



Submission to the

Protecting Victoria's Vulnerable Children Inquiry

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EXECUTIVE SUMMARY

RELEVANT TERMS OF REFERENCE

This submission is relevant to the following terms of reference of the Inquiry:

3. The quality, structure, role and functioning of:

- *family services;*
- *statutory child protection services, including reporting, assessment, investigation procedures and responses; and*
- *out-of-home care, including permanency planning and transitions;*

and what improvements may be made to better protect the best interests of children and support better outcomes for children and families

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.

7. Measures to enhance the government's ability to plan for future demand for family services, statutory child protection services and out-of-home care; and ensure a workforce that delivers services of a high quality to children and families.

KEY ARGUMENTS

The key arguments underpinning this submission are:

1. Australian research supports research findings and professional medical opinion in the UK and US that children who have experienced substantiated abuse and/or neglect are likely to have chronic and complex health difficulties which impact significantly on their quality of life.
2. The responsibility of governments described in the UN Convention on the Rights of the Child (UN General Assembly 1989), to assure that each and every child who has experienced abuse or neglect has every opportunity to overcome the detrimental effects of such experiences on their health and development, is an underlying principle which must be more strongly recognized and acted on in Victoria.
3. The Australian health system relies on parents to monitor their own child's development and health, recognise health difficulties, identify appropriate health service providers, maintain a record of the child's health history, coordinate and advocate for appropriate health services and provide legal consent for treatment. When a parent is unable or unwilling to perform these roles a robust system is needed to reliably ensure that the health of children and young people who have been abused is not further neglected.
4. The essential features of an approach which would assure opportunities for overcoming the detrimental health effects of abuse or neglect include the creation and maintenance of comprehensive, accessible and current individual child health records, initial health screening, periodic comprehensive health needs assessment, health care planning, access to appropriate treatment and therapy, and ongoing health monitoring.

The submission will highlight some of the current weaknesses in the way health needs are addressed, particularly in out-of-home care, and suggest areas for improvement.

VULNERABLE CHILDREN HAVE CHRONIC AND COMPLEX HEALTH CONCERNS

Children and young people subjected to abuse or neglect are among the most vulnerable in our community. Chronic and complex health conditions have been found to be more prevalent in this cohort than in the general Australian population (Chambers et al 2010, Kaltner & Rissel 2010, Tarren-Sweeney 2010 and 2008, Fernandez 2009, 2008, 2007, Milburn et al 2008, Reynolds & Ralph 2008, Frederico et al 2007, Sawyer et al 2007, Nathanson & Tzioumi 2007, Carbone et al 2007, Tarren-Sweeney & Hazell 2006).

Recent Australian studies in which health professionals have systematically, comprehensively and individually assessed the health of cohorts of children in out-of-home care have described the variety of problems and calculated the frequency of occurrence, as shown in Table 1.

Qualitative studies alert us to additional difficulties, such as eligible young people not receiving disability support services they would be entitled to. Health risk behaviors are also reported as more prevalent, including teenage pregnancy and parenthood, and drug and alcohol dependence (Mendes 2010, 2008).

Not only do children and young people experience a complex array of health difficulties but their quality of life is significantly lower as a result and is similar to that of children with life-long health conditions such as diabetes, cystic fibrosis and asthma (Carbone et al 2007).

Type of health problem	Frequency among children in out-of-home care study samples	Research studies
Immunisation not up to date	24% to 53%	Kalter & Rissel 2010 Reynolds & Casey 2008 Nathanson & Tzioumi 2007
Vision difficulties	18% to 33%	Chambers et al 2010 Kaltner & Rissel 2010
Hearing difficulties	24% to 26%	Chambers et al 2010 Kalter & Rissel 2010
Growth abnormalities	14%	Nathanson & Tzioumi 2007
Eating disorders	24%	Tarren-Sweeney 2006
Expressive or receptive language delay	57%	Chambers et al 2010
Educational problems	60%	Reynolds & Casey 2008
Clinically significant emotional /behavioural difficulties	48% to 62%	Jackson et al 2009, Milburn et al 2008, Sawyer et al 2007, Tarren-Sweeney & Hazell 2006
Psychotropic medication used for behavioural management	16%	Tarren-Sweeney 2010
Child required multiple referrals for further health assessment or treatment	70%	Kalter & Rissel 2010, Nathanson et al 2009

Table 1. Types of health problems identified, and ranges of frequency of problems, among children in out-of-home care research studies in Australia 2005-2010.

SPECIAL MEASURES ARE WARRANTED TO ADDRESS HEALTH ISSUES

The complex and chronic nature of health difficulties faced by children and young people in out-of-home care have been extensively researched in the UK and US and their special health care needs are now well accepted as being above and beyond those of other young people. This is reflected in the American Academy of Pediatrics *Fundamental principles for health care for children in foster care* (AAP 2010) which provides a best practice guide to comprehensive health assessment and planning.

The Royal Australasian College of Physicians (RACP 2008) has agreed that periodic, comprehensive health assessment and health care planning are also vital for Australian children in out-of-home care. The RACP recommendations are consistent with current legislation and standards in the US (US Congress 2008) and the UK (Department of Children, Schools and Families 2009).

It should be noted that new Australian standards for out-of-home care (FAHCSIA 2010) being introduced from 1 July 2011, while not inconsistent, are not as comprehensive as the best practice guidance provided by paediatric professional bodies.

The most compelling reason to adopt a systematic, comprehensive approach to health assessment for children entering out-of-home care is the likelihood of these children having already experienced chronic maltreatment. Study of a random sample of 100 Australian cases of child abuse notification over several years found that 65% of these children experienced chronic maltreatment, many repeat notifications were treated in isolation, and parents, rather than children, tended to receive an intervention (Bromfield and Higgins 2005). The study indicated that the impact of chronic maltreatment on child health and wellbeing is quite unlikely to be assessed. These findings have led to the call for more child-focused responses in the child protection and health sectors (Bromfield and Horsfall 2009).

WEAKNESSES IDENTIFIED BY AUSTRALIAN RESEARCHERS

Research has identified gaps in meeting the health needs of children in the child protection system in Australia which include:

- Health care management tends to be excluded from accountability measures in child protection (Tilbury 2006);
- Individual health histories are often not available (Chambers et al 2010);
- Individual histories of the trauma experienced by a child may not be cumulative, accurate or available (Tarren-Sweeney 2010, Tregeagle 2010, Frederico et al 2008);
- Carers and family members may be unable or unwilling to provide child health information (Chambers et al 2010, Tregeagle 2010);
- Carers and case managers detect less health problems than health professionals (Kaltner & Rissel 2010);
- Carers require additional practical supports to attend health care appointments with children (Chambers et al 2010);
- More systematic measurement of health needs for all children in out-of-home care is needed and children require pre-emptive, population based assessment of all aspects of their health at the time of entry to care (Crawford 2006, Tarren-Sweeney 2010).
- Different types of assessment are called for depending on the age and stage of the child. Infants and young people leaving care, for example, have particular but different monitoring needs (Milburn 2008, Zhou 2010).
- Additional assessment, monitoring and research is required for some sub-populations in out-of-home care e.g. Aboriginal and Islander children, immigrant and refugee children and children with intellectual disabilities (Tarren-Sweeney 2010, Tilbury 2009).
- Recommendations made by doctors for further health assessments and treatment are often not followed up by case managers or carers (Chambers et al 2010, Nathanson et al 2009);
- Where health assessments or treatments do take place, the outcomes of these for the child are often not recorded or known to the case manager (Nathanson et al 2009).
- Lack of adequate health workforce planning and training as to competence and scope of practice for different health professionals who can contribute to the care of this vulnerable population (Tarren-Sweeney 2010);
- Undeveloped systems for managing medico-legal issues in relation to consent and exchange of child health records (Webster & Temple-Smith 2010);
- Lack of effective information technology-based systems for managing child health information between health and child protection sectors (Webster & Temple-Smith 2010)
- Australian authorities cannot meet best practice standards in health management for children in out-of-home care without a large expansion in service delivery (Tarren-Sweeney 2010, Crawford 2006);
- More systematic measurement is needed of the outcomes of health assessment and treatment for children in out-of-home care, both in terms of access to services and response to treatment or therapy (Chambers et al 2010, Tarren-Sweeney 2010, Ronan et al 2009, Tilbury 2006).

THE VICTORIAN GOVERNMENT HAS RECOGNISED THE NEED FOR IMPROVEMENT

In 2004-05 the Victorian Auditor-General and the Premier's Children's Advisory Committee were both critical of the Department of Human Services (DHS) for its failure to demonstrate that management of children in out-of-home care had positive outcomes for child well-being. In 2005, the Victorian Premier created a new Minister for Children and a position of Child Safety Commissioner and began a period of reformation to address the concerns.

The Child Safety Commissioner developed a Charter for Children in out-of-home care which included the right of each child to stay healthy and well, and go to a doctor, dentist or receive other professional help when necessary (OCSC 2008).

Subsequently, registration standards developed by DHS for community service organizations (CSOs) providing out-of-home care included guidance about child health assessment, consistent with the Charter (DHS 2008). These standards are also consistent with the policies of the Royal Australian College of Physicians (RACP) and the American Academy of Pediatrics (AAP). The standards require that each child has a comprehensive assessment (including medical, dental and mental health) as soon as possible and at least within one month after entering out-of-home care. DHS has recognised that meeting service standards for health assessment of children in out-of-home care has been challenging for the child protection sector (DHS 2003).

THE CURRENT PROCESS FOR ADDRESSING HEALTH NEEDS IN VICTORIA IS AD HOC

Common practice has been that the carer takes a child informally, within the first few weeks of entry to care, to a local GP or other health professional for a 'check up'. GPs use a standard consultation (taking an average of 10-15 minutes and attracting a minimal Medicare Benefits Schedule general attendance patient subsidy) to determine whether a child has current signs or symptoms of a health condition. Time is only available for the GP to deal with currently presented symptoms. Child and family medical histories are unlikely to be available. It is usual for the child to see the carer's GP rather than a GP who knows the child.

Anecdotal child protection staff report that as many as 60 % of children entering care have not previously had regular care from an identifiable, family GP.

No written reports or records are routinely shared as to the occurrence or outcome of such a 'check up'. This process is a very limited and ineffective approach to assessing and addressing complex or chronic health needs.

No systematic, aggregated records are kept at a regional or state-wide level to monitor the extent to which this process happens, the outcome of the health checks or the children's health needs. One limited study of a sample of 614 client records provided voluntarily by community service organizations in Victoria found only moderate levels of health needs being met (Champion and Wise 2009). It has been difficult to evaluate how well the service standards about health care have been met in this informal system.

AN ALTERNATIVE SYSTEM OF HEALTH ASSESSMENTS WAS PILOTED BUT NOT ADOPTED

In 2006 DHS convened an Entry to Care Advisory Group to provide advice about the development of a sustainable, statewide system for health assessment and health care planning. The group included representation from paediatricians, general practitioners, allied health providers, child protection services, community service organisations and foster parent groups. The Advisory Group provided input about system requirements, debated alternative models and subsequently endorsed an Entry to Care health assessment system. There was significant debate in the Advisory Group meetings about the most appropriate health settings for comprehensive health assessments. The then GP Advisor to DHS, the late Dr Peter Waxman, advocated for the general practice setting on the following grounds:

- There are GP clinics across Victoria and a significantly greater number of GPs than paediatricians. GPs are the most readily accessible, medically qualified health professionals;
- GPs are the first point of entry in the Australian health system and can identify where a child or young person may need other health professionals and refer appropriately;
- GPs have the medical skills to identify and manage a breadth of health care needs for children and young people across different ages and stages of development;
- Attending a local GP clinic is a normal, non-stigmatising experience for Australian children and such experience is desirable for those in out-of-home care.

On reflection, this view came to be shared by other members of the Advisory Group and after considering many alternative models and their financial implications the proposed model was agreed on.

It was accepted, after advice from Medicare Australia that comprehensive health assessments in general practice could not attract a Commonwealth Medical Benefits Schedule rebate (because a medical report was needed for DHS as to the outcome) and that DHS would need to offer a fee-for-service to GPs. One advantage of a fee-for-service approach was seen as being that “the money would follow the child”.

The choice of a primary care setting was consistent with practice in the UK where looked-after children are seen in general practice for health assessments.

In 2008-09 the new system was piloted in one metropolitan region, in collaboration with General Practice Victoria and Berry Street Victoria. In the pilot, DHS commissioned comprehensive medical assessments by GPs on a fee-for-service basis. These assessments took 60-90 minutes and were usually undertaken jointly by a GP and practice nurse.

An additional brief mental health assessment was commissioned simultaneously from a specialist service which provided clinical child and adolescent emotional and behavioral health services in out-of-home care (in most cases this was from the Take Two service at Berry Street Victoria). Children aged 0-6 years were also referred to a paediatrician for developmental assessment. All children were to have a dental health check.

The pilot was overseen by a DHS Implementation Group with representatives from DHS, General Practice Victoria, local Divisions of General Practice, the Australian Childhood Foundation, Berry Street Victoria Take Two Program, University of Melbourne and community service organisations.

An Issues Paper was provided to DHS after the first 25 children had been assessed which reviewed the interim learning from the pilot (Webster 2010). The paper recommended that the pilot be continued until at least 100 children had been assessed and further process refinement had taken place. This recommendation was not accepted by DHS.

General Practice Victoria evaluated the pilot from the GP point of view (GPV 2010).

Unfortunately no funding was allocated for an independent evaluation of the pilot to assist DHS to consolidate learning.

PILOT LED DHS TO JUDGE ALTERNATIVE SYSTEM TO BE UNAFFORDABLE

DHS advised the collaborative partners in October 2010 that:

- the cost and complexity of this model was financially and administratively unsustainable for the child protection sector, and
- the task of resourcing health assessment for children and young people in out-of-home care had been referred to the Victorian Department of Health.

No revised or alternative system has yet been implemented and the former ad hoc approach remains current. In reality, this outcome means that five years after determining that health management for vulnerable children needed significant improvement, opportunities for children who have been abused or neglected to recover from the effects on their health are still not assured in Victoria.

IDENTIFIED WEAKNESSES IN VICTORIA

GAPS IN KNOWLEDGE AND UNDERSTANDING ABOUT CHILD HEALTH

The pilot highlighted that child protection staff and carers need additional professional development activities to improve their knowledge and understanding about:

- the range and complexity of physical and mental health issues after childhood trauma;
- the processes and benefits of comprehensive health assessment and health care planning;
- how to liaise effectively with the health sector.

The need for further learning in the child protection system about health assessment and planning has been recognised previously (Hunter et al 2008). A lack of understanding of purpose may contribute to poor future follow up of recommendations made in health assessments. Studies have identified unacceptable rates of such recommendations not being followed up (Hill and Watkins 2003, Nathanson et al 2009)

INADEQUATE RECORD MANAGEMENT SYSTEMS

The pilot also demonstrated how complex it is to keep track of where each child who comes into care is up to in the health assessment process. DHS information technology systems proved clumsy for the health assessment records process. Cohort tracking required additional staff resources, and a very proactive approach. Workforce pressures in the child protection sector are such that additional records management tasks presented an unwelcome burden.

An important foundation of any future quality improvement in health care planning will be to strengthen systems for collecting, recording and maintaining comprehensive child health information for individuals as well as de-identified and aggregated data for the cohort of children in care. From a health sector point of view, the current Looking After Children (LAC) records system used in Victoria does not appear adequate for either purpose. Even if the LAC records system design was adequate for health monitoring, compliance with its use in community service agencies is very inconsistent across Victoria (Collins 2010).

UNCERTAINTY ABOUT RESPONSIBILITY FOR HEALTH CARE PLANNING

In Victoria the majority of parents retain legal consent to medical assessment and treatment even after their child is removed from their care. This leaves a large scope for uncertainty and inaction in relation to health care when others are trying to manage child health records

and facilitate timely and appropriate health assessment and care without clear and continuous authority to do so.

A new approach is needed to ensure that arrangements are in place for effective and efficient legal decision making about health care for children after abuse or neglect. Lessons could be taken from Texas in the US where a comprehensive approach to managed health care for children in out-of-home care, including medico-legal decision making, has been in place for the past three years. (Centre for Public Policy Priorities 2008, Texas Dept of Family and Protective Services 2011)

GAPS IN THE HEALTH SECTOR

Unlike the US and UK, the Australian health sector does not yet universally recognise children and young people in out-of-home care as a population group requiring more than opportunistic health care. Consequently, the pilot highlighted significant gaps which include:

- Lack of a clearinghouse collection of information which is readily available to both health and child protection professionals about the health issues and management options for Australian children who have experienced significant abuse or neglect ;
- Lack of clarity and efficiency in the availability of Medicare Benefits Schedule patient subsidies for health assessment and health care planning for children and young people in out-of-home care, particularly where any written report about a child's health status, health care needs or health care plan is required for a third party such as DHS;
- The absence of an agreed Clinical Assessment Framework to guide health professionals as to best practice in health assessments for this population (there was a broad national consultation on this issue in 2010, after the pilot);
- The need for professional development for GPs and GP nurses to support them in the task of comprehensive health assessment for children and young people who have experienced abuse or neglect.

RECOGNITION OF THE HEALTH NEEDS OF THE VULNERABLE POPULATION

The Victorian government must give greater recognition to health needs of children and young people who have been subject of substantiated child abuse or neglect. The 1989 Convention on the Rights of the Child provides guidance as to how a civil society must respond to such needs. Further efforts are needed to assure that all children are assured the opportunity to maximize their physical and mental health recovery, both in the short and long term.

Measurable performance objectives must be implemented to enable the government to demonstrate accountability for actions to address the health needs of children who have been abused or neglected.

ADOPTING A STANDARDISED, SYSTEMATIC APPROACH TO HEALTH NEEDS ASSESSMENT

A Clinical Assessment Framework for use with vulnerable children has been developed for use in Australia and is currently with the Australian Health Ministers Advisory Council (FAHCSIA 2011). Implementation of such a framework for assessment of each and every child who has been subject to substantiated abuse or neglect in Victoria would be a significant improvement on the current ad hoc approach.

ENGAGING THE HEALTH WORKFORCE – THE ROLE OF NURSES

An essential way to create a more robust system for addressing child health needs is to engage the health workforce more fully. Some lessons are available from overseas experience which can indicate a way forward.

In the UK a significant contribution has been made to case-tracking and management by the introduction of ‘looked-after children’ or ‘child protection’ nurses. Nurses are employed at a senior level, and take a lead role in identifying and recording the health needs of children. The positions are funded through the National Health Service but span the health and child protection sectors. Local authorities may have a small team of such nurses. The role is not standardized, but commonly includes the following, as described by the British Association for Adoption and Fostering:

- Initial screening of individual children and collection of child and family medical histories;
- Arrangement of comprehensive medical and other health-related assessments;
- Ensuring treatments are carried out, medical appointments are kept and the child’s health is monitored once a health plan is in place;

- Attending case planning meetings;
- Maintaining aggregated health assessment system and child health needs data;
- Liaison between the child welfare and health sectors with social workers, GPs, specialists, school nurses, maternal and child health nurses, hospitals and allied health providers;
- Offering health management advice to carer groups and health promotion education to groups of children in care;
- Contributing to policy development, health service planning and clinical pathway development for children in care.

This model is now being rolled out in NSW through Area Health Services. Nurses are also playing a pivotal role in the WA system. The introduction of Child Health Nurses in co-ordination roles in Victoria could be a major step forward in improving the quality of health records and of health care planning for out-of-home care.

ENGAGING THE HEALTH WORKFORCE – THE ROLE OF GENERAL PRACTITIONERS

The DHS pilot program in Victoria demonstrated that general practitioners with a special interest in child and adolescent health can be successfully engaged in health assessment processes for children in out-of-home care. Attention is needed however to effective support for this engagement (Webster & Temple-Smith 2010, GPV 2010). GPs' ethical concerns, professional development needs, medico-legal concerns, financial pressures and communication problems with the child protection sector all require recognition and understanding.

Lessons can be taken from the way general practice in the UK has been engaged in improving health care.

Statutory guidance has been in place in England since 2002 which requires local authorities to address the needs of looked-after children. Regular health assessment has been a key mechanism for this. GPs play a significant role and have designated responsibilities. A study conducted by the University of London (DCFS 2009) to inform the review of the statutory guidance found there has been a considerable improvement in the rates of health assessment since the guidance was first issued, with an increase from 33% of eligible children being assessed in 2001-02 to 89% being assessed in 2006-07. However researchers identified quality issues with these assessments including lack of consistency in the dimensions of health assessed, difficulties in sharing medical information, and health care plans not being in place. The report called for health to be made a statutory responsibility of health services as well as local authorities.

In 2009 the English Department for Health and the Department for Children, Schools and Families issued revised statutory guidance and stipulated that all initial child health

assessments must be conducted by a doctor, health care plans must be made by a doctor and the GP held record should be the lead health record for looked-after children (DCFS 2009). While social workers retained responsibility to ensure that health care plans are implemented, the clinical responsibility and medical decision making rests with doctors. These changes hoped to address quality issues and clarify responsibility for health care planning.

ENGAGING THE HEALTH WORKFORCE – THE ROLE OF MENTAL HEALTH SERVICES

The Take Two intensive therapeutic service at Berry Street Victoria has developed valuable expertise over several years in assessment and treatment of the trauma- related emotional, behavioural and developmental difficulties of children in out-of-home care (Jackson et al 2009, Milburn et al 2008, Frederico et al 2007). Further coordination and integration of the work of this service with the health assessment and health care planning roles of other health services would be of significant benefit to children.

ENGAGING THE HEALTH WORKFORCE – THE ROLE OF SPECIALIST MEDICAL SERVICES

It is vital that specialist paediatric medical services be sufficiently resourced to enable them to provide teaching and clinical leadership for the health workforce, and assessment and management of especially complex cases. This level of service is needed in both rural and metropolitan areas. This work is additional to the important work already undertaken by the Victorian Forensic Paediatric Medical Service related to the initial identification of child abuse and neglect.

PROVIDING CONTINUITY OF HEALTH CARE

In the UK and US fragmented health care and poor health outcomes have led to the decision that children and young people in child protection require a designated medical home. In the US this requirement is included in legislation (US Congress 2008). In the UK, children must be registered with a specific general practice and that practice becomes responsible for health assessment and care planning, even if the child's accommodation proves transient. Experience of devolving health assessment to child protection nurses in the UK increased the rate of eligible children being assessed but did not ensure quality or comprehensiveness of assessment.

The Victorian government must consider how continuity of health care can be improved for children who have been abused or neglected through the provision of a medical home for each child, and how doctors can be empowered to play a lead role in managing health care planning for this vulnerable population group.

MONITORING HEALTH NEEDS

A statewide framework for assessment of the health and wellbeing of children and young people in out-of-home care can potentially serve two key purposes. Firstly, to systematically explore and record the individual health needs of each and every child over time. This then contributes to a comprehensive health record which can assist those responsible for the child's welfare to ensure that their health care needs are met on an ongoing basis. The second key purpose is to record the collective health status and health service needs of the cohort of children in out-of-home care who are known to be among the most vulnerable in our community. The aggregate picture of the health of this cohort would facilitate health service planning, enable evaluation of services provided and allow tracking of the health of the cohort over time in comparison to other Australian children.

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NATIONAL SYMPOSIUM REPORT

HEALTH, HOPE & RESILIENCE:

Fostering better health for Australian children and young people living in out-of-home care

BACKGROUND

“Good enough care is not good enough for children and young people living in out-of-home care. They have a right to the highest quality health care Australia can provide” argued Dr Maree Crawford, Paediatrician and Senior Staff Specialist at the Child Advocacy Service, Royal Children’s Hospital, Brisbane, speaking at a national symposium held on 18 and 19 October 2010 at The University of Melbourne.

The idea for the symposium, which attracted more than 100 clinicians, policy makers, researchers and program managers from around Australia, was initiated by a PhD candidate in the General Practice and Primary Health Care Academic Centre, Ms Susan Webster.

Children and young people living in out-of-home care following abuse or neglect are among the most vulnerable in Australia and are known to experience a range of health and developmental problems.

New draft national standards for out-of-home care released in July 2010 by the Commonwealth Minister for Families, Housing, Communities & Indigenous Affairs, challenge the child protection sector to improve how health is managed for this vulnerable group. The draft standards are consistent with the policy of the Royal Australasian College of Physicians that complete health needs assessment, better health records, improved access to health services and ongoing monitoring are all needed to reduce the burden of complex and chronic conditions.

Mr Bernie Geary AM, the Child Safety Commissioner for Victoria who opened the symposium, called for the development of comprehensive health services tailored to the long-term needs of children and young people in out-of-home care and underpinned by better research and improved data collection.



Mr Bernie Geary

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SYMPOSIUM AIMS

More than 34,000 Australian children currently live in out-of-home care*. The child protection sector cannot address the health needs of this growing population without the expertise, resources and collaborative efforts of the health sector and in particular of our doctors. The aims of the national symposium were:

1. To enable sharing of the best available evidence from Australian research and everyday practice about how we manage health needs in out-of-home care, including systems for comprehensive health needs assessment, models for improving continuity of health service and methods of managing child health records.
2. To identify factors likely to affect the achievement of national standards for child health assessment and management.
3. To identify where increased advocacy is needed to improve access to ongoing health services for children and young people in out-of-home care.
4. To discuss minimum requirements for change in health and child protection sectors to meet proposed new standards in relation to child health.

* Out-of-home care is one of a range of services provided through state and territory governments to children in need of care and protection and provides alternative accommodation to children and young people aged 0-17 who are unable to live with their parents often after experiences of abuse or neglect. Accommodation includes foster care, placement with relatives or residential care.

PROGRAM

“Is it worth the effort and expense to improve health needs assessment and health service access for children and young people living in out-of-home care, especially as most kids in foster care seem healthy enough on a day to day basis and can just be taken to the doctor if they feel sick?” Prof Graham Vimpani AM, Head of the Discipline of Child Health at University of Newcastle and Clinical Chair of Kaleidoscope Children’s Health Network, Greater Newcastle delivered a persuasive response to this question in the keynote address, arguing not only for systematic assessment once children are in care, but also for more attention to these children’s health needs earlier in their life, from the time vulnerability related to abuse or neglect is determined.

In the second keynote session, a multi-disciplinary panel addressed the complex question of how the ‘best interests of the child’ principle should be applied to decisions about child health in out-of-home care.

Panel members:

- Dr Maree Crawford, Paediatrician and Senior Staff Specialist, Child Advocacy Service, Royal Children’s Hospital, Brisbane
 - Ms Annette Jackson, Assistant Director, Berry Street Victoria Take Two Program
 - Assoc Prof John Tobin, Melbourne Law School
 - Dr Hubert Van Doorn, a general practitioner based in private practice in Victoria
- explored a range of perspectives, drawing on their professional experience and the wisdom of their respective disciplines.

A call for papers attracted wide interest in the symposium with 17 papers being selected for inclusion addressing four key themes:

1. Diversity of age, cultural background and geography among the out-of-home care population and consequent implications for health services design and access.
2. The variety of state-based models for providing systematic health needs assessment.
3. The shared challenges of assuring all eligible children receive such assessments.
4. The outcomes of Children’s Commissioners and Child Guardians monitoring and reporting on the performance of states and territories in meeting statutory responsibilities for the health and well-being of children in out-of-home care.



Prof Graham Vimpani AM



Dr Nicole Milburn

Much of the research we draw on comes from the US and UK. Short structured sessions embedded in the symposium program provided an opportunity for participants to reflect on and discuss the implications of overseas research findings in the Australian context. These sessions reviewed:

1. Elements shown in the US to have affected the quality of health care for children in out-of-home care such as coordination of care, data and information management systems and family participation.
2. The future minimum features required of child health record systems, for example paper-based records versus electronic records.
3. The testing question of who should have final responsibility for making health care planning decisions for children in out-of-home care, eg, parents, carers, child protection case managers, health professionals or independent advocates, which has been the subject of some significant policy reviews in other countries.

The National Clinical Assessment Framework, currently under development, will be an important future driver of increased cross-sector endeavour to address the recognised health disadvantages faced by young Australians in out-of-home care, according to Ms Fran Thorn, Secretary of the Victorian Department of Health, who described these children to the symposium as *“our great challenge”*.

WHAT DID WE FIND OUT?

There are strong imperatives to improve the way health is managed in out-of-home care in Australia. *“Children and young people who have experienced abuse or neglect can’t afford bureaucratic or court delays to keep hampering the timely assessment of their individual health needs”*. This was the argument made by clinicians who explained that available evidence about the high incidence of chronic and complex health difficulties and the need for early intervention to address the effects of trauma on the development of the growing child are compelling. Furthermore, from a clinical perspective presenters drew on evidence to support implementing health assessments much earlier in the child protection trajectory, eg, from the time of a first substantiated report of abuse or neglect.

Clinical challenges in assessing the health needs of these children are closely intertwined with both research and policy questions including:

- How child and family health histories can be more effectively collected, analysed, stored and shared among those involved in assuring the child’s health and well-being.
- How to establish the competencies and capacities required to collect and manage health records and to exercise final responsibility for making health care decisions about individual children.
- How processes to engage parents in child health assessment can be improved.
- How to resource high quality comprehensive health assessments which take more time than usual health care. (The average time varies significantly between current state-based systems ranging from a few hours up to one and a half days.)
- How to increase systematic screening using standardised assessment tools both to minimise the risk of health needs going unrecognised and to more effectively identify those children with the highest levels of need for further assessment, treatment and therapy.

Prof Vimpani cautioned that *“One group of children at risk of being missed ... are kids with hidden emotional distress, sometimes referred to as ‘closed-book’ children or children who are ‘too good to be true’; the quiet children who internalise their pain and distress. They have a relationship style that hides their needs from view. No one misses the disruptive child.”*

Importantly, the dimensions of health which are routinely assessed are critical. Cultural health for example cannot be seen as an *“add-on”* according to Ms Yolanda Glenn from the Victorian Aboriginal Child Care Agency, but *“as an overlay; the first and foremost aspect of a child’s health”*. Dr Kirsty Walsh from the Royal Children’s Hospital Immigrant Health Clinic argued for careful additional assessment and screening of refugee and other immigrant children who are known to have a higher incidence of communicable diseases such as Hepatitis B and TB and often require catch-up immunisations. The inclusion of positive measures in health assessment and a focus which includes preventive care and health promotion, alongside identification of health problems was stressed by presenters.

Health professionals, carers and case managers involved with managing health for children in out-of-home care need ongoing training and support to understand the health impacts of trauma, avoid misdiagnosis of health problems, ensure reparative parenting and improve the quality of record keeping and health care planning.



Ms Yolanda Glenn

WHERE CAN YOU FIND OUT MORE ABOUT THIS SYMPOSIUM AND RELATED ISSUES?

PROCEEDINGS:

The Symposium program, abstracts, audio recordings of keynote sessions and powerpoint presentations are available on-line . Abstracts include references to relevant published research by presenters.
www.gp.unimelb.edu.au/FosteringHealthSymposium

PUBLICATIONS BY PRESENTERS NOT LISTED IN ABSTRACTS:

Woodland L, Burgner D, Paxton G, Zwi K. Health service delivery for newly arrived refugee children: A framework for good practice. *Journal of Paediatrics and Child Health*. 2010; 46(10): 560-567

OTHER RELEVANT PUBLICATIONS:

Webster S, Temple-Smith M. Children and young people in out-of-home care: are GPs ready and willing to provide comprehensive health assessments for this vulnerable group? *Australian Journal of Primary Health*. 2010; 16:296-303

National Standards for Out-of-home care from 1 July 2011

www.fahcsia.gov.au/sa/families/pubs/nat_std_4_outofhome/Pages/default.aspx

Royal Australasian College of Physicians. *Health of Children in Out-of-Home Care Policy 2008*

www.racp.edu.au/page/policy-and-advocacy/paediatrics-and-child-health

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www.ranzcp.org/images/stories/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps59.pdf

United Nations 1989 Convention on the Rights of the Child

www2.ohchr.org/english/law/crc.htm

IMPLICATIONS FOR POLICY AND PRACTICE

ACKNOWLEDGEMENTS

The General Practice and Primary Health Care Academic Centre would like to thank the Office of the Child Safety Commissioner Victoria and General Practice Victoria for their significant financial contribution to this event.

Representatives from those organisations joined the Planning Advisory Group and generously gave their time and energy to the development and implementation of the Symposium.



Planning Advisory Group members: Tony Lunken, Victorian Department of Human Services; Debra Clayton, GPV; Yildiz Araz, OCSC; Susan Webster; Karen Scobell, Centre for Excellence and Sonya Tremellen, GPV (missing Eliza Sanneman, GPV)

Assurance of children's rights under the 1989 UN Convention on the Rights of the Child is a significant policy and practice challenge in Australia according to Assoc Prof John Tobin. "A *human rights- based approach dictates that children in out-of-home care must be assured all appropriate measures are taken to promote their physical and psychological recovery from the effects of abuse or neglect*".

While no single model is likely to suit all geographical locations or jurisdictions, Australia does need a single, joint policy direction when it comes to addressing the health needs of maltreated children and young people. This would entail firstly developing a shared language about dimensions of health need and processes of health needs assessment and care that is well understood in both the health and child welfare sectors. The National Clinical Assessment Framework will be a first step towards achieving this, but further developmental work will be needed to implement such a framework. Secondly we must face the challenge of how to significantly improve continuity of health care. This not only involves developing robust systems for building and maintaining the integrity and portability of child health records, but also ensuring that one of the significant therapeutic relationships available to vulnerable young people is with their own doctor.

Dr Clare Rocznik urged the symposium to consider how we can 'embed' GPs and paediatricians with child protection teams to improve information sharing and understanding. The new role of Out-of-Home Care Health Coordinator recently introduced in NSW shows promise, not only in introducing further health sector expertise, but in recognising that additional resources are needed to support child protection professionals in their important and complex work.