuse. Sexual and physical abuse also frequently occur together.

Despite these limitations, statistics in relation to child abuse provide our best guide to prevalence and changes in abuse patterns.

1.5.1 The Extent of Child Abuse

General Community

For 1998–99[1] the statistics were:

Total notifications in Australia	103,302
Finalised investigations	50,009
Substantiated abuse	25,255
Unsubstantiated notifications	24,666

'Substantiated abuse' means that after investigation, it is concluded that the child has been, is being or is likely to be abused or neglected or otherwise harmed.

'Unsubstantiated notifications' means that, on the evidence available, the child was not considered to be abused or at risk of abuse when investigated. It does not necessarily mean the concerns are unwarranted. Indeed, for many of these children the circumstances of their lives are chronically unsatisfactory.

Tasmania also uses the category 'child at risk', which refers to situations where the notification is not substantiated, but where there are reasonable grounds for suspecting the possibility of previous or future abuse or neglect, and it is considered that continued involvement of community services departments is warranted.

Approximately 4.3 per 1,000 children aged 0–16 years were the subject of a substantiation in Australia 1998-99.[1]

Aboriginal and Torres Strait Islander Children

The very high rate of reported and substantiated abuse or neglect of Aboriginal and Torres Strait Islander children is of particular concern. The Child Protection Australia 1998-99 report[1] found that:

- approximately 13.7 indigenous children per 1,000 have been abused or neglected – compared with 4.3 per 1,000 for non-indigenous children; and,
- in Western Australia and South Australia, indigenous children were 5.8 times more likely to be the subject of a substantiation than other children, and in New South Wales they were 4.2 times more likely.

The reasons for these high rates of abuse are complex, and are associated with the social and cultural challenges that these communities have faced since colonisation. The report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families[32] found that indigenous children are over-represented in the child welfare system because of:

- intergenerational effects of previous separations from family and culture;
- poor socioeconomic status; and,
- cultural differences in child-rearing practices.

The pattern of substantiated abuse and neglect for indigenous children appears to be different from the pattern for other children. The proportion of substantiated cases due to neglect are far higher for indigenous children (for example 58% in Queensland) than for non-indigenous children (36% in Queensland).[1]
These statistics are a further indictment of services, supports and interventions available to indigenous communities and further emphasise the urgent need to work in close collaboration with these communities to improve the range and appropriateness of supports and services available.

1.6 Child Abuse in New Zealand

Mandatory reporting has not been legislated in New Zealand. There is currently vigorous debate in both lay and professional circles about the role of, and need for, mandatory reporting of child abuse in New Zealand.

Statistical information about child abuse is collected by several agencies, and once again, because of the difference in the way that each agency defines abuse and collects information, it is difficult to use the data to interpret long-term trends.

The most useful sets of data are the hospitalisation rates for children as a result of 'homicide and injury purposely inflicted by other persons'[6]. However, it is important to note that this data does not include cases of abuse which may occur, but do not lead to hospitalisation. Once again, these figures underestimate the true numbers of children being abused.

1.6.1 The Extent of Child Abuse

General Community

In 1995, a total of 194 children aged 0-14 years in New Zealand were hospitalised as a result of child abuse[2]. This is an incidence rate of 0.23 per 1,000 children. Overall, the rate increased from 1989 to 1991, and decreased from 1991. However, it is difficult to compare before and after 1991 because hospital admission procedures changed – with more patients being treated and sent home rather than being admitted. Therefore, the

decrease in admissions does not necessarily indicate a decrease in child abuse.

A number of other studies indicate much higher rates of reported abuse. The Dunedin Multidisciplinary Health and Development Study[2] found that 4% of 13 year olds and 3% of 15 year olds reported to have been physically injured by another person. The Christchurch Health and Development Study[33] found that between the ages of 0-16 years, 4% reported severe or harsh and abusive treatment from their parents with most of them being injured. Another study[2] of children aged 11–13 years found that 10% had been punched, kicked or beaten by an adult at least once during the previous nine months, while 5% had been 'belted' by an adult.

Overall, the rate of children who died as a result of abuse has risen steadily since 1981 as follows[6]:

1981–83	0.68 per 100,000
1984–86	0.82 per 100,000
1987–89	1.15 per 100,000
1990–92	1.23 per 100,000

In 1994 a total of 13 children aged 0-14 years died as a result of child abuse[2].

Maori Children

The rate of reported and substantiated child abuse amongst Maori is much higher than for non-Maori. For example, the hospitalisation rates for Maori children (0.62 per 1,000 children) as a result of child abuse were 3.7 times greater than for non-Maori (0.17 per 1,000 children) in 1995.[3]

For the period 1990-94 the mortality rate for Maori children aged 0-14 years as a result of child abuse was slightly higher at 1.33 males and 1.22 females per 100,000 in comparison with 1.33 males and 1.13 females for non-Maori.[3]

The Child Abuse Prevention report[6] by the Ministry of Health found that the breakdown of tribal structures has led to social stresses on families, in particular women and children.

In 1991, almost half the Maori children under the age of 5 years lived in homes with a sole parent (usually women). These families often face socioeconomic difficulties and lack of whanau† support.

2. WHAT CAN BE DONE

2.1 A Systems Approach

A discussion paper[15] by the NSW Child Protection Council which examines the structural barriers to the prevention of child abuse and neglect concludes that in order to prevent child abuse:

> *"…it is not enough to adopt a simplistic model which addresses child abuse and neglect via prevention, identification and treatment. Effective child abuse prevention strategies require the consideration of the means to address the social forces underpinning child abuse, neglect and other family violence."*

The College supports the policy directions recommended by the NSW Child Protection Council's discussion paper as follows:

- the adoption of a health promotion approach which focuses on the promotion of positive, life-enhancing strategies;
- the development of a solid knowledge base of the definitions and aetiology of child maltreatment;
- the promotion of child rights and the empowerment of children by developing positive societal perceptions of children;
- recognition that social forces are central to the realisation of children's rights and the prevention of child abuse;
- the need to change the societal attitudes to violence;
- the development of effective coordination, cooperation and communication at all

† Traditionally, the basic unit in Maori society is the whanau which included extended family spanning three generations.

levels of government, and between government and non-government sectors;

- ensuring adequate resources are put in place to meet the current service demands of tertiary clients, yet enabling the child welfare system to devote resources to primary and secondary prevention initiatives;
- the development of a prevention strategy that encourages families to seek assistance proactively from adequately resourced services; and,
- the adoption of holistic, cross-sectoral approaches to child abuse prevention that involve both the professional sector and the broader community.

These views are reflected in the discussion paper[34] on children's rights by the New Zealand Office of the Commissioner for Children and Ministry of Youth Affairs which outlines a range of policy and research measures to improve child health including:

- "making the legislative framework consistent with children's rights;
- developing a comprehensive national strategy or agenda for children;
- developing permanent mechanisms in government to ensure effective coordination, monitoring and evaluation of policy and practice affecting children;
- establishing a system of child impact assessment in all policy areas to encourage children's interests to be systematically taken into account;
- carrying out budget analysis for policies and services relating to children;
- collecting good data on the state of children;
- raising awareness of children's rights amongst adults and children; and,
- establishing and supporting an independent office for children (like a Commissioner for Children) to promote and monitor children's rights."

This highlights the importance of intersectoral collaboration in preventing and responding to child abuse and the need for the various professions working with children to foster partnerships.

2.1.1 Data Collection

It is essential that national data in relation to child abuse (including notifications, investigations and substantiations) in Australia and New Zealand be improved so that the true extent of child abuse is known and can be addressed. Satisfactory data collection is unlikely to occur unless there are uniform child protection laws within both nations.

In Australia, the National Child Protection and Support Services (NCPASS) Data Group is assessing the feasibility of a national framework to make State/Territory data comparable.[35]

The College supports initiatives which aim to improve data in relation to child abuse in Australia and New Zealand.

2.1.2 Regional and General Paediatricians

Most child protection work in rural and regional areas is undertaken by primary health care workers (such as general practitioners, nurses, allied health care workers and where appropriate indigenous health workers) and paediatricians. Children in these areas are referred to Tertiary Reference Centres where necessary. The essential role of regional and general paediatricians in supporting primary health care workers must be acknowledged and enhanced.

General paediatricians, particularly in rural regions, need support to continue their work in this area. Ongoing education should be provided following a needs assessment to ensure that the particular needs of each paediatrician are met.

2.1.3 Tertiary Reference Centres

Whilst recognising the central role of the general practitioner and the general paediatrician in the identification and assessment of, and advocacy for, children at risk of or being abused, there remains an important role for Tertiary Reference Centres.

Tertiary Reference Centres of excellence need to be established with direct links to district paediatric centres. Tertiary Reference Centres should be multi – disciplinary in their

composition and provide a broad range of clinical services to children suspected of having been abused or neglected. The clinical services should include medical and psychosocial assessment and treatment. These Centres should have knowledge of, and involvement with, local child abuse prevention strategies and agencies.

The Tertiary Reference Centres should provide assessment, treatment and educational facilities. They would also act as a referral centre for second opinions and an ongoing education centre for the district paediatric centres. The Tertiary Reference Centres would have a role to provide Advanced Trainee education.

In particular, these Centres should be centres of excellence which:

- establish standards of training and practice for health professionals in the area of child protection. Such centres should provide rotating service positions for training medical officers and advanced training fellowships for paediatricians wishing to specialise in child protection work;
- are available to consult with all professionals working with children, particularly isolated general practitioners and paediatricians, in relation to medical assessment and diagnosis, treatment, report preparation and court appearances. Such consultation should be regularly available and preferably conducted via Tele-Medicine video links;
- provide regular training workshops for medical professionals, particularly those working in isolation;
- facilitate the growth of an optimal working relationship with the relevant department of community services and the police through the joint development of referral protocols and procedures, outlining the range and uses of the various types of medical assessments and the process of formulating a medical opinion and the preparation of medical reports and recommendations;
- provide up-to-date information and training in relation to child abuse assessment;
- work with universities and medical colleges to improve the training of health professionals and child health workers; and,
- focus on research and development in relation to child abuse, from a health perspective.

The Centres should conduct regular peer review clinical meetings to discuss diagnostic

and management controversies with a view to reaching a consensus medical opinion. Such peer review meetings should involve paediatricians undertaking child protection work and isolated medical practitioners through Tele-Medicine facilities. The district paediatric centres would act in their areas as the first point of referral. An established team would function in those centres headed by the paediatrician and also, especially if appropriate partnerships are developed, be able to provide some outreach education for Advanced Trainees. They would also be involved in providing local education, and have the responsibility for establishing their local and subregional partnerships.

It is essential that both the Tertiary Reference Centres and the district centres develop inter-professional partnerships especially with Child Protection Units and the legal profession. Providing mock Court training for Advanced Trainees and trainee barristers is essential.

Not all paediatricians choose to have initial or ongoing involvement in the assessment and management of abused children. A register of those paediatricians willing to be involved should be developed. This would be facilitated by developing the partnerships between district centres and Tertiary Reference Centres.

2.1.4. Child Death Review Panels (Australia)

There is general acceptance by all State/Territory paediatric services that there is a need for a comprehensive mechanism within each State/Territory to review all child deaths.

The functions of such a body should be:

1. the collection of accurate and timely data concerning all child deaths;
2. the creation and maintenance of a register of all child deaths, classifying these deaths according to cause of death as determined by the team;
3. detailed reviews of deaths where abuse or neglect might be suspected, or where issues of preventability are evident;
4. analysis of data, identifying patterns and trends;
5. use of information to educate and inform policy;
6. contribution to collaborative research regarding specific causes of death; and,

7. evaluation of outcomes.

The basic principles underlying the development of such review groups should be:

1. An acknowledgment that the responsibility for responding to and preventing child death lies with the community and the whole of government, not with any single government agency.
2. That the improvement of interagency coordination, communication and cooperation in all aspects of child protection and injury prevention is imperative.
3. A child death review process should be based on a comprehensive, systematic assessment of the preventability of deaths.
4. Timely, accurate and local data are essential to develop effective community education and other preventative strategies.
5. The focus of child death review is not the criminality of any alleged offender nor the individual responsibility or performance of duty. The investigation of child deaths remains the role of the Police and the Coroner. Government agencies involved with children should continue to investigate departmental responses to the circumstances surrounding the death of a child for whom they are responsible. The child death review mechanisms are not an alternative for these procedures.

At this time only NSW and Tasmania have legislated for such reviews. The Tasmanian Council has a majority of health members. The NSW team is more truly multi-disciplinary in its composition.

Victoria has a comprehensive process for reviewing deaths of children in the care of the state welfare department. This review does not include other children not known to the department.

All other States and the ACT are in the process of developing similar review bodies considering children's deaths.

It is of concern that our information regarding the circumstances surrounding children's deaths in Australia is so fragmented and incomplete, especially at a time when the rest of paediatric health services are so sophisticated.

If the States/Territories were to attempt to develop ways to collect comparative data, it would be of great benefit and would hopefully circumvent the difficulties resulting from the non-comparable child protection laws in each State/Territory. A more comprehensive, Australia-wide understanding of the most grave aspects of child abuse and neglect – child fatalities – could give direction to the provision of the most timely and intensive interventions to prevent such deaths.

2.1.5. Early Intervention

Literature about the importance of the early years of life and the benefits of preventive and early intervention programs is increasing. These programs aim to improve the developmental and health outcomes for children by either reducing the risk factors (eg low birth weight or family conflict) or increasing protective factors (eg positive social skills or family harmony).[36]

An Australian review[36] of national and international early childhood literature examined the effectiveness of selected interventions and concluded that:

- preschool and high quality child care services can have a positive effect on child developmental outcomes, particularly for children in low income families;
- early childhood and development programs improve disadvantaged children's IQ during the early years, and skills in reading and maths;
- home visiting programs can be effective, particularly for very disadvantaged women; and,
- community based group education programs for parents produce positive changes in children's behaviour, and these programs are more cost-effective than individual clinic-based programs.

A US study found that investing in early intervention programs for disadvantaged children and families can lead to considerable cost savings.[37]

The Australian review[36] states that the results of overseas studies cannot necessarily be extrapolated to Australia because of differences in service systems, socio-economic

patterns and cultural characteristics. For example, unlike the US, Australia provides universal early childhood services at relatively low cost to most children and their families.

Interest in early intervention programs is increasing in Australia. The Commonwealth Government of Australia has funded a Stronger Families and Communities Strategy[38] which focuses on prevention and early intervention programs. Some of the States/Territories have their own policies/strategies aimed at improving the well-being of young children, and many of these include early intervention programs which support parents following the birth of their child. For example, the NSW Government has funded a Families First strategy[39] to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well-adjusted children.

The College is currently working with the National Investment for the Early Years, which involves representation from various disciplines, to promote the importance of early childhood to governments, professionals working with children and the community.

In New Zealand, as part of its Strengthening Families Initiative, the Government has funded the development of Family Start, a series of early intervention programs targeted at high risk families with young children. These programs provide intensive home based support services which seek to bring about improved outcomes in areas such as child health and health care; parenting and family functioning, child abuse and family violence; child development; and parental mental health.

One of the difficulties inherent in the provision of such programs is the need to provide an adequate evaluation of program efficacy. This issue is being addressed as part of a large randomised controlled trial of one such program based in Christchurch called Early Start. As part of this trial, the outcomes for a group of 220 children/families enrolled in the Early Start program will be compared with outcomes for a similar group of 220 children/families not enrolled in the program. Both series of families will be followed for a minimum of three years.

It is essential that all early intervention programs be evaluated appropriately to determine whether they achieve their goals and are the most cost-effective method to achieve those outcomes.

2.1.6. Social Policy

Due to the broad social/structural forces that may cause harm to children and act as barriers to the effective prevention of child abuse (as noted earlier), social policies must be evaluated and reviewed to improve outcomes for children. This must occur within a coordinated framework which examines policies relating to economics, women, children, families, justice, employment and communications. Examples of policies which should be examined are outlined below.
It is essential that health and social services are accessible to those who need them most. This is particularly important for disadvantaged children and families, and those in regional and rural areas.

Social Justice

The gap between rich and poor has increased in Australia over the past two decades[40], and economic restructuring in New Zealand has resulted in a greater portion of society becoming economically marginalised.[41] Older disadvantaged people, children and sole parents are more likely to be living in poverty and are particularly susceptible to social isolation, malnutrition and illness because of limited mobility and support networks.[42, 43, 44]

Research suggests that countries with a more egalitarian distribution of income have better health outcomes, and that policies which aim to reduce health inequalities must first address inequities in income distribution.[45, 46, 47]

The paucity of resources to address the issue of child abuse in rural and remote areas of Australia and New Zealand is recognised. The College supports the equitable distribution of resource allocation to ensure optimal servicing of these children and their families.

To improve health outcomes for children and their families, policies based on the principles of social justice must be supported.

Child Care

Child health professionals should lobby for, and work with governments to improve and maintain quality child care services. For example, they should lobby to ensure that people

from all socio-economic backgrounds have access to quality child care, and that child care settings are more focused towards health promotion. Child health professionals should participate in policy relating to child care workforce training/accreditation and funding.

Violence

Children are exposed to high levels of violence constantly in their lives through entertainment (television, videos and computer games), and at times through their environment for example from family violence or violence experienced in their community). Often the forms of violence which children are exposed to, such as television programs and movies, are portrayed as consequence-free. For example, television characters may be severely beaten or shot without dying or showing much pain. Characters are often violent towards others without being punished.

It is essential that the use of physical force, whether it be violence (including physical punishment) in the community or the home, be challenged and that this be reflected in everyday culture. This involves reviewing policies in relation to communications, as well as through education for children, parents and for professionals who work with children in daycare centres and schools) and in the justice system.

Physical Punishment and Discipline (including smacking)

Paediatricians and other child health professionals can play a vital role in changing attitudes and behaviour in relation to the physical abuse of children carried out under the guise of punishment or discipline. Society's views on physical punishment are not consistent – although it may be acceptable by some adults to hit children as a form of discipline, it is unacceptable for adults to hit one another. Studies show that most parents smack their children.[48] One study found that 94% of parents had physically punished their toddlers in the previous 12 months, and 35% had hit their babies.[49]

The Paediatrics and Child Health Division believes that the use of physical force (in any form and including psychological threats) is an ineffective and unhelpful method of punishment and discipline of children.

A meta-analysis[50] on the short and long term effects of corporal (or physical) punishment

concluded that although children are more likely to comply with adults' demands following physical punishment in the short term, they do not actually learn the desired good behaviour. Consequently, repeated and escalating levels of physical punishment then occur in the longer term to force the children to maintain the good behaviour. This increases the risk of physical injury to children, may lead to severe child abuse and reinforces in children a model of parenting which relies on physical punishment.

Other studies show that the use of physical punishment is associated with a range of negative consequences including[50, 51]:

- increases in physical abuse;
- increased prevalence of disruptive behaviour (ODD and conduct disorder);
- long term anti-social behaviour;
- later in life, the abuse of a partner or child;
- anxiety disorders; and,
- alcohol abuse or dependence

There are many reasons why parents physically punish their children. Most parents who hit their children were hit as children.[48] Parents often lose their temper and don't know how to manage the situation.[52] One study[53] found that, in families, there was an association between poor marital relationships and severe punishment of children.

Alternative methods of discipline†, which are far more effective and beneficial for children, include[54]:

- parents responding positively, rewarding desired behaviour combined with ignoring undesirable behaviour; and,
- setting appropriate limits and applying fair consequences for breaking them, related logically to the misdemeanour where possible.

† For further information contact NAPCAN on (02) 9211 0224 or http://www.napcan.org.au; or EPOCH at http://epochnz.virtualave.net/kit_principles.html

Sweden banned all forms of physical punishment in 1979, and research[55, 56] suggests that this has led to:

- reduced child mortality as a result of physical abuse;
- a decline in public support for physical punishment;
- an increase in the identification of children at risk; and,
- improved social services which are more supportive and preventive.

In Australia, each State/Territory has its own legislation in relation to physical punishment. For example, in New South Wales physical punishment is banned in all schools including private schools. At present parents can use the defence of lawful chastisement if they hit their children. In 2000, a private Members Bill was submitted to the NSW Parliament which would limit the use of excessive physical force to discipline, manage or control children. It would remove the right of parents to use the defence of lawful chastisement if they hit their children from the neck upwards or use an implement to hit them below the neck. The Paediatric and Child Health Division strongly supports the intent of this Bill.

In New Zealand, several organisations such as the End Physical Punishment of Children (EPOCH) and Repeal 59 Group are lobbying government to repeal section 59 of the Crimes Act 1961 which allows physical punishment of children.

2.2 Appropriate Training for the Various Professions

All professionals working with children must understand the basic principles of child health and development so that they are better able to provide care for children and families. For example, they should understand:

- children's physical and developmental needs being different to those of adults;
- what is meant by child abuse, including the various forms such as physical, sexual, emotional, psychological and the complex nature of the problem;
- how to listen and respond to children being abused;
- the professional responsibilities and local procedures for mandatory reporting and interagency consultation;

- the impact of family dysfunction on the management of all childhood disease and disability, and how to facilitate access to community supports;
- be able to recognise patterns of illness and family situations where protecting the child from abuse is a primary diagnostic consideration; and
- how to deal with Factitious Illness, or Munchausen Syndrome By Proxy (MSBP) and recognise the contribution of complex investigations and treatments in susceptible families to the evolution of this serious, often life threatening situation. They need to consider MSBP in all bizarre and atypical illness presentations and seek early expert consultation.

2.3 The Role of Paediatricians

Paediatricians have expertise in the developmental needs of children and play an important role in the lives of children at risk of, or being abused. This involves the following:

- listening to children;
- identifying children at risk of or being abused;
- diagnosis of child abuse; and,
- management (including referral and consultation where appropriate) of children and their families.

Paediatricians are advocates for children at an individual and community level.

Due to the complex nature of child abuse and problems within families, effective prevention of child abuse and enhanced child protection can only be achieved if the various professions and agencies work in partnership. This includes child protection, child welfare, family support and community health.[15] Paediatricians must work with the various professions to find solutions to improve outcomes for the children and their families.

Child protection is a vital component of the work of Paediatricians.

CONCLUSION

Child abuse is a significant problem in both Australia and New Zealand, particular for children whose families are disadvantaged in society. Such abuse does not occur in isolation, it occurs within a family and social environment. There are various social and structural factors that are associated with child abuse and these must all be taken into consideration when trying to prevent child abuse or manage the problem.

Society has the responsibility to ensure that children are able to grow in a safe environment. Consequently, the community as a whole (including governments, professions working with children, policy makers and parents) must acknowledge, take responsibility for, and play a vital role in child protection.

The best strategy to protect children is to prevent child abuse from occurring; however, when a child is at risk of or is being abused, action must be taken quickly and intensively.

Effective child abuse prevention and management strategies must be based on the following:

- a systems approach to ensure that:
  - policies and data collection methods are consistent;
  - early intervention programs (which focus on families with young children) are used to reduce risk factors and increase protective factors; and,
  - social policies are evaluated and reviewed to improve outcomes for children (for example in relation to social justice, violence, physical punishment and child care);
- appropriate training for the various professions involved with children; and,
- highlighting the vital role of paediatricians in child protection.

Due to the complex nature of child abuse and problems within families, effective prevention of child abuse and child protection can only be achieved if the various professions and agencies work in partnership. The College is committed to improving links between the professions to ensure better outcomes for children.

APPENDIX 1

Children at Risk

There are a number of social factors which are associated with child abuse. Children who live in the following social circumstances are more likely to be at risk of being abused[6, 57]:

- unsatisfactory and unstable housing ;
- low socioeconomic status;
- carers whose main income is through government support;
- single parent family;
- parents who have a violent relationship;
- parents have problems such as alcohol and substance abuse or psychiatric problems; and,
- social isolation or lack of social support.

Other risk factors include that the mother had[6]:

- young maternal age;
- had an unplanned pregnancy;
- considered abortion or adoption during the pregnancy; and,
- a child with a disability or chronic illness.

It must be emphasised that these risk factors for child abuse are very complex and do not operate in isolation.[6] Children who have a cluster of risk factors are much more at risk of child abuse. Also, the risk factors must be considered within the cultural environment. Some risk factors relate more to some cultures than others.

The highest proportion of children who are a subject of substantiated abuse are in the age groups 5-9 years and 10-14 years, and females are far more likely than males to be at risk of sexual abuse.[57]

Other children at risk also include children of indigenous communities, children with disabilities and children in foster care.

Children of Indigenous Communities

As outlined in Section 1, indigenous children (in both Australia[57] and New Zealand[6]) are more at risk than non-indigenous children of being abused and neglected.

Children with Disabilities

It is now well recognised that the abuse of children with disabilities is far more frequent than for other children.[12,13] These children are particularly vulnerable because of their prolonged dependency and high incidence of communication problems.

Deaf children and those who are severely physically disabled have been identified as being at particular risk.[14] This is particularly problematic if the child's "interpreter" or carer is also the abuser.

There is an immediate need for trained, skilled communicators to be available for investigation of abuse and accurate assessment of care situations for these children. Paediatricians are in a unique position to monitor these children and advocate for them when the need arises.

Children in Foster Car e

Current child care policies support the continued placement and care of children in their own homes, with support, unless the risks are overwhelming.

If this is not feasible, every attempt is made to place the children with extended family in kinship care. It is not generally recognised just how stressful such placements can be for both the child and carers, as such placements get less support (including financial support) than other placements in most cases yet have to deal with the complexities of extended family dynamics.

Children placed in out-of-home care have more often experienced extreme family dysfunction over a long period of time, as well as episodes of abuse. They frequently have significant emotional and behavioural problems[58], as well as developmental delays and neglected health needs.[59]

Extended family and foster carers are expected to care for these frequently difficult and distressed children. The support and advice they receive are often inadequate. It is recognised that such children remain an at risk group for abuse, even in foster care.[58, 60]

Many of these children need ongoing paediatric monitoring (and dental monitoring) because of their longstanding neglected health needs. Such monitoring can be of vital importance in recognising that ongoing behavioural and developmental problems, as well as being consequences of the original abuse, might also be indicators that abuse is continuing. Abuse can occur either in the care situation or during parental contact. Children can find contact with their family quite distressing. They are confronted both by their past experiences and their loss of family. All these issues need to be considered during paediatric review.

Recognition of the efforts and achievements of the carers by the paediatrician can be a very positive support in a trying situation.

Paediatricians are frequently the most comprehensively informed people in these children's lives and their role as advocate for the child with the many agencies involved is often vital and can influence the appropriateness of the care plans.

Children in Institutions

Children in institutions are particularly vulnerable and may face abuse from either staff or older children in the institution.[7] Children who have a history of abuse are even more at risk because often they have been placed in the institution as a consequence of prior abuse, and they feel guilt and may believe that reporting any further abuse will lead to further punishment.

A Commission of Inquiry into Abuse of Children[7] found that children in some institutions had suffered child abuse for a range of reasons including:

- inadequate training of, and support to, staff;
- inadequate levels of staff;
- inappropriate social norms or forms of punishments (eg children being stripped of their individual identity, humiliating children etc);
- hierarchical nature of the institution which made it difficult for front-line workers to make positive changes; and,
- isolation of the institution (for example physical isolation may lead to fewer visits by family and professionals to the children.

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HEALTH of CHILDREN in "OUT-OF-HOME" CARE

Paediatric Policy

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Paediatrics & Child Health Division, RACP
145 Macquarie Street
Sydney, New South Wales 2000, Australia
Tel +612 9256 9600, Fax +612 9256 9610
Email: hpu@racp.edu.au
Website: http://www.racp.edu.au/hpu/paed/index.htm

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Key working group

Dr Susan Cadzow, FRACP
Dr John Clarkson, FRACP
Dr Jan Connors, FRACP
Dr Maree Crawford, FRACP - Chair
Ms Mary Osborn

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Executive summary

Children in "out-of-home" care are a vulnerable and at-risk group in the population. This group of children are likely to have poorer physical, mental and developmental health than their peers. Existing data regarding the health status of this population in Australia and New Zealand is limited. The College currently relies largely on overseas data and has identified this as a major research gap.

There are many gaps and barriers in providing effective health care for children living in out-of-home care. This document identifies models of care that demonstrate some solutions to these problems.

This document outlines the best available evidence from the research literature surrounding children in out-of-home care and proposes strategies to deliver effective health care within Australia and New Zealand. The key proposals involve the following:

- Ensuring that physical, developmental and mental health assessments are performed on all children who enter into out-of-home care;
- Encouraging ongoing monitoring of needs by identified health care co-ordinators;
- Ensuring appropriate timely access to therapeutic services;
- Developing a transferable health record system;
- Improving training and support for foster carers;
- Coordinating a health care centred approach between all agencies involved with this group of children, including Community Services and Education;
- Encouraging governments to adequately fund the implementation of the suggested recommendations; and,
- Collecting aggregated data and ensuring evaluation of programs.

Efficient and effective implementation of these recommendations requires utilisation of local health systems and resources. The College and individual Paediatricians need to advocate with Community service departments in each jurisdiction, and at the Federal level, to assist in provision of optimal care for this group of vulnerable children. The College recognises that at present there are shortfalls in resources, particularly in remote and rural locations, to fulfil these recommendations.

Recommendations

Considering what is known about the health and social needs of children and young people in out-of-home care placements, the College suggests the following recommendations for the best optimal care. In addition, it is recognised that the most efficient way to implement these recommendations is in partnership with key stakeholders including relevant government and non-government organisations.

1. *Routine health screening and assessment of all children entering alternative care.*

   That the College advocate for all children entering care, in line with international recommendations, to have a comprehensive assessment within 30 days of placement. Depending on local resources this care may be provided within a specialised clinic, by an individual Paediatrician, a General Practitioner, or Nurse Practitioners or by Aboriginal Health workers. Staff should be appropriately trained and skilled and the setting must be child-focused and culturally appropriate. The assessment must include the following:

   - General health assessment including a health history of the child and family, physical examination, growth assessment, vision, hearing and dental screening, and an immunisation register check. The health assessment information must be documented to ensure easy access for medical professionals;

   - Developmental assessment incorporating standardised screening tools e.g. Ages and Stages or Brigance, as an adjunct to clinical assessment, and access to formalised assessment. Local systems must be developed to fast track therapeutic developmental services to children with identified deficits. Systems need to be established for liaison with Education representatives;

   - Mental health screening using accessible and validated tools e.g. Strengths and Difficulties Questionnaire, or Achenbach Child Behaviour Checklist (CBCL). Infants and toddlers must be assessed for attachment disorders. Local systems must be developed to provide a therapeutic response to identified needs.

2. *Formulation of health plan*

That the College, through the Paediatrics & Child Health Division, work with community services in the relevant Australian and New Zealand health

jurisdictions to develop a framework to implement an individual health management plan based on the above assessment including:

- Identifying a health coordinator for each child; and,
- Promoting a follow-up health review to occur within three months of assessment and subsequently at least on an annual basis.

3. Enhanced care, management and treatment services

That government departments including Community Services, Health and Education, Child Youth and Family Services (New Zealand), and the relevant Australian and New Zealand health jurisdictions, work together to ensure that children and young people who are placed in out-of-home care receive similar care, management and treatment to their peers by:

- Developing local systems to ensure that this group of children is not disadvantaged in their receipt of health care services compared to their peers;
- Promote the use of fast tracking therapeutic services, given the often, small window of opportunity available due to transient care placements; and,
- Ensure that such services are provided for all health needs and in particular mental health needs, utilising both public and private therapeutic services as required.

4. Data collection

That the College encourage governments to develop and resource permanent and easily transferable health records on children who are in out-of-home placements which will be accessible to future health providers and available to parents and carers by:

- Using electronic health records linked to Community Services files;
- Ensuring these are stored in a safe manner while at the same time allowing them to facilitate health communication;
- Recording information that includes a patient hand-held record containing past history, relevant family history, health assessment information, treatments and interventions; and,

- Evaluating the health needs of children placed in out-of-home care and aggregating this data to monitor and identify the effective interventions.

5. Improved access to health records of birth parents

That the College assist Community Services workers to have access to health records of birth parents in a fashion which is consistent with privacy legislation by:

- Developing a proforma to enable these workers to collect a satisfactory health history from parents, and engage with parents over consent for health treatment of their child at the point of entry into care; and,

- Entering into discussions with Privacy Commissioners, or similar bodies, to explore the availability of this information to Community Service workers.

6. Enhanced communication

That the College, with other health professionals and Community Services, in the relevant Australian and New Zealand health jurisdictions, advocate increasing the level of communication by:

- Facilitating effective communication channels between health professionals, Community Services Departments and other key people in the foster child's life e.g. schools, carers and parents;

- Establishing specific communication avenues such as community based inter-agency forums for more complex cases;

- Listening and responding to foster children's opinions and ideas as to how their health needs may be best met; and,

- Engaging birth parents in their child's ongoing health planning where possible.

7. Improved support and training for foster carers

That the College, with Community Services in the relevant Australian and New Zealand health jurisdictions, advocate strengthening support and training programs for foster parents by:

- Ensuring the provision of therapeutic foster placements by providing adequate support and training for foster carers and

ensuring that foster placements are not overcrowded or in other ways unable to meet the needs of the child; and,

- Developing optimal permanency planning for children in alternative care.

Implementation of recommendations

In order to implement these recommendations, all Paediatricians working with children in out-of-home care, must assist with the utilisation of existing health systems and if necessary, development of new ones. Dialogue and communication with other key agencies, particularly Community Services Departments (Australia) or the Department of Child Youth and Family Services (New Zealand), who have the statutory role and often guardianship for these children, will be necessary. The National Plan for Foster Children, Young People and their Carers has proposals to assist with some areas e.g. research and training.[1]

Introduction

Children and young people in out-of-home care have been recognised globally as a highly vulnerable group of children with increased physical, mental and social health needs and with associated limited access to resources. As such, they are a group of children for whom Paediatricians and The Royal Australasian College of Physicians (RACP) have a responsibility in advocating for provision of improved health services catering for physical, emotional and social needs.

This document aims to deal specifically with children and young people in foster care or residential care on statutory court orders, but may be equally applicable to children on statutory orders in kinship placements. It aims to overview the extent and nature of health problems and offers recommendations for Paediatricians and others working with these children and young people to address these problems.

Types of alternative care in Australia and New Zealand

Out-of-home care encompasses a variety of living arrangements for children and young people other than living with their parents. Arrangements include foster care, kinship placements and residential care. These placements can be instigated either by voluntary arrangement or via a court order.

There are no national data on the reasons for placement out-of-home. [2] [3] The majority of children in out-of-home care will have been the subject of substantiated child protection notifications and will also be on care and protection orders of some kind. A small number of children will be placed voluntarily, usually on a temporary basis, with alternative carers if families are unable to care adequately for them.

Numbers of children involved and demographics

In 2004-05 there were 12,531 children admitted to out-of-home care in Australia.[4] Family and Community Services data for 2003-04 uses different population definitions and reported 9,214 children admitted to out-of -home care. [5] [1] This was a decrease from the 12, 819 admitted in 2002–03. Indigenous children are 6.5 times more likely to be placed in out-of-home care than non-Indigenous children. [6]

Trends in numbers of children in out-of-home care showed that in 30 June 2005 there were 23,695 (4.9 per 1,000) children aged 0-17 years in out-of

[1] In this case defined as care outside usual home by a person other than a parent, whether or not for fee, and if on a court order being for a period of more than 14 days, and excluding relative care except on court

home care in Australia.[7] The number of children has increased steadily between 1996 and 2005 with an increment of 70 per cent in that period. The majority of children (94 per cent) were in home-based care with only four per cent in residential care and one per cent in independent living. Since 1996 there has been a trend of increased use of placements with relatives and kin or foster carers, and decreased use of placement in residential care.[8] This is reflected in 2005 with the numbers of children aged 0-17 years accounting for 57 per cent in foster care and 42 per cent in relative or kinship care. [9]

In Australia, the majority of children (84 per cent of out-of-home children) were on court orders with state variations ranging from 70 per cent in Western Australia to 100 per cent in Northern Territory. [10] Since 1997, there has been a steadily increasing trend for children to be placed on orders in all jurisdictions except Tasmania and the Australian Capital Territory.

For children subject to court orders, gender distribution was equal. Twenty four per cent of children were aged less than five years with three per cent younger than 12 months. Thirty three per cent were between 5–9 years, 32 per cent 10–14 yrs, and 8 per cent were 15–17 yrs. [11]

Child protection orders are of three broad categories. Guardianship orders involve the transfer of legal guardianship to an authorised department or in some jurisdictions transfer to an individual. This involves transfer of responsibility for the child's long-term welfare including education, health, religion and financial matters.

Custody orders place the children in the custody of a third party giving them responsibility for the day-to-day requirements of the child but leaving guardianship responsibility with the child's parents.

The third type of order is a supervisory order where the relevant community services department has some responsibility for the child's supervision, but care is provided by parents and guardianship or custody is unaffected.

Of children on orders across Australia at 30 June 2005, 90 per cent were guardianship or custody orders and 9 per cent of orders were temporary or interim. [12] However, of children admitted into care during the same period 33 per cent were on interim or temporary orders indicating shorter term changing placements. Current policies are to reunite and support families and most children are eventually returned home.

The majority of children (51 per cent) were in out-of-home care for less than two years but 22 per cent had greater than five years in continuous out-of-home care. [13]

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are over-represented within the population of children in alternative care. At 30 June 2005 there were 5,678 (26.4 per 1000) Aboriginal and Torres Strait Islander children aged 0–17 years in out-of -home care. This rate is 6.5 times the rate for non-Indigenous children in out-of-home care. These rates vary between jurisdictions from 8.9 per 1,000 in Northern Territory to 40.7 per 1,000 in Victoria. [14]

Aboriginal and Torres Strait Islander children have been shown to already have a heavier health burden compared with the general population.[15] This includes social, emotional, and mental health problems in addition to the increased rates of illness and death related to almost all disease and injury categories. [16] [17]Hence, Aboriginal and Torres Strait Islander children coming into out-of-home care suffer an adverse double- effect on wellbeing. This is further exacerbated by the known difficulties of the Indigenous population in accessing services and receiving culturally appropriate services. [18]

Aboriginal and Torres Strait Islander peoples see the separation of children "from land and kin" as a form of abuse in itself and disruption of cultural ties and identity can result in life-long harm and trauma as recognised in “the stolen generation”.[19]

All jurisdictions have adopted the Aboriginal Child Placement Principle either in legislation or policy. This outlines preference for the placement of Aboriginal and Torres Strait Islander children, firstly, with their family, alternatively within their Indigenous community and as a third option, with other Aboriginal and Torres Strait Islander people. Factors such as availability of Indigenous carers affect achievement of this goal. At 30 June 2003, 77 per cent of Aboriginal and Torres Strait Islander children had been placed according to these principles.[20]

The Northern Territory Government (Australia) has developed a framework that attempts to increase the capacity of Indigenous people to develop and support local initiatives by advancing the social, cultural, and economic well-being. Strategies used to combat violence and enhance family cohesion work with Indigenous controlled family support centres to assist them to increase recruitment, training, career development and retention of Indigenous employees in Child Protection Units.[21]

Out of home care in New Zealand

New Zealand data are similar to Australian but not directly comparable in that orders refer only to custody or guardianship of the Chief Executive, (equivalent of Australia Director General) and do not include supervisory orders. At 30 June 2004, 5071 (4.4 per 1,000) children were in care placements in New Zealand. [22]As with Aboriginal Australians, Maori children are over-represented making up 45 per cent of the total. Kinship placement is the preferred policy of the New Zealand Child protection services, and is therefore prevalent with 36 per cent of children in care placements living with carers who are defined as family or Whänau (Extended family). Average length of stay in care has been increasing and is currently almost three years.

Health status and developmental needs of children entering out of home care

There is clear evidence from studies conducted in the United States and the United Kingdom that children entering foster care have a high prevalence of acute and chronic health problems and developmental disabilities, and subsequently have a broad range of health care needs.[23] [24] [25] [26] [27]

There are multiple reasons for vulnerability in these children including their high prevalence of abuse and neglect, their greater likelihood of disadvantaged backgrounds, and their increased biological weighting e.g. with parents with mental health and drug abuse problems. These factors also contribute to fragmented health care.

Early studies from the United States reported only 13 per cent of children entering care had a normal physical examination, 50 per cent had multiple abnormalities, most frequently involving growth and development. [28] More recent studies[29] [30] [31]report similar findings. Many children entering care (25 per cent) had failed a vision screen, 15 per cent failed a hearing screen, and 23 per cent of children under 5 yrs had suspected developmental delays.[32] Over half of the children over three years required referral for dental or mental health services. Children under three years had an increased incidence of poor growth. Other studies have documented rates of developmental delays in preschool aged children entering foster care ranging from 20 per cent to 60 per cent.[33]Furthermore, children entering care are less likely to be fully immunised.[34]

Australian data is at present limited but suggests a similar pattern of high needs. The Kari Clinic Pilot Program, a New South Wales (Australia) program for Aboriginal and Torres Strait Islander children, observed high levels of language delays or disorder (63 per cent) and reported 37 per cent with oral health problems.[35] A Victorian (Australia) pilot program reported nearly two thirds of children and young people in out-of-home care required medical or allied health follow-up. [36] A screening program conducted in New South Wales (Australia) with children in foster care found that a fifth of the 80 children failed hearing tests with a similar number failing vision tests. Half of this group of children were found to have delayed speech development and had not reached their usual developmental milestones.[37]

Health service requirements for Children in Care

This section of the document highlights the extra health care services required to meet the needs of children in-out-of home care. The importance of providing the best available care to children in-out-of-home care is essential in order to prevent problems. The effectiveness of clinical interventions for children in care has not been well researched. It is not appropriate to extrapolate findings on the effectiveness of treatments from children in the general population as their problems are different.

Entry into care does not necessarily ameliorate these health problems. There are data suggesting that children in care have ongoing unmet health needs such as poor uptake of immunisations and inadequate oral health care.[38] [39] Developmental disabilities remain prevalent (reported in up to 60 per cent) as do chronic medical conditions (45–76 per cent).[40] [41]

Studies examining children already in care highlight the frequent lack of available information about past medical history and accurate information about current health status.[42] This deficit is particularly marked in those who have experienced multiple placements and presumably lack of continuity of health care. Perceived confidentiality issues may also impact on outcomes by limiting information sharing between health providers, carers and child protection agencies.

To date there is limited published data relating to the health and developmental status of children in out-of-home care in Australia or New Zealand. However, similar high needs and obstacles to providing optimal care are most likely to be present.

Psychological needs

The high prevalence of psychological and mental health problems of children in foster care has also been well documented. There are multiple causes including environmental, social, biologic and psychological risk factors.[43]

There is good evidence about the need for infants to establish secure attachment with their primary caregiver and about the long-term impacts of abnormal early attachment. [44] [45] [46]Chronic physical abuse and emotional neglect can cause insecure, avoidant and ambivalent attachment to primary adult care takers and subsequent poor relationships with new caregivers.[47]

Children who have been placed in foster care have experienced parent-child separation and the subsequent breaking and making of attachments. Feelings of rejection, guilt, anger, abandonment and shame are common responses to loss of family and neighbourhood.[48] Children may blame the system and show destructive externalising behaviours. While these behaviours may test a foster parent's ability to nurture and place the stability of the placement at risk, the response of a carer can be crucial to the child's emotional wellbeing.

The process of re-unification with natural parents can further destabilise the child, and access visits need to be positive and aimed at strengthening relationships and improving interactions. The visitation process can be a negative experience, resulting in deterioration in behaviour and stress on the child as well as on their developing relationship with the foster parent.[49]

The disruption experienced by a child as part of the placement process can often compound pre-existing conditions. Even for children who have been harmed severely thus making removal necessary, removal from parents is rarely a positive experience.[50] A therapeutic foster placement that is nurturing, caring and accepting is essential, rather than one that is overcrowded, unsupportive and transient.

From the above understanding, it is therefore not surprising that a large proportion of children in alternative care have been found to have mental health problems. Many studies have reported high incidence of moderate to severe mental health problems. In the United States, 70 per cent of children placed for at least a year in alternative care reported moderate to severe mental health problems.[51] Another United States study found 84 per cent of a foster care sample had developmental or psychological problems.[52] Emotional, self- regulatory, relational and behavioural abnormalities were most prevalent in school age children.

United States children in out-of-home care have 10-20 times the utilisation rates of mental health services.[53] Seventy-five percent of this is accounted for by adjustment, conduct, anxiety and emotional disorders, [54] and in a group of

children older than three years, 15 per cent reported suicidal ideation and 7 per cent homicidal ideation.[55] A baseline for comparison is a New Zealand study of children which reported up to 30 per cent by 21 years admitting to suicidal ideation. [56]

It has been observed that foster parents and social workers tend to under-report psychological problems (33 per cent compared with 84 per cent found following careful assessment)[57] hence the need for screening and careful assessment as well as effective intervention.

In the longer term, adult longitudinal studies identify that those who have been in care during childhood, have significantly higher mental health, educational and vocational problems than the general population.[58]

Mental health, socialisation and self esteem were assessed in a prospective study of children in court ordered foster and kinship care in Australia. This study reported that these children were at high risk of mental health problems. [59] The study recommended further research into providing effective health services that focus not on discrete disorders but rather a more holistic and complex view of mental, social and emotional aspects of care.

Children in care in Australia are over-represented in the juvenile justice[60] system and in prisons.[61] In New South Wales (Australia) an inmate health survey reported that 23 percent of women and 21 percent of men had been in care before they were sixteen years old.

There is a clear need for evidence based services and interventions to enhance children and young peoples mental wellbeing.

International systems and policies

Given this recognition of a high level of health, developmental and psychological needs of children in alternative care, recommendations have been developed for management of these problems.

In the United States the Child Welfare League of America and the American Academy of Pediatrics[62] recommended that all children entering foster care have an initial physical examination before or soon after placement, focussing on identification of acute and chronic conditions requiring expedient treatment. All children should then receive comprehensive physical, mental health and developmental evaluations within one month of placement. In addition all children should be assigned a consistent source of health care.

In the United Kingdom regulations under the Children Act (1989) recommend a statutory annual health assessment (biannual if under 5 years of age).[63] The initial health assessment includes information gathered from the child, social worker and parent / carer about current health status as well as personal or family history which may aid in identification of genetic risk or infection risk. The child receives a physical examination including assessment of hearing, vision and growth, and developmental assessment (preschool age) or functional school report (school age).

Unfortunately, in both countries uptake of these assessments has been poor [64] [65] and while assessments have been helpful in identifying health problems and needs, there has been a disappointingly low rate of action on recommendations. [66] [67]

More recent *Quality Protects* initiatives in England and *Children First Initiative* in Wales (1998) have increased resources and performance monitoring via the *Framework for Assessment of Children in Need and their Families* which aims to improve life health chances of children in care. [68] The 2002 guidance *Promoting the Health of Looked after Children* has further formalised a framework for delivery of services and health promotion for children and young people in the care system.[69]

In Australia and New Zealand, to date there is no unified response or specific policies or recommended standards of health assessment interventions for children in out-of-home care. In Victoria (Australia) a feedback / complaints project[70] conducted by the Advocate for Children in Care (the Advocate) established the *Minimum Standards and Outcome Objectives for Home-based Care in Victoria & Minimum Standards and Outcome Objectives for Residential Care in Victoria*.[71] These sets of standards require a medical and dental examination within one month of entering out-of-home care.[72] . This service is provided by General Practitioners using the *Looking After Children (LAC) program*.

The different jurisdictions have a range of systems and initiatives to address the health needs of children and young people in care. These have been comprehensively researched in the *Report card on Health 2006*.[73] This report highlights the need to further develop a framework for health care and particularly highlights the need for a national research capacity around health of children in out-of -home care.

Identified barriers to effective care provision

While recognising the needs of these children it is also necessary to acknowledge and address the barriers to intervention. The American Academy of Pediatrics reports that the health care of children in alternative care is frequently compromised by insufficient funding, poor planning, lack of access, prolonged waits for services, poor co-ordination and lack of adequate communication.[74] The same could be said for many children in alternative care across Australia.

There are recognised barriers to adequate medical care for foster children. They often experience multiple moves usually with no provision for permanent and accessible health records. There is frequently a lack of specific health policies and utilisation of health services occurs in an ad hoc manner. Resource shortages within both health and child support agencies discourages routine screening and support and promotes crisis management. Lack of permanency plans for children in care further exacerbates the above concerns.[75] [76]

Children placed in kinship care may receive even less support and therefore receive fewer services despite similar levels of need.[77] Ethnic differences can add further to inequitable service provision as some cultures are less inclined to acknowledge mental health issues and actively seek support. [78] Aboriginal and Torres Strait Islander peoples have difficulty with both access to and availability of culturally appropriate services generally, let alone for the subgroup of children or young people in care.

Absence of information about birth families, birth history and early health issues is commonplace and problematic, and an important function of any health assessment is searching for and collation of what information is available. [79] In Victoria (Australia) the *Looking after Children* project which aimed to overcome problems of collation of essential information reported poor compatibility with this new set of information and previous records. [80].

Communication between different groups such as health professionals, child welfare workers, foster carers, and biologic parents is often very poor. Medical information and recommendations need to be transferred to everyone involved in the care of children in out-of-home care. Certain parties may be left out of the loop to the long-term detriment of the child. In the case of foster carers, issues sometimes arise with regards to confidentiality and what health information they are entitled to know.

Change of placement in care often results in change of primary health practitioner and change in school and contributes to poor communication and difficulties of information transfer. Change of caseworker has a similar effect. [81]

Instability in foster care placement in the United States was associated with increased mental health costs during the first year in care and this was especially so among children with increasing health costs.[82] This study again raises the importance of early interventions that target health care resources for these children.

There is often ambiguity in who has responsibility for co-ordinating health needs whether it is the foster carer, the case worker or the medical provider. These children need a strong advocate and health care co-ordinator to ensure that health care needs continue to be met over time.

Models and effectiveness of 'out-of-home' care

Previously mentioned models indicate that there is no question that children entering foster care have multiple needs, the question that remains is how to provide complex services to these children in a timely and cost-efficient manner.

Foster care clinics - community based multi-disciplinary clinics

A number of centres in the United States [83] [84] [85] [86] have developed multidisciplinary community based clinics to provide services to children in foster care. These services have included assessment, usually incorporating standardised screening and assessment tools, health care co-ordination, and often treatment of identified problems. Program evaluations demonstrated that these clinics were more effective in identifying developmental and mental health problems but no more effective in detecting medical and educational problems than community health providers. [87] However, children in these clinics were more likely to receive recommended services.

Given the high prevalence of developmental and mental health problems in children and young people in out of home care, assessment for Australian or New Zealand children should incorporate the principles of developmental surveillance.[88] Screening tools must also be used with adequate psychometric properties e.g. Ages and Stages Questionnaire or Brigance Screen, and Strengths and Difficulties Questionnaire or Achenbach CBCL, with ready access to diagnostic tests.

This multi-disciplinary clinic model may be effective in identifying developmental and mental health problems and linking to services, there is still paucity of clear evidence as to effectiveness of various interventions with this population.[89]

Family support programs

It is recognised that in parallel with assessment and treatment of a child's specific needs by professionals, interventions must be ecologically based incorporating the significant others in the child's life such as foster carers, parents if possible, and educational staff.[90]

Given the nature of the attachment difficulties in abused children it is to be expected that issues may play out within a foster placement and within a school setting, and that carers need awareness and special skills to support these children.

Foster parents have to face multiple and seemingly incompatible expectations. They must make emotional investments into nurturing a child who may be

difficult to live with, and to simultaneously support eventual reunion with birth parents and separate easily when the time comes.

Access, while extremely important, can be very stressful for all. Children can become anxious before and may be aggressive or tantrum after. Birth parents may act inappropriately, yet foster carers are expected to deal with the child's reactions and to support the biological parents and ongoing visits.

Various publications address the importance of adequate services and training for foster carers [91] and the association of such services with better placement and behavioural outcomes for children. [92]However, in the United States fewer than one third of carers reported being well prepared to foster.[93] Short-term training and supports for foster carers did not impact on children's psychopathology however carers perceived benefits for themselves.[94]

Support services can provide a range of interventions for children and their carers. [95] [96] This can include education for caregivers eg on effects of early trauma and management of common behavioural problems, guidance in individual or group settings, peer support, and respite care for young children and case management. Relative carers may have greater needs but may receive less support than foster parents. [97] [98]

Over and above the mainstream fostering services there have been trials of "specialised" foster care where there is enhanced pay, and training and regular mental health services. These services have been shown to provide improvements in the children's psychopathology but are expensive. [99]

Recruitment and training of foster carers are major issues in all Australia and New Zealand. Training is minimal and many foster carers are under-resourced to manage the complexity of the problems, both physical and emotional, that they encounter.

Permanency planning

Children who have experienced abuse with family disruption and who have poor attachment have a heightened need for permanency, security and emotional constancy. Lack of placement stability and multiple moves is unfortunately very common. While the goal of placement is usually to work towards the child being safely reunified with biological parents, there are some children for whom this is not possible and for these children permanency planning at the earliest possible time is essential to stop drift within placements.

The way ahead

Efforts to improve outcomes for these children and young people in Australia and New Zealand must address the existing barriers. The frequent multiplicity of problems mandates a comprehensive and collaborative assessment and treatment approach. Ongoing health care should incorporate systematic monitoring with improved continuity of care and information sharing between involved parties, and attention to preventative health care, health education and health promotion. The effectiveness of therapeutic interventions requires ongoing evaluation and is contingent on accurate data collection and ongoing research.

The recommendations in this document are a framework to allow these goals to be achieved.

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