



Library Fellowship Paper



Children and Young People in Statutory Out-of-Home Care: Health Needs and Health Care in the 21st Century

No. 1, March 2016

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Acknowledgements

The author would like to thank Prof Meredith Temple-Smith, Peter Rogan and Brigitte Rogan for kindly reviewing drafts of this paper. The author also gratefully acknowledges the valuable help of her colleagues in the Parliamentary Library & Information Service in editing, formatting and proof-reading the paper: Rachel Macreadie, Jon Breukel, Bella Lesman, Alice Jonas, Marianne Aroozoo, and Debra Reeves.

ISSN 2204-4752 (Print) 2204-4760 (Online)

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Key Messages

For more than 20 years, Victorian governments have been criticised for failing to monitor the health needs of children and young people in statutory care. Victorian systems to identify and provide for children's individual health needs have not reflected international best-practice. As we move well into the 21st century, this failure continues to have an impact. In Victoria, many of the 9525 children in statutory out-of-home-care (OOHC) in 2013-14 may not have received sufficient health care. A review of legislation, policy and practice since 1989 points to key contributing factors, including:

- Victorian child protection legislation and policies have underestimated the life-long impact of child maltreatment on physical, developmental, and psychological health;
- Increasing legislative and regulatory emphasis on preventing maltreatment as well as family support and re-unification has deflected attention from the individual health needs of children and young people ordered into statutory care;
- An ill-defined legislative principle that responsible parties should act 'as a good parent would' has been too vague to assure adequate attention to children's health needs;
- Allocation of responsibilities for decision making about health needs identification and health care receipt for children in statutory OOHC care has been diffuse and unwieldy;
- Health needs data has not been adequately collected or analysed to inform policy and practice;
- Medical professional colleges' recommendations have not been actively embraced in legislation or practice;
- In order to fulfil statutory obligations Victorian government departments have been highly dependent on services contracted from community service organisations (CSOs). CSOs have played a vital role in their primary tasks of recruiting and supporting foster carers, supporting kinship carers and operating residential care units. CSOs have been increasingly required within government service agreements to also undertake the equally important task of implementing systems for children's health care coordination. However the capacity and expertise of the CSOs to effectively and efficiently manage such a task remain unproven;
- Administrative systems have relied too heavily on foster and kinship carers to identify and meet children's complex and chronic health care needs, often without adequate or reliable health histories or adequate input from health professionals;
- Carers have struggled to navigate complex health service systems on children's behalf and to bear significant out-of-pocket medical care costs for children;
- Weak systems for collecting and sharing child and family health histories in statutory OOHC have left health professionals struggling to effectively assess children's real health needs;
- Universal health service systems have not been adequately supported to cater for the additional health service needs of children in statutory OOHC.

The most compelling and unanswered questions for the Victorian government are:

1. What is the **real nature and extent of the short, medium and longer-term health burden** among children and young people who experience statutory OOHC in Victoria?
2. What **legislative and regulatory changes** are needed to more effectively assign responsibility and assure accountability for health needs monitoring and health care receipt for children and young people who experience statutory OOHC?
3. What **health service systems changes** might better meet the health needs of children experiencing statutory OOHC, now and in the future?

These are the questions explored in this research paper.

Executive Summary

Abuse and neglect in childhood can be detrimental to health and development in childhood and through the whole life-course. This explains why children and young people living in out-of-home care (OOHC) have higher rates of complex and chronic health conditions than other children. International conventions, research and medical practice guidelines now recognise that most children¹ in statutory OOHC need better health care to redress the health impacts of past maltreatment and minimise impacts on their future health.

The Victorian challenge

For more than 20 years, public inquiries in Victoria have repeatedly documented a lack of careful and systematic health needs assessment and appropriate health care provision for children and young people in statutory OOHC. The extent of these children's health needs is a complex challenge for those working in the field.

Several factors help to explain the ongoing challenge for Victorian governments. Historically, child health in OOHC has struggled for attention in a labyrinth of contested and complex legislative, economic and social child protection policy issues. Secondly, the small amount of current Australian research around child health needs and effective health care in OOHC is fragmented and incomplete. This has prevented Victorian governments from making robust, evidence-informed decisions. The nature and extent of children's health needs have been well documented in international research. So too have common health care gaps. However Australian health policies and funding differ from those in other countries. Local health systems re-design has been required to better meet children's needs. A third challenge has been inadequate health monitoring in OOHC. This has left Victorian governments without data: a key handrail of policy. Even the most basic reporting such as the proportion of children in statutory OOHC who have had their physical, developmental, psychosocial and mental health needs checked by health professionals has not been possible.

Why the Research Paper has been introduced

In 2014, the previous Victorian government developed a five year plan for OOHC in response to recommendations of the Victoria's Vulnerable Children Inquiry in 2012. The present government commenced a *Roadmap to Reform* review of Victoria's child protection and family services systems, including the OOHC system, in September 2015. This research paper has been prepared at the initiative of the author who is currently a Parliamentary Library Fellow undertaking a study of the history of Victorian government policy about health care for children in OOHC since colonisation. This paper focuses on the period from 1989 to 2015 and forms part of that larger study. The paper is presented at this time to contribute to ongoing policy discussion and debate about statutory OOHC systems in Victoria.

Positions of major interest groups

Medical Colleges

The Royal Australasian College of Physicians (RACP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommended to governments that it is vital to regularly and comprehensively assess children's health needs in statutory OOHC, and to continually plan and monitor their health care. Those recommendations were consistent with medical professional policies in the U.S. and England where such policies have become embedded in legislation, statutory OOHC standards and performance monitoring.

¹ The term children should hereafter be read as including children and young people aged 0-17.

Australian Government

The Australian government's concerns, partly arising from repeated criticisms by the United Nations Committee on the Rights of the Child, prompted development of the first *National Framework for Protecting Australia's Children 2009-2020*. A priority project under that framework led to publication in 2011 of the first voluntary national standards for OOHC, developed in consultation with state and territory governments. The standards called for periodic comprehensive assessment and review of child health needs in OOHC. The then Australian Department of Health and Ageing subsequently introduced a *National Clinical Assessment Framework for Children and Young People in OOHC* which opened up a new opportunity for state governments to call on the national public health insurance scheme (Medicare) to subsidise medical fees for children's health assessment and health care planning.

In August 2015 the Australian government's Senate Community Affairs References Committee heard evidence of continuing poor health outcomes for children in OOHC and recommended that the *National Framework for Protecting Australia's Children, Action Plan 2015-2018* should include strategies to improve health outcomes for children and young people in care. While the subsequent Action Plan re-affirmed the shared goal 'to ensure that children grow up to become resilient, independent and productive members of society' the Action Plan did not include any new Australian government-led strategies to address the health needs of children and young people in statutory OOHC.

What the Research Paper provides

The paper begins by briefly explaining how maltreatment impacts on child health and development, and summarising clinical research evidence about health needs found in samples of children in OOHC in Australia. An overview of the associated economic burden helps to broaden the picture.

The second section of the paper briefly outlines how health systems in England, the U.S. and other Australian jurisdictions have responded to the health needs of children in OOHC. It then reviews Victorian child protection legislation, policies and systems since 1989, as they relate to health and health services for children in statutory OOHC. The review examines the ways in which statutory responsibilities have been assigned, quality standards developed and program performance measured. The paper gives an overview of OOHC systems for keeping child health records and the types of health services where children's health needs have been assessed. In particular the paper discusses four different models of health assessment for children in statutory OOHC which have been trialled since 2002.

In the third section, the paper summarises the key challenges for government and identifies important building blocks for improved systems design. The first building block is strengthened accountability. This will involve philosophical, legislative and administrative changes. A stronger system for collecting and managing child health information is the second building block. This needs a broader workforce understanding about exactly what child information is needed for efficient and effective health care. Thirdly, further development and evaluation are vital of both organisational and inter-sectoral systems to better identify and monitor children's health in statutory OOHC. Continuity is the fourth building block. Continuity of health care provision for children in statutory OOHC is as important as the provision of safe OOHC placements. The development of 'medical homes' for children in statutory OOHC has shown demonstrable benefits in the U.S. and England. A 'medical home' is a primary health care practice which provides coordinated, proactive health care, along with continuity of health service providers and child health records. Given that international and Australian health systems differ, improving continuity of primary care will need new, creative, approaches. Partnering with Primary Health Networks which bring key regional health service planners and general practitioners may provide a starting point to build better continuity.

Conclusions

An historical review of public policy and programs since 1989 clearly indicates that significant changes will be needed if Victorian governments are to halt the repeated criticisms they have faced for failure to address children's health needs in statutory OOHC. In order to bring about such change, the government would need to:

1. Review and revise the underlying philosophy around what constitutes 'good parenting' by the state;
2. Amend legislation in order to strengthen government responsibility and accountability for identifying the health needs of each and every child ordered into statutory OOHC in Victoria;
3. Re-assign responsibility for health needs identification, health care provision and health care planning for children in statutory OOHC to departments or organisations with a skilled health professional workforce;
4. Register all children in statutory OOHC into a single effective, accessible state-wide electronic health records system;
5. Improve the systems for health needs assessment, health data collection and longitudinal health outcomes measurement for children in statutory OOHC
6. Deliver a measurable and managed framework to actively supporting health care continuity for children in statutory OOHC.

Improved health care and health outcomes for this significant group of children are vital. Doctors and other health professionals need additional authority and support from the Victorian government in order to lead health policy and systems development towards this goal.

Limitations

The author is mindful that Aboriginal and Torres Strait Islander children are disproportionately represented in statutory OOHC. Victorian policies and programs acknowledge particular cultural meanings surrounding health, health care and cultural safety for these children. The author has not attempted to review or to write about policy or practice specifically related to these children. Such research needs community involvement and specific cultural competence and thus is outside the author's scope.

A number of children in statutory OOHC receive specialised disability support services which are important in addressing their health needs. This paper does not discuss these specialist systems which cater for the particular needs of children with disabilities.

The Victorian Forensic Paediatric Medical Service (VFPMS) is a state-wide specialist medical service which provides forensic and holistic health assessments for children under the age of 18 when child abuse or neglect is suspected. Similarly the Children's Court Clinic conducts child psychological and psychiatric assessments for the Children's Court of Victoria. Some of the children assessed by the VFPMS or the Children's Court Clinic may subsequently enter statutory OOHC. This research paper does not address health policy or systems issues relating to forensic or other health assessments which precede entry to OOHC.

Introduction

Every year the rate of children living out-of-home care² (OOHC) increases. In Victoria six in every 1000 children aged 0-18 years live in some form of OOHC,³ most commonly as a result of legal orders designed to protect them from different forms of maltreatment including emotional, physical or sexual abuse or neglect. Removal to OOHC is usually a last resort for keeping children safe.

This research paper reviews systems for health needs identification and health care for children in statutory OOHC in Victoria between 1989 and 2015. The legislative scaffolding for the roles played by Victorian governments in the provision of statutory OOHC includes the *Children and Young Person's Act 1989* and the subsequent *Children, Youth and Families Act 2005*. However the legislative history dates from 1864.

Maltreatment can have lifelong impacts on health. Removal to a place of safety may not in itself be sufficient to ameliorate those impacts once maltreatment has occurred. National, state and territory governments are agreed on the need to provide children and young people who have experienced maltreatment with support not only for their ongoing safety but also for their future wellbeing.⁴

While the public health case for child maltreatment prevention is now widely accepted, reparative health care for maltreated children has received somewhat less attention. In the past 20 years successive inquiries and evaluations in Australian jurisdictions, including Victoria, have been critical of the inadequacy of supports provided to ameliorate the effects of maltreatment and maximise the potential for healthy futures for this significant group of children. This means that 9,252 children who lived in OOHC in Victoria during 2013-14 may have lacked adequate reparative health care. It also means in that year alone 2,282 foster care families and 4,249 kinship carer households may have been left poorly supported on a day-to-day basis to manage children's higher than average risk of chronic and complex health concerns.⁵

² Out-of-home care (OOHC) refers to the care of children and young people up to 18 years who are unable to live with their families (most often due to unacceptable risk of child abuse and neglect). It involves the placement of a child or young person with alternate caregivers on a short- or long-term basis. OOHC can be arranged either formally or informally. Informal care refers to arrangements made without intervention by statutory authorities or courts, and formal care occurs following a child protection intervention (either by voluntary agreement or a care and protection court order). The purpose of Out-of-Home Care (OOHC) is to provide children who are unable to live at home due to significant risk of harm with a placement which ensures their safety and healthy development.

The Australian Institute of Health & Welfare describes the four main types of OOHC as:

- *Residential care*: placement is in a small residential building where employed staff care for children.
- *Family group homes*: homes for children provided by a department or community-sector agency, with live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.
- *Home-based care*: placement is in the home of a carer who is reimbursed for expenses for the care of the child. There are three categories of home-based care: relative or kinship care, foster care and other home-based out-of-home care.
- *Independent living*: includes private board and lead tenant households.
- *Other*: placements that do not fit into the above categories and unknown placement types. This may include boarding schools, hospital, hotels/motels and the defence forces.

³ While the overall rate of children in OOHC in Victoria was 6 in 1000 in 2013-14, among Indigenous children the rate was 62.7 per 1000.

⁴ Australian Department of Social Services (2009) National Framework for Protecting Australia's Children 2009-2020, Canberra, DSS.

⁵ Australian Institute of Health and Welfare (2015) Child protection in Australia 2013-2014, Child welfare series no. 61. Cat no. CWS 52, Canberra, AIHW.

This research paper aims to provide:

- A brief introduction to the mechanisms by which maltreatment impacts on child health and development;
- An overview and synthesis of evidence from clinical research about health needs found in samples of children and young people in OOHC in Australia;
- A comparison of approaches taken in other jurisdictions, including policy and accountability mechanisms to address such health needs;
- A brief overview of Victorian initiatives since the Children and Young Persons Act 1989⁶;
- An analysis of key factors which have contributed to the problematic situation in Victoria; and
- A discussion of key points of healthcare at which systemic changes may contribute to improved health outcomes in the future.

⁶ *Children and Young Person's Act 1989.*

Impacts of child maltreatment on healthy child development

Children's development and health are intertwined and dynamic. One useful way to think of 'health' is as a capability; an ability to cope with life.⁷ Rather than being a static state, health is:

... the extent to which a child is able and enabled to develop and realise their potential, to satisfy their needs and to develop the capacities that allow them to interact successfully with their biological, physical and social environments.⁸

The inner world of children and young people is affected by gender, genes, physical health, temperament and development. In the first five years of life children rapidly develop their:

- gross motor skills;
- hearing, speech and language;
- vision and fine motor skills; and
- social, emotional, and behavioural skills.

These skills continue to mature through the school years as children's cognitive skills and abstract thinking also develop. Children's development and health can both be adversely affected by nutrition, infections, diseases, disorders or exposure to risks in their environment.⁹

Mechanisms impacting on health and development

Emotional, physical or sexual abuse, neglect or exposure to family violence, are types of maltreatment which pose a serious threat to children's development and health. Aside from immediate injury which may lead to impairment or death, there are three potential mechanisms associated with maltreatment which can have profound and life-long impacts. These are firstly physiological and neurological changes in early life, secondly the cumulative harms of repeated maltreatment and thirdly, individual children's development of harmful stress responses.¹⁰

(i) Physiological and neurological impacts

Brain development can be physiologically altered by maltreatment in infant and pre-school years. Research since the late 1990s has revealed the impact on physical, cognitive, emotional and social growth while continuing to explore the exact mechanisms through which this occurs.¹¹ Maltreatment can lead to life-long psychological, learning and behavioural difficulties.¹²

⁷ I. Law & H. Widdows (2007) Conceptualising health: Insights from the Capability Approach. *Health Care Analysis Journal*, 16(4), pp. 303-315.

⁸ National Research Council and Institute of Medicine Committee on Evaluation of Children's Health (2004) *Children's Health. The Nation's Wealth: Assessing and improving child health*, Washington DC, The National Academies Press, p. 33.

⁹ T. Lissauer & G. Clayden (2012) *Illustrated textbook of Paediatrics* (4th edition), Edinburgh, Mosby.

¹⁰ R.E. Norman et al. (2012) The long-term health consequences of child physical abuse, emotional abuse and neglect: A systematic review and meta-analysis. *PLOS Medicine* 9(11), e1001349, pp. 1-31.

¹¹ A.M. La Greca et al. (2016) Commentary: Key issues, concluding thoughts and future directions for the study of trauma and child health, *Journal of Pediatric Psychology*, 41(1), pp. 149-158.

¹² S.Twardosz & J.R. Lutzker (2010) 'Child maltreatment and the developing brain: A review of neuroscience perspectives', *Aggression and Violent Behaviour*, 15, pp. 59-68.

A systematic review of international academic literature over a 65 year period to 2012 confirmed that:

...children experiencing neglect or emotional abuse exhibit far-reaching impacts on their behavioural, emotional, cognitive and social development. The cascading effect of maladaptive externalising and internalising behaviours, impaired emotional regulation, delayed numeracy, literacy and language development can manifest in difficult interpersonal relationships, low school attainment and negative feelings of anxiety and depression.¹³

The process of 'biological embedding' offers a further explanation for the effects of stressful childhood experiences on health. In response to stress the central nervous system sends messages to the body's immune, hormonal and clotting systems which can decrease resistance to disease and change the way the body's organs function.¹⁴

Newer research has begun to examine just when physical health effects begin to emerge for children who have experienced maltreatment. Prospective studies have shed new light on the association between maltreatment and physical illness appearing in childhood. Analysis of data from a U.S. survey of a nationally representative group of 0-17 years old whose families were investigated for child maltreatment estimated the prevalence of chronic health conditions among maltreated children was 1.5 times that of the general population. These chronic conditions include diabetes, asthma, hypertension, arthritis and eating disorders.¹⁵ In longitudinal studies published since 2010 which controlled for individual, family and community factors, maltreated children have shown 74-100 per cent higher risk of hospital treatment for asthma, cardio-respiratory and infectious diseases. First hospital admissions can occur from as early as age three. Recurrent reports of maltreatment can be associated with a greater number of hospital care episodes for such illnesses.¹⁶

(ii) Impact of cumulative harm

The cumulative harm resulting from repeated maltreatment is the second mechanism which increases health risk.¹⁷ A longitudinal study of a random sample of 100 Australian cases of child abuse notifications found that 65 per cent of the children had experienced chronic maltreatment. Many repeat notifications were treated in isolation, and interventions tended to focus on parents, rather than children.¹⁸ That study indicated that the impact of chronic maltreatment on children's health and wellbeing was unlikely to be assessed.

Health care neglect can also have cumulative impacts on children's health and development. Lack of attention to preventive health care such as immunisation, dental hygiene, or nutrition can be detrimental. Failure to access assessment or provide adequate treatment of childhood illnesses or infections may result in preventable impairment such as hearing loss. In worst case scenarios this

¹³ S.A. Maguire et al. (2015) A systematic review of the emotional, behavioural and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse. *Child: Care, Health and Development*, 41(5), pp. 641-653.

¹⁴ S. Maggi et al. (2010) The social determinants of early child development: An overview, *Journal of Paediatrics and Child Health*, 46, pp. 627-635.

¹⁵ R.E. Stein et al. (2013) Chronic conditions among children investigated by child welfare: A national sample, *Pediatrics*, 131, pp. 455-462.

¹⁶ P. Lanier et al. (2010) Child maltreatment and pediatric health outcomes: A longitudinal study of low-income children, *Journal of Pediatric Psychology*, 35(5), pp. 511-522.

¹⁷ M. Jonson-Reid et al. (2012) Child and adult outcomes of chronic child maltreatment, *Pediatrics*, 129, pp. 839-845.

¹⁸ L.M. Bromfield et al. (2007) Cumulative harm and chronic child maltreatment, *Developing practice*, 13 (Winter/Spring), pp. 34-42.

may also contribute to preventable child deaths e.g. from asthma.¹⁹ Children may be adversely affected if growth or developmental delays are not remediated through appropriate early intervention services.

Foster and kinship carers are critical gatekeepers to health services in OOHC but may fail to seek services for children, even in the presence of clinical signs of health difficulties.²⁰ Even after comprehensive health needs assessment, health care recommendations are not always implemented by carers or case managers.²¹ Without consistent attention, advocacy and support, young people whose development and health have been impaired may also not receive disability support services to which they are entitled.²²

(iii) Impact of harmful stress responses

Thirdly, children and young people may develop ways of responding to the distress caused by maltreatment which can further impact on their health and development. Maladaptive responses include disordered eating, substance abuse or social risk-taking.²³ Consequential health issues can be serious and chronic. Addiction to tobacco, alcohol and other drugs, obesity, malnutrition, sexually transmitted diseases and unplanned pregnancies are examples.²⁴

Health impacts over the life-course

Retrospective studies have shown that childhood maltreatment is also associated with an increased likelihood of a complex and chronic range of serious physical health conditions in adulthood including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease.²⁵ A meta-analysis of 31 studies comparing health outcomes after childhood sexual abuse similarly found higher rates of subsequent physical health problems including gastrointestinal and gynaecological conditions, musculoskeletal pain and cardiopulmonary symptoms.²⁶ A longitudinal Australian study which has followed a large group of Victorians since infancy has found a significant association

¹⁹ D.A. Fitzgerald & J. Gillis (2015) Asthma deaths in children in New South Wales 2004-2014: Could we have done more? *Journal of Paediatrics and Child Health*, 51, pp. 1127-1133.

²⁰ M. Kaltner & K. Rissel (2011) Health of Australian children in OOHC: Needs and carer recognition, *Journal of Paediatrics and Child Health*, 47, pp. 122-126; M. Tarren-Sweeney (2010) It's time to re-think mental health services for children in care, and those adopted from care, *Clinical Child Psychology and Psychiatry*, 15, pp. 613-626.

²¹ D. Nathanson et al. (2009) Children in out-of-home care: Does routine health screening improve outcomes? *Journal of Paediatrics and Child Health*, 45 (11), pp. 665-669.

²² P. Mendes (2010) 'Health outcomes for young people transitioning from out-of-home care in rural Victoria', paper presented to the Health, Hope & Resilience National Symposium, Melbourne, 18-19 October; CREATE Foundation (2012) Supporting children and young people with a disability living in out-of-home care in Australia: A literature review. South Brisbane: CREATE Foundation.

²³ M. Tarren-Sweeney (2006) Patterns of aberrant eating among pre-adolescent children in foster care, *Journal of Abnormal Child Psychology*, 34, pp. 623-634; P. Mendes (2010) 'Health outcomes for young people transitioning from out-of-home care in rural Victoria', paper presented to the Health, Hope & Resilience National Symposium, Melbourne, 18-19 October; P. Mendes (2008) Improving the physical and emotional health of young people transitioning from state out-of-home care. *Developing Practice*, 20, pp. 33-40.

²⁴ C. Schenk et al. (2015) Contamination in the prospective study of child maltreatment and female adolescent health, *Journal of Pediatric Psychology*, 41(1), pp. 37-45; J.G. Noll et al. (2011) Childhood maltreatment, psychological dysregulation and risky sexual behaviours in female adolescents, *Journal of Pediatric Psychology*, 36(7), pp. 743-752.

²⁵ R.F. Anda et al. (2006) [The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology](#), *European Archives of Psychiatry and Clinical Neuroscience*, 256, pp. 174-186.

²⁶ L. Irish et al. (2010) Long term physical health consequences of childhood sexual abuse: A meta-analytic review, *Journal of Pediatric Psychology*, 35(5), pp. 450-461.

between maltreatment and impairment in areas of personal functioning (including autonomy, clarity about personal identity and ability to plan), as well as higher levels of depression and anxiety.²⁷ Australia's 2007 *National Survey of Mental Health and Wellbeing* found self-reported childhood abuse was significantly associated with increased numbers of long-term physical and mental health conditions. Furthermore, childhood abuse was associated with greater rates of adult self-harm as indicated by suicide attempts or drug or alcohol problems.²⁸

Notwithstanding that retrospective studies are hampered by differing methodologies, inconsistencies in how child maltreatment is measured and potential variability in personal recall, there is now an accepted international body of evidence which consistently points to long-term health consequences of child maltreatment.²⁹

Impact on health-related quality of life

Not only are children and young people in OOHC at increased risk of a complex array of health difficulties but their health-related quality of life may already be significantly reduced. When health or development is impaired after maltreatment or neglect, the impact on children's health-related quality of life can be similar to the impacts associated with life-long health conditions such as diabetes, cystic fibrosis or asthma.³⁰ In the area of mental health alone, a large recent English cross-sectional study clearly established a significant reduction in health-related quality of life among the overwhelming majority of children who experienced mental health problems, when compared to other children their age.³¹

Health impacts in Australian research study samples

Although public policies acknowledge that child maltreatment poses a risk to children's health and development,³² relatively little has been recorded about the health of children in OOHC. The Australian Institute of Health and Welfare (AIHW) monitors the health, development and wellbeing of Australia's children but not the health status of children in OOHC.³³ Australian research studies support international findings that maltreated children are at risk of more chronic and complex health difficulties compared with the general Australian population. In a small number of studies Australian health professionals have systematically, comprehensively and individually assessed the health of samples of children in OOHC. They have described the range and frequency of health issues found on clinical examination among those samples, as shown in Table 1. The table also notes which studies included children in Victorian OOHC.

²⁷ R. Price-Robertson et al. (2010) [Family is for life: Connections between childhood family experiences and wellbeing in early adulthood](#), *Family Matters*, 85, pp. 7-17.

²⁸ R. Reeve & K. Van Gool (2013) Modelling the relationship between child abuse and long-term health care costs and wellbeing: Results from an Australian community-based survey, *Economic Record*, 89(286), pp. 300-318.

²⁹ J.G. Noll & C.E. Shenk (2015) Introduction to the special issue: The physical health consequences of childhood maltreatment – Implications for public health, *Journal of Pediatric Psychology*, 35(5), pp. 447-449.

³⁰ J. Carbone et al. (2007) The health-related quality of life of children and adolescents in home-based foster care, *Quality of Life Research*, 16, pp. 1157-1166.

³¹ H. Sharpe et al. (2015) Exploring the relationship between quality of life and mental health problems in children: Implications for measurement and practice, *European Child & Adolescent Psychiatry*, Advance publication DOI: 10.1007/s00787-015-0774-5.

³² Australian Institute of Family Studies (2014) Effects of child abuse and neglect for children and adolescents, CFCA Resource, Melbourne: AIFS; Victorian Department of Human Services (2007) *Child Development and Trauma Guide*, Melbourne: DHS.

³³ Australian Institute of Health and Welfare (2015) op. cit.

Table 1: Health issues in samples of children in Australian OOH research studies 2005-2015

HEALTH ISSUE	FREQUENCY RANGE	REFERENCES
Immunisations not up-to-date	15% - 53%	Arora, Kaltner & Williams 2014 Raman & Sahu 2014 Kaltner & Rissel 2011 Kaltner & Rissel 2010 Nathanson & Tzioumi 2007
Vision difficulties	18% - 33%	Arora, Kaltner & Williams 2014 Raman & Sahu 2014 Kaltner & Rissel 2011 Chambers et al. 2010 Kaltner & Rissel 2010
Hearing difficulties	10% - 28%	Arora, Kaltner & Williams 2014 Raman & Sahu 2014 Kaltner & Rissel 2011 Chambers et al 2010 Kaltner & Rissel 2010
Growth abnormalities/ nutrition deficits	14% - 18%	Raman & Sahu 2014 Nathanson & Tzioumi 2007
Eating disorders/ overweight/ obesity	24%-63%	# Cox et al. 2014 Tarren-Sweeney 2006
Expressive or receptive language delay or referral to speech pathology	11% -69%	Arora, Kaltner & Williams 2014 Raman & Sahu 2014 Kaltner & Rissel 2011 Chambers et al. 2010
Clinically significant emotional/behavioural difficulties	48%-62%	# Jackson et al. 2009, # Milburn et al. 2008, Sawyer et al. 2007, Tarren-Sweeney & Hazell 2006
Learning/education difficulties	9% -60%	Arora, Kaltner & Williams 2014
Psychotropic medication used for behavioural management	16%	Tarren-Sweeney 2010
Child required two or more referrals for further health assessment and/or treatment	70%	Kaltner & Rissel 2011 Kalter & Rissel 2010 Nathanson et al. 2009
Hepatitis screening required	8%-14%	Arora, Kaltner & Williams 2014 Nathanson & Tzioumi 2007
Mental health difficulties	15% - 62%	Arora, Kaltner & Williams 2014 Kaltner & Rissel 2011 Tarren-Sweeney 2010 # Frederico, Jackson & Black 2008 # Milburn et al. 2008 Sawyer et al. 2007 Tarren-Sweeney & Hazell 2006
Referral for formal developmental assessment required	5%	Arora, Kaltner & Williams 2014
Ongoing monitoring of growth and development concerns by paediatrician required	30% -41%	Arora, Kaltner & Williams 2014 Raman & Sahu 2014 Kaltner & Rissel 2011
Dental problems	26%	Raman & Sahu 2014

denotes references which describe research findings relating to samples of children in OOH in Victoria

Health impacts in Victorian OOHc populations

The Victorian Child and Adolescent Outcomes Framework shaped the Department of Education and Early Childhood Development's (DEECD) analysis of the state of health of Victoria's children from 2006.³⁴ Systematic reporting however was criticised by the Auditor General as being inconsistent and incomplete.³⁵

Relatively little is recorded about child health in OOHc in Victoria. There have been no performance measures in place to monitor how statutory OOHc services meet children's health and development needs. Very little administrative data has been published about children's health status.³⁶

The Department of Human Services published four case file audit reports between 2001 and 2014. Conclusions about children's health from these reports are somewhat limited. Firstly, auditors noted that it was difficult to assure the validity and reliability of the case file record sampled. Secondly, case files contained case-manager or carer judgments more often than medical opinions. Thirdly, there were significant data gaps where information had not been recorded. Furthermore, the types of information analysed changed over time. These reports do however suggest areas of concern.

Among a sample of children in home-based OOHc in 2001, case managers reported that 20 per cent had disabilities and 18 per cent had diagnosed mental health conditions.³⁷ In contrast, a 2002 sample audit of young people in residential OOHc found 38 per cent had diagnosed mental health conditions.³⁸

More recent case file systems have incorporated standardised screening questions about children's emotional and behavioural health. Audits of case file samples with these screening scores included reported clinically significant emotional and behavioural difficulties among 40 per cent of children.

More than 50 per cent of children had moderate to high anxiety levels and 25 per cent were not receiving the mental health services they needed.³⁹ Reports indicated 60 per cent of children had moderate or significant difficulties with concentration and managing their own behaviour. 35 per cent of children were not able to manage self-care tasks in an age-appropriate way.

Only 86 per cent of children had been seen by a doctor within the last 12 months. Among children aged 10-17 years, 45 per cent were reported as having moderate or high health risks associated with

³⁴ Victorian Department of Education and Training, 'Victorian Child and Adolescent Monitoring System', (VACMS), 'VCAMS Outcomes Framework', DEAT website.

³⁵ Auditor-General, Victoria (2013) *The state of Victoria's Children: Performance Reporting*, Melbourne, VAGO.

³⁶ Victorian Department of Human Services (2003) *Public parenting: A review of home-based care in Victoria*, Melbourne, DHS, Community Services Division; P. Cummins et al. (2012) *Report of the Protecting Victoria's Vulnerable Children Inquiry*, report prepared for the Minister of Community Services, Melbourne; Victorian Government (2013) *Victoria's Vulnerable Children – Our Shared Responsibility: Baseline Performance Data Report*, Melbourne, p. 58; Auditor-General Victoria (2014) *Residential Care Services for Children*, Melbourne, Government Printer; Commission for Children and Young People (2015) *"...as a good parent would..." Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Melbourne: CCYP.

³⁷ Victorian Department of Human Services (2002) *The audit of children and young people in home-based care services*, Melbourne, DHS.

³⁸ Victorian Department of Human Services (2001) *Findings of the audit of children and young people in residential care*, Melbourne, DHS.

³⁹ Victorian Department of Human Services (2014) *The 2011 Looking after children Outcomes Data Project: A summary of findings*, Melbourne, DHS.

using alcohol, tobacco or drugs. A further striking estimate from a 2012 survey indicated that 77 per cent of children aged 12 and over smoked tobacco every day.⁴⁰

Disturbingly, that survey of 391 OOHC carers reported higher rates of concern about children's emotional and behavioural health, with 38.5 per cent of children screened as being clinically at risk and a further 9 per cent considered borderline. Carers believed that 48 per cent of children were either receiving or were in need of psychological treatment or counselling. These descriptions compared poorly against state-wide estimates of emotional health among all Victorian children which found 5.4 per cent to be clinically at risk and 10.6 per cent to be borderline.

Immunisation rates for children in statutory OOHC have not been routinely monitored. The 2007 DHS audit report indicated that while infant immunisation rates in the audit sample were high, the numbers of older children whose immunisations were up-to-date fell significantly. Only 24 per cent of sample children aged 10 to 14 years were fully immunised. On average, 68 per cent of all children in home-based OOHC were fully immunised. This was well short of the state average and left many children at risk. The more recent audit results did not report immunisation data.

The same audit also reported that 15 per cent of children had a disability or serious health condition and 6.6 per cent received specific disability services.⁴¹ In 2011 a separate report found 15.4 per cent of children entering OOHC had disabilities (more than twice the rate in the broader population).⁴²

As Table 1 indicates, only a handful of academic research studies have examined the health status of children and young people in statutory OOHC in Victoria. These studies were mainly confined to studying children referred for specialised emotional and behavioural health services. Only two studies have examined children not previously referred for health-related services. The most recent study with young people living in residential OOHC examined nutrition. It found higher than average incidence of obesity and overweight.⁴³ The only study undertaking comprehensive, multi-disciplinary health assessments was with all children entering OOHC for the first time in 2002 in one metropolitan region. The study found clinically diagnosed mental health conditions in 62 per cent of the 131 children, which was four times higher than the national average. Among these children, only 17.6 per cent had a previously recorded mental health history, indicating a high level of unmet need. The results represented an under-estimate of children with mental health diagnoses as an additional eight children who were already receiving mental health services were ineligible for the study.⁴⁴ Furthermore, among the 46 children without mental health conditions, 22 were aged less than 12 months and could not be screened using standardised measures. The strengths of this study were that all children entering OOHC in a broad geographical region were eligible, regardless of the type of OOHC placement or court order they experienced. Secondly, children took part in a sequence of multi-disciplinary assessments and health information was obtained from a range of sources including parents, carers and teachers. All children were assessed 'in person' by a paediatrician, clinical psychologist and other health professionals across multiple appointments. A psychiatrist was available to assess children as required. As this was a study of therapeutic mental health assessments

⁴⁰ Victorian Department of Human Services (2013) *The Child and Family Services Outcomes Survey 2012: Final report*, Prepared by the Queensland University of Technology and the Social Research Centre, Melbourne, DHS.

⁴¹ S. Wise & S. Egger (2007). *The Looking-After Children outcomes data project: Final report*, Melbourne, Australian Institute of Family Studies.

⁴² Victorian Department of Education and Early Childhood Development (2011) *Early Childhood Agreement for Children in Out-of-Home Care*, Melbourne, DEECD, p. 9.

⁴³ R. Cox et al. (2014) Rates of overweight and obesity in a sample of Australian young people and their carers in out-of-home residential care, *Australian and New Zealand Journal of Public Health*, 38(6), p. 591.

⁴⁴ N. Milburn et al. (2008) Early identification of mental health needs of children in care: A therapeutic assessment program for statutory clients of child protection, *Clinical Child Psychiatry and Psychology*, 13 (1), pp. 131-147.

no data was reported as to children's physical health, immunisation status, vision, hearing, speech development or dental health.

Recorded health status of children in OOHC

What can we conclude about the health status of children in statutory OOHC in Victoria? Administrative records have included case manager and carer reported concerns about higher than average numbers of children with mental health difficulties. The results of the only published clinical study involving assessment by teams which include medical specialists suggest administrative records may underestimate the extent of children's mental health problems. A number of children were reported to have disabilities and/or chronic health difficulties. Small percentages received specialist disability or therapeutic psychological services. Carers have reported unmet needs for health services and the clinical study bore this out. Audits suggest that immunisation rates have been unacceptably low in the past and current rates are unknown. An academic database search suggests that since 1989 there has only been one published clinical study of a community sample of children entering OOHC in Victoria who have had their health assessed by a paediatrician.

Economic and social costs of health impacts

In addition to the personal costs of increased health risk, the societal costs are considerable. A U.S. study calculated the associated lifetime cost for a child maltreated during 2008 as broadly similar to or higher than that of stroke or Type 2 Diabetes.⁴⁵

Estimated lifetime health costs in Australia of child maltreatment cases occurring for the first time in 2007 ranged between \$90.2 million and \$1,644 million with a best estimate of \$437.4 million.⁴⁶ A recent prevalence-based approach to understanding the health-related burden of depressive disorders, anxiety disorders and intentional self-harm in Australia found that a substantial proportion of the burden is attributable to childhood maltreatment. This was estimated to cause 1.4 per cent of all lost years of healthy life years in men and 2.4 per cent in women in 2010.⁴⁷

In a report commissioned by the Protecting Victoria's Vulnerable Children Inquiry, Deloitte Access Economics estimated the incidence costs of abuse in Victoria in 2009-10 to be in the range of \$29.8 million to \$187.7 million.⁴⁸ The report estimated that the state government meets 81 per cent of the total cost of child maltreatment in Victoria, while the Australian government bears 9 per cent, and the community bears 10 per cent of costs. The burden of short and longer term health system costs (estimated in the range \$20.4 to \$124.2 million) falls differently, as shown in Figure 1, with a percentage of health care costs being met by the Australian government.

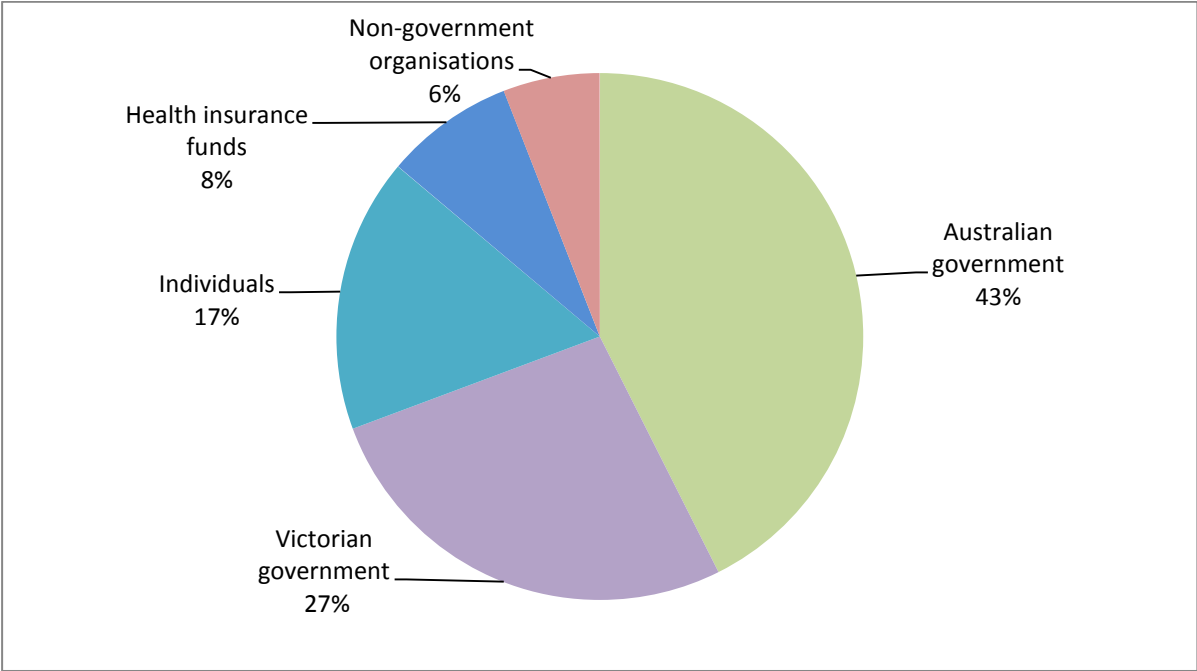
⁴⁵ X. Fang et al. (2012) The economic burden of child maltreatment in the United States and implications for prevention, *Child Abuse & Neglect*, 36, pp. 156-165.

⁴⁶ P. Taylor et al. (2008) The cost of child abuse in Australia, Melbourne, Australian Childhood Foundation and Child Abuse Prevention Research Australia.

⁴⁷ S.E. Moore et al. (2015) Burden attributable to child maltreatment in Australia, *Child Abuse & Neglect*, 48, pp. 208-220.

⁴⁸ Deloitte Access Economics (2011) *The economic and social cost of child abuse in Victoria 2009-2010*, Protecting Victoria's Vulnerable Children Inquiry, Melbourne.

Figure 1: Percentage of health system costs related to child abuse and neglect met by various sectors



Source: Deloitte Access Economics (2011) op. cit.

Summary of health impacts of child maltreatment

There is sufficient international evidence to indicate that the Victorian government should be concerned about the negative short and long term impacts of child maltreatment on the health and development of children who come into statutory OOHC, both while they are in care and into the future. The available data from Australian research studies reinforces this conclusion.

Maltreatment can be detrimental not only to children’s health status but to their health-related quality of life and the extent to which they are able to develop and reach their potential, satisfy their needs in life and develop key capabilities.

The exact nature and real extent of health care needs in the Victorian statutory OOHC population cannot be quantified without improved systems for health needs assessment, data collection and analysis.

The estimated life-time social and economic costs of child maltreatment indicate that governments should be as concerned to reduce the health impacts of child maltreatment as they are to reduce the incidence of diabetes or stroke in the community.

Responding to health and development risks

Accessible and effective paediatric medical care can support healthy child development. Paediatric health care is a particular area in medicine concerned with the management of medical conditions, diseases and disorders across different stages of growth and development of infants, children and young people aged 0-18 years. Paediatrics differs from adult health care. It recognises children's immature physiology. It also understands the guardianship, privacy, legal and consent issues which are at play in the care of minors. Health professionals in paediatric health care include general practitioners (GPs), maternal and child health nurses, dentists, psychologists and other allied health disciplines, school nurses, paediatric specialists and psychiatrists.

The development and health of children in OOHC is time-sensitive and children with developmental delays have particular vulnerabilities. Early assessment, support and intervention are vital.⁴⁹

Health system responses in overseas countries

Ten years ago the international child protection sector did not necessarily agree that medical leadership was a minimum requirement (or even desirable) when deciding on the health-related best interests of individual children or young people in OOHC.⁵⁰ However in more recent years the special health care needs of maltreated children have become widely accepted as being above and beyond those of other young people. The medical workforce has become more actively involved.

Health system responses in England

In England, children and young people in OOHC are referred to as 'looked-after children'. 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 currently play a significant role and have designated responsibilities.

A study conducted at the University of London to inform the review of the statutory guidance found a considerable improvement in the rates of health assessment since the guidance was first issued, with an increase from 33 per cent of eligible children being assessed in 2001-02 to 89 per cent being assessed in 2006-07.⁵¹ 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.

Arising from the concept of 'corporate parenting',⁵² current statutory guidance in England describes health sector performance requirements for services to children and young people in OOHC.⁵³ The

⁴⁹ M. Tarren-Sweeney (2008) Retrospective and concurrent predictors of the mental health of children in care, *Children and Youth Services Review*, 30, pp. 1-25.

⁵⁰ F. Wulczyn et al. (2005) *Beyond Common Sense; Child welfare, child well-being and the evidence for policy reform*, New Brunswick, Aldine Transaction; B. Corby (2006) *Child abuse: towards a knowledge base* (3rd edition), Maidenhead New York, Open University Press.

⁵¹ A. Mooney et al. (2009) *Promoting the health of looked after children: A study to inform revision of the 2002 Guidance*. Department for Children, Schools and Families. Research Report No DCSF-RR125. London: Department for Children, Schools and Families.

⁵² 'Corporate parenting' is now enshrined in the *Children and Young People (Scotland) Act 2014*. The Act names organisations with statutory 'corporate parenting' responsibilities for children in OOHC and describes accountability mechanisms.

guidance contains specific directions and accountabilities about health assessments. 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 is the lead health record for looked-after children. While social workers retain responsibility to ensure that health care plans are implemented, the clinical responsibility and medical decision making rests with doctors. These provisions were developed over time to address quality issues and clarify responsibility for health care planning. Clinical governance at a regional level for the health sector response to the cohort of children in care has become increasingly important, with Primary Care Trusts and Clinical Commissioning Groups playing a key role.

In England, a significant contribution has been made to case-tracking and management by the employment 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 small teams 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; and
- Contributing to policy development, health service planning and clinical pathway development for children in care.

De-identified and aggregated child health status and health assessment data is collected and published on-line in continually updated national datasets. This data enables local health services to plan and monitor the quality of their responses.

English medical colleges have recently described the health workforce competencies needed to undertake health needs assessment and health care provision for children and young people in OOH. The competency framework now underpins specific workforce training and provides an important platform for quality assurance.⁵⁴

⁵³ Department for Education, Department of Health (2015) *Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups and NHS England*, March, London, Department for Education and Department for Health.

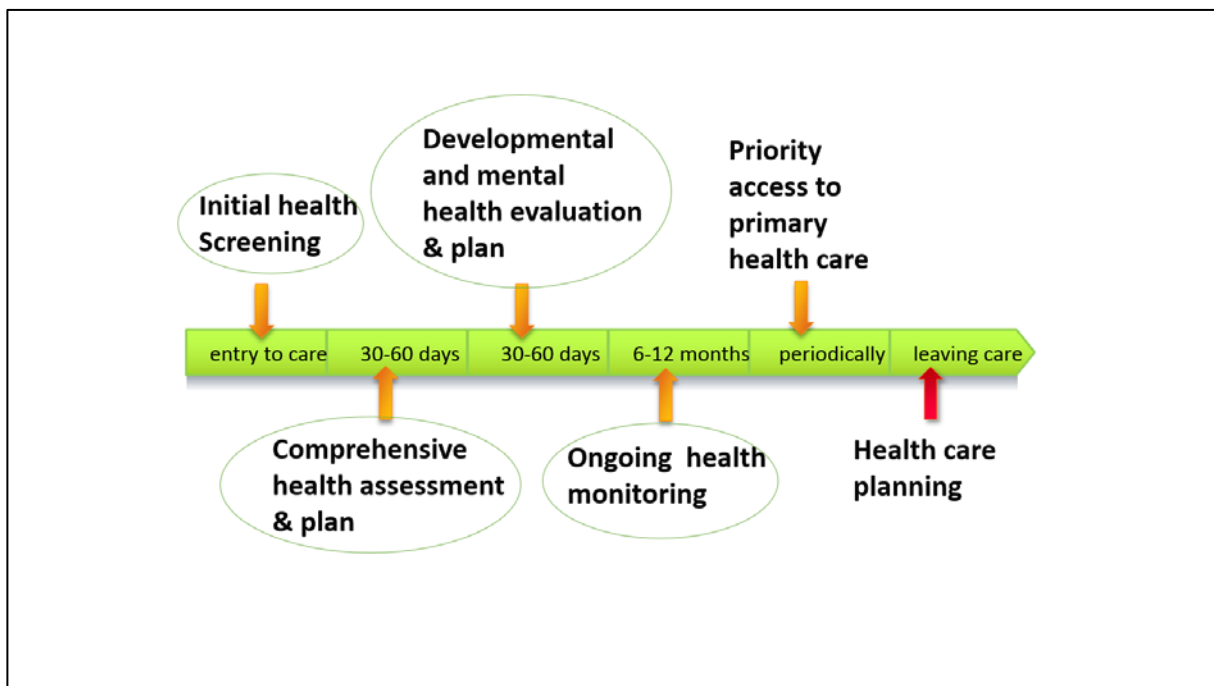
⁵⁴ Royal College of Nursing, Royal College of Paediatrics and Child Health, Royal College of General Practitioners (2015) *Looked-after children: Knowledge, skills and competences of health care staff, Inter-collegiate role framework*, March. London: Authors.

Health system responses in the U.S.

Since 1992, the American Academy of Paediatrics and the Child Welfare League of America have held a consensus position about individual health needs assessment and the need for special attention to the provision of health services for all children in OOHC, as illustrated in Figure 2.⁵⁵ This professional position was enacted in U.S. legislation in 2008, calling for children and young people in care to have:

- health screening visits within 72 hours of placement;
- comprehensive health assessments within 30 days of placement, including mental health, dental health, developmental and educational assessments; and
- follow-up health visits within 60-90 days of placement in care.⁵⁶

Figure 2: Consensus view on recommended health screening, assessment and monitoring pathway.



Source: American Academy of Pediatrics (2002) Health care of young children in foster care, *Pediatrics*, 93, pp. 335-338.

An extensive U.S. study of more than 73 initiatives in 35 states identified the following key elements of effective systems to better address the health and development risks faced by children and young people in OOHC:⁵⁷

- Initial health screening and comprehensive health assessment;
- Access to health care services and treatment;
- Management of health care data and information;
- Coordination of care;
- Collaboration among systems;
- Family participation;
- Attention to cultural issues;
- Monitoring and evaluation;

⁵⁵ American Academy of Pediatrics (2002) *AAP Policy Statement, Health Care of Young Children in Foster Care, Committee on Early Childhood, Adoption and Dependent Care*, *Pediatrics*, 109 (3), pp. 536-541.

⁵⁶ Fostering Connections to Success and Increasing Adoptions Act 2008, United States Congress.

⁵⁷ J. McCarthy (2002) *Meeting the health care needs of children in the foster care system: Summary of state and community efforts, Key findings*, Washington, Georgetown University Child Development Centre.

- Training and education;
- Funding strategies; and
- Managed care designed to fit the needs of children in the child welfare system.

U.S. legislation has mandated assignment of each child in OOHC to a 'medical home'.⁵⁸ The American Academy of Pediatrics' policy provides a current best-practice guide to comprehensive health assessment and planning.⁵⁹ State spending on health care for children in OOHC is tracked.⁶⁰ In some states, managed-care organisations⁶¹ provide OOHC patient registration, centralised health services intake, shared e-health records systems and clinical pathway development.⁶² These organisations also track exactly which health services individual children receive over time.⁶³ Registration of children in statutory OOHC with specified primary health care providers in the U.S. has been associated with increased immunisation rates and more effective and cost-efficient use of health services among the OOHC population.⁶⁴

In summary, significant advances have been made in the U.S. and in England in the collection of national data sets (summarised in Table 2) which form a handrail for policy and service improvement. English and U.S. governments have taken positive legislative action to stipulate and reinforce statutory obligations for improving inter-sectoral coordination and accountability for addressing the health needs of children in statutory OOHC. Systems in these countries are significantly more developed than those in Victoria.

⁵⁸ The 'medical home' model of primary health care is one which encompasses accessible, comprehensive, co-ordinated, patient-centred health care by a team of doctors and other health professionals who maintain an ongoing relationship with a patient.

⁵⁹ American Academy of Pediatrics, Council on Foster care, Adoption and Kinship care and Committee on Adolescence and Council on Early Childhood (2015) [Health care issues for children and adolescence in foster care and kinship care](#), *Pediatrics* 136 (4), pp. e1131-e1140 .

⁶⁰ R. Geen et al. (2005) '[Medicaid spending on foster children](#)', Child Welfare Research Program, The Urban Institute, Brief No. 2, August.

⁶¹ 'Managed care' is a healthcare delivery system organised to simultaneously manage costs, service use and service quality. Managed care organisations include private and not-for profit organisations which are funded on a capitation basis. Governments may grant such organisations per capita incentive or performance payments for people with complex health needs, including children in OOHC.

⁶² A 'clinical pathway' is a structured, multi-disciplinary plan of care used to translate guidelines or evidence into practice within local health systems. Clinical pathways describe steps of care and desirable timeframes and aim to standardise care for particular types of care of specific patient populations, such as children in OOHC.

⁶³ P. Cunningham et al. (2012) Safety-net providers in some US communities have increasingly embraced coordinated care models, *Health Affairs*, 31(8), pp. 1698-1707.

⁶⁴ P.K. Jaudes et al. (2012) Expanded medical home model works for children in foster care, *Child Welfare* 91(1), pp. 9-33.

Table 2: National outcome measurements collected for children in OOHC in England and the US

COUNTRY	DATA REPOSITORY/ DATASET TITLE/ REPORT TYPE	DATA COLLECTION METHOD	DATASET CONTENT EXAMPLES
England	Public Health England (PHE 2015) National Child and Maternal Health Intelligence Network, Children and Young People's Health Benchmarking Tool, Looked-After Children Aggregated, de-identified data available on-line, benchmarked against national and regional data	Unique child identifiers used for all children in OOHC Local authorities mandated to submit periodic data for all children in OOHC	<ul style="list-style-type: none"> • Number of children in OOHC • % of children 0-4 years with up-to-date developmental assessment • % of eligible children with annual health assessment • % of eligible children who have had emotional and behavioural assessment • Average emotional wellbeing score among children in OOHC • % of children with up-to-date immunisation
U.S.	US Department of Health and Human Services Children's Bureau (2015) Adoption and Foster Care Analysis and Reporting System (AFCARS) Aggregated, de-identified data reported annually on-line	Unique child identifiers used for all children in OOHC. State governments mandated to provide case-level information every 6 months on all children in OOHC or who have been adopted	<ul style="list-style-type: none"> • Number of children in OOHC • Number of children with clinically diagnosed disabilities, including mental retardation, vision, hearing, physical, emotional and other medical diagnoses • Number of children requiring special medical care
U.S.	Office of Planning, Research and Evaluation, US Administration for Children and Families, US Department of Health and Human Services, Children's Bureau (2015) National Survey of Child and Adolescent Wellbeing (NSCAW) Public reports published providing data analysis Data used by academic researchers for additional studies	Longitudinal survey of national sample of children and families investigated by child protection services Two cohorts enrolled Children in OOHC purposefully over-represented in samples Data collected by face-to-face interviews with carers and administration of standardised survey instruments/health screening tools	<ul style="list-style-type: none"> • Physical health status • Mental health status • Cognitive development • Social-emotional development • Adaptive behaviour/daily living skills • Neurodevelopmental status • Cognitive development • Language development • Depression symptoms • Trauma symptoms • Health insurance status • Usual place of health care • Preventive healthcare receipt • Dental care receipt • Delayed medical care due to cost • Urgent medical care used • Behavioural health services receipt • Psychotropic medication prescribed

Source: S.M. Webster (2015) Children and young people in out-of-home care: Canaries in the coal mine of healthcare commissioning, *Australian Journal of Primary Health*, Published online 12 October 2015 DOI: 10.1091/PY15040.

Australian health systems responses

There have been a variety of health systems responses in Australia, including policy development by medical colleges, state and territory legislation, policies and approaches, the development of quality standards for organisations and publication of information guides for carers.

Medical college recommendations

The Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists are agreed that periodic, comprehensive health assessment and health care planning are vital for Australian children in OOHC and have provided recommendations to Australian governments that are consistent with current legislation and standards in the U.S. and England.⁶⁵

Legislation, standards and policies

State and territory jurisdictions in Australia each determine their own legislation, policies and standards which shape responses to health and development risks for children in statutory OOHC. Table 3 provides examples of formal inter-departmental or whole-of-government agreements in Australian jurisdictions other than Victoria which relate to the provision of health assessments and health care for children and young people in OOHC.

Accountability measures relating to health assessments in OOHC vary between jurisdictions. The Australian Capital Territory Health Directorate, for example, reports annually on the proportion of children aged 0-14 years entering OOHC within the jurisdiction, who have been referred to the Child at Risk Health Unit for a Health and Wellbeing Screen.⁶⁶

In Western Australia (WA) a *Health Care Planning for Children in Care Steering Group* has provided a coordination role which includes:

- Reviewing clinical pathways;
- Identifying and implementing changes required;
- Determining where further staff guidance is required;
- Addressing recommendations of any government reports on clinical pathway processes.

Each WA health district has a designated staff member who receives all referrals for health assessments for children in care. Local service agreements between district offices of WA Health and the Department for Child Protection and Family Support guide local area service provision.

The NSW Children's Guardian has monitored legislative compliance and audited case records for children in statutory OOHC. The Guardian has reported on the quality of health record keeping, childhood immunisation records, documentation around consent for psychotropic medications, psychological and psychiatric wellbeing, health assessments received at entry to OOHC, and annual health reviews undertaken. A \$12 million budget was allocated over a four year cycle from 2009 for the introduction of an OOHC Clinical Pathway for Children and Young People. Evaluation of that state-wide program is publicly available.⁶⁷

⁶⁵ Royal Australasian College of Physicians (2008) *Health of children in 'out-of-home care'*, Paediatric Policy, Sydney: RACP; Royal Australian and New Zealand College of Psychiatrists (2015) *The mental health care needs of children in out of home care. Policy Statement No. 59*, Melbourne: RANZCP.

⁶⁶ Australian Capital Territory Government Health Directorate *Annual Report 2013-14*, Canberra: Health Directorate p. 60.

⁶⁷ Nous Group (2014) *Formative evaluation of health assessment processes and coordination for children and young people entering statutory out-of-home care: Final Evaluation Report*, Sydney: Nous Group.

Table 3: Examples of agreements relating to health care for children in OOHC

JURISDICTION	AGREEMENTS
New South Wales	Memorandum of Understanding between NSW Health and Community Services on Health Screening, Assessment, Intervention and Review for Children and Young People in Out-of-Home Care
	The Model Pathway for the Comprehensive Health and Development Assessments for all children and young people entering Out-of-Home Care
	NSW Kids & Families (2013) Health Assessment of Children and Young People in Out-of-Home Care: Clinical Practice Guidelines
	Keep them Safe: A shared approach to child wellbeing 2009-2014
Queensland	No formal agreements identified
South Australia	Government of South Australia (2014) Health Standards for Children and Young People under the Guardianship of the Minister, Policy Directive
Western Australia	Schedule between the Department for Child Protection and Family Support and WA Health, Health Care Planning for Children in Care (January 2015)
	Bilateral Schedule between the Department for Child Protection and Family Support and Child and Adolescent Mental Health Services (June 2012)
	Department for Child Protection and Family Support, Rapid Response- Prioritising services for children and young people in care (2011)
	Joint guidelines on the mutual exchange of relevant information between WA Health and the Department for Child Protection for the purpose of promoting the wellbeing of children (2011)
	Level 1 Strategic Bilateral Memorandum of Understanding between WA Health and Department for Child Protection (June 2011)
Tasmania	No formal agreements identified
Australian Capital Territory	Department of Community Services, A step up for our kids: Out-of-Home Care Strategy 2015-2020
Northern Territory	No formal agreements identified

Australia’s first voluntary national OOHC standards framework called for all children entering OOHC to have their health needs assessed through a preliminary check then a comprehensive health and development assessment.⁶⁸ These standards were not as comprehensive as the consensus guidance provided by international and Australian medical professional bodies, nor did the standards have any statutory force. Australian governments have lacked adequate data or research to determine the efficacy of the various health assessment approaches and models which have been trialled over the past 15 years.⁶⁹

Model approaches

Questions about the most appropriate settings for health assessment, and the most economically sustainable models of assessment, remain open for debate. In the absence of any systematic,

⁶⁸ Australian Department of Social Services (2011) *An outline of national standards for out of home care*. Canberra: DSS.

⁶⁹ Australian Institute of Health and Welfare (2015) op. cit; ACIL Allen Consulting (2013) [Health assessments and interventions for children and young people in the child protection system: Options paper to Department of Social Services](#). Canberra: ACIL Allen Consulting; Parliament of Australia, The Senate Community Affairs References Committee (2015) *Out of home care*, Canberra, Senate Printing Unit.

national approach, several different models have been piloted in various Australian states in recent years. One type has involved hospital or community health centre-based, multi-disciplinary assessment clinics headed by a paediatrician or psychologist. A second model has been based on nurse-led health checks. An alternative approach introduced salaried regional health coordinator positions to promote and facilitate service integration and information coordination. The least effective model has relied on paper-based hand-held health records for recording and sharing information about child health assessments and health care plans for children entering OOHC. These records were intended to act as both a record and a prompt.

Resources and guides which explain the association between maltreatment and children's socio-emotional development and mental health have been disseminated to carers and child protection professionals by national and state bodies.⁷⁰

Several jurisdictions have grappled with how to engage GPs in health needs assessment and health care planning for children in statutory OOHC. A 2005 systematic review of published research about OOHC in Australia identified limited research about the experiences of health professionals, including doctors.⁷¹ An unpublished study in Western Australia noted that barriers for GPs in effective medical management for children in OOHC included:

- GPs were not a part of the child protection system and lacked clarity about their responsibilities within that system;
- there was a lack of medical histories for children in care;
- transience of children's care placements disrupted continuity of medical care;
- GPs lacked specific training about the health impacts of child abuse and neglect;
- GPs lacked clear clinical guidelines for assessing these children.⁷²

Similar barriers had been identified by the Royal College of General Practitioners (RCGP) in the UK and were also found in a Victorian research study.⁷³

Factors limiting health systems' effectiveness

An overview of models of health assessment in OOHC in each jurisdiction was first provided in 2011.⁷⁴ It was updated two years later in a comprehensive analysis for the Australian government's Standing Council on Community and Disability Services Advisory Council, and identified the following challenges which limited effective responses to the health needs of children in OOHC:⁷⁵

- Absence of high level direction for joint accountability and inter-agency collaboration;
- Lack of clarity around roles and responsibilities of government bodies;

⁷⁰ Australian Institute of Family Studies (2014) *Effects of child abuse and neglect for children and adolescents*. CFCA Resource Sheet – January 2014. Victorian Department of Human Services (2007) op. cit.

⁷¹ L. Bromfield & A. Osborn (2007) Getting the big picture: A synopsis and critique of Australian out-of-home care research. *Child Abuse Prevention Issues* No. 26, pp. 1-40, Melbourne, Australian Institute of Family Studies.

⁷² P. Underwood et al. (1999) Understanding and improving the provision of general practice services to children in state care: Final report, General Practice Evaluation Program, GPEP Report 705, Adelaide, Primary Health Care Research and Information Service, Flinders University.

⁷³ S.M. Webster & M. Temple-Smith (2010) 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* 16, pp. 296-303.

⁷⁴ Australian Department of Health, Australian Population Health Principal Committee, National Clinical Assessment Framework for Children and Young People in Out-of-Home Care, Appendix 3B Current models in Australia.

⁷⁵ ACIL Allen Consulting (2013) op. cit.

- Structural gaps in health service provision arising from lack of staff skills and disincentives for health provider participation;
- Inadequate resourcing for ‘whole of jurisdiction’ implementation of good practice;
- Quality improvement initiatives limited by lapsing funding;
- Inadequate information management and information sharing capabilities.

Gaps in systems performance

Australian research studies have identified gaps in how child health needs are addressed in state and territory child protection systems, namely:

- Health care management tends to be excluded from accountability measures in child protection;⁷⁶
- Individual health histories are often not available;⁷⁷
- Individual histories of the trauma experienced by a child may not be cumulative, accurate or available;⁷⁸
- Carers and family members may be unable or unwilling to provide child health information;⁷⁹
- Carers and case managers detect less health problems than health professionals;⁸⁰
- Carers require additional practical supports to attend health care appointments with children;⁸¹
- The extent to which carers are reimbursed for children’s health care costs differs significantly across jurisdictions;⁸²
- Recommendations made by doctors for further health assessments and treatment are often not followed up by case managers or carers;⁸³
- 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;⁸⁴
- 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;⁸⁵
- Undeveloped systems for managing medico-legal issues in relation to consent and exchange of child health records;⁸⁶
- Lack of effective information technology-based systems for managing child health information between health and child protection sectors.⁸⁷

In 2015, the Senate Community Affairs References Committee reported on its inquiry into OOHC in Australia.⁸⁸ That Committee similarly found that currently available data still does not provide

⁷⁶ C. Tilbury (2006) Accountability via performance measurement: The case of child protection services, *Australian Journal of Public Administration*, 65(3), pp. 48-61.

⁷⁷ M.F. Chambers et al. (2010) Assessment of children coming into care: The processes, pitfalls and partnerships, *Clinical Child Psychology and Psychiatry*, 15, p. 511.

⁷⁸ Tarren-Sweeney (2010) op. cit.; S. Tregeagle (2010) Red tape or gold standard? Australian service user’s experiences of child welfare case managed practice, *Australian Social Work*, 63(3), pp. 299-314; M. Frederico et al. (2008) Understanding the impact of abuse and neglect on children and young people referred to a therapeutic service, *Journal of Family Studies*, 14 (2), pp. 342-361.

⁷⁹ Chambers et al, (2010) op. cit.; Tregeagle (2010) op. cit.

⁸⁰ Kaltner & Rissel (2011) op. cit.

⁸¹ Chambers et al. (2010) op. cit.

⁸² M. Mc Hugh & K. Valentine (2011) *Financial and non-financial support to formal and informal out-of-home carers*, Occasional Paper No. 38, Canberra, Department of Families, Housing, Community Services and Indigenous Affairs.

⁸³ Chambers et al. (2010) op. cit.; Nathanson et al. (2009) op. cit.

⁸⁴ Nathanson et al. (2009) op. cit.

⁸⁵ Tarren-Sweeney (2010) op. cit.

⁸⁶ Webster & Temple-Smith (2010) op. cit.

⁸⁷ ibid.

⁸⁸ Parliament of Australia, Senate Community Affairs References Committee (2015) op. cit.

sufficient information to assess outcomes for children in OOHC. The Committee expressed concern that children in OOHC remain more likely to experience chronic health and mental health conditions but less likely to receive necessary treatment than in the general population. The Committee recommended:

...that COAG include in the third action plan (2015-2018) of the National Framework (for Protecting Australia's Children) a project to develop and implement strategies to improve health outcomes for children and young people in care, including access to health services, particularly youth mental health treatment and support services, and consideration of health outcomes in case planning.⁸⁹

However that recommendation was not addressed in the subsequent action plan.⁹⁰

Australian researchers have recommended that:

- 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;⁹¹
- 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;⁹²
- Additional assessment, monitoring and research is required for some sub-populations in OOHC e.g. Aboriginal and Islander children, immigrant and refugee children and children with intellectual disabilities;⁹³
- Australian authorities cannot meet best practice standards in health management for children in OOHC without an expansion in health service delivery;⁹⁴
- More systematic measurement is needed of the outcomes of health assessment and treatment for children in OOHC, both in terms of access to services and response to treatment or therapy.⁹⁵

Summary of Australian health systems responses

The problematic situation facing Victorian governments is both a state and national problem. Australian government responses have been limited. A national voluntary code of standards for OOHC has been agreed. The Australian Department of Health has opened the door to patient subsidies under the national health insurance scheme for health checks and healthcare plans for children in OOHC. However the Council of Australian Government's has not accepted recommendations for greater attention to children's health in OOHC.

While states and territories have previously developed model agreements, clinical pathways, performance measures and specialist services which can provide good-practice examples, none has yet had a fully developed, proven and sustained system in place for responding effectively to the health needs of children in statutory OOHC.

⁸⁹ *ibid*, p. 283.

⁹⁰ Australian Department of Social Services (2015) *Protecting children is everyone's business: National framework for protecting Australia's children 2009-2020-Third Action Plan 2015-2018, Driving change, intervening early*, Canberra, DSS.

⁹¹ M. Crawford (2006) Health of children in out-of-home care: Can we do better? *Journal of Paediatrics and Child Health*, 42, pp. 77-78.

⁹² Milburn et al. (2008) *op. cit.*; A. Zou & M. Chilvers (2010) Infants in Australian out-of-home care, *British Journal of Social Work*, 40, pp. 26-43.

⁹³ Tarren-Sweeney (2010) *op. cit.*; Tilbury (2006) *op. cit.*

⁹⁴ Tarren-Sweeney (2010) *op. cit.*; Crawford (2006) *op. cit.*

⁹⁵ K.R. Ronan & J. Feather (2009) Child maltreatment: Introduction to the special issue, *Australian Psychologist*, 44(3), pp. 143-145.

Health systems responses in Victoria

In the past 20 years increasing numbers of children have been taken into statutory OOHC in Victoria. Over the same period, a persistent lack of performance indicators or systemic monitoring of the quality of care has been documented.⁹⁶ This has been despite accumulating evidence of poor physical and psychological outcomes for some children in OOHC, raising concerns about the quality of services provided to children.⁹⁷

The next section of this paper considers five key elements relevant to the quality of systemic responses to the provision of health services for children and young people in statutory OOHC in Victoria and describes how these manifest between 1989 and 2015. These elements are:

- a) Responsibility and accountability mechanisms;
- b) The availability of quality standards which benchmark expectations about how children and young people's health care needs are to be met in OOHC;
- c) The availability of children and young people's health records in OOHC, including record collection, maintenance and dissemination;
- d) The accessibility of health care services;
- e) Health care coordination and decision making for children and young people.

Responsibility and accountability mechanisms

Legislative assignment of responsibilities

Statutory responsibility for health-related decisions for children in OOHC has been diffuse. Between 1989 and 2016 a number of different government ministers have been assigned to administer child protection legislation, as is illustrated in Table 4. Department heads have not been given statutory responsibility to assure that health needs were identified and met when a child was placed in statutory OOHC. Rather, legislation included a range of softer directions.

In 1989 the department head was limited to making provision for children's development when placing them with a CSO and providing consent to medical examination or treatment in certain circumstances.

The Children, Youth and Families Act 2005 added further, general responsibilities including:

- working with other government agencies and CSOs to ensure that children in OOHC received health opportunities;
- publishing and promoting a Charter for children in OOHC;
- researching child development, abuse and neglect;
- evaluating the effectiveness of community based and protective interventions in protecting children from harm; and
- protecting children's rights and promoting children's development.

⁹⁶ Victoria, Protecting Victoria's Vulnerable Children Inquiry (2012) op. cit.

⁹⁷ Victorian Department of Human Services (2003) op. cit.

Table 4: Summary of Ministerial portfolios and assignment of statutory responsibility relating to medical examination, healthcare and health-related treatment of children in OOHC

LEGISLATION	RESPONSIBLE MINISTERS	HEAD OF THE DEPARTMENT RESPONSIBILITIES
Children and Young Person's Act 1989	<i>Under General Orders from March 2001 #</i> Attorney General, and Minister for Community Services	According to the Children and Young Person's Act 1989, Version incorporating amendments as at 2 January 2007: In placing a child in a community service or secure welfare service, the Secretary, Department of Human Services: <ul style="list-style-type: none"> • S. 124 (2) must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would • S.271 (1) The Secretary may order that a person...may be examined in order to determine his or her medical, physical, intellectual or mental condition • S.271 (3) On the advice of a registered medical practitioner...the Minister, the Secretary or any other person authorised ...by the Secretary to do so may consent to the medical treatment or surgical or other operation or the admission to hospital even if the child's parent objects
Children Youth and Families Act 2005	<i>Under General Orders from 1 December 2006 to 8 August 2007</i> Attorney General, Minister for Children, and Minister for Community Services <i>Under General Orders from 8 August 2007 to 4 December 2014</i> Attorney-General, and Minister for Community Services <i>Under General Orders from 4 December 2014 to 1 March 2016</i> Attorney-General, and Minister for Families and Children	According to the Children, Youth and Families Act 2005, Version 059, incorporating amendments as at 4 January 2016: <ul style="list-style-type: none"> • S.16(e) to work with other government agencies and community services to ensure that children in out of home care receive educational, health and social opportunities • S.16(f) to publish and promote a Charter for children in out of home care to provide a framework of principles to promote the wellbeing of those children • S.16 (h) to conduct research on child development, abuse and neglect and to evaluate the effectiveness of community based and protective interventions in protecting children from harm, protecting their rights and promoting their development • S.174 In placing a child in an OOHC service or in secure welfare The Secretary of the Department of Human Services • S.174 (1) (b) must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would • S.174 (1) (d) must have regard to the treatment needs of the child • S. 597 (1) may at any time order that a person...be examined to determine his or her medical, physical, intellectual or mental condition • S.597 (3) On the advice of a registered medical practitioner...the Minister, the Secretary or any other person authorised ...by the Secretary to do so may consent to the medical treatment or surgical or other operation or the admission to hospital even if the child's parent objects

Details of General Orders made before March 2001 are not readily available.

Financial responsibilities for meeting healthcare needs

In 2013-14 the Victorian Government's real recurrent expenditure on child protection, OOHC and intensive family support services per child aged 0-17 years in the population was the second lowest in Australia, continuing the pattern of previous years. Victoria's annual real expenditure on OOHC per child in OOHC decreased over the five years to 2014.⁹⁸

Historically Victorian governments have been reluctant to accept sole financial responsibility for the provision of health assessment and medical care for children in OOHC. The government's employment of Medical Superintendents and Medical Officers for children in statutory OOHC ceased when state-run reception centres were closed in the early 1990s. For much of the 20th century charitable organisations providing institutional places for children in statutory OOHC were responsible for arranging health and medical services and engaged doctors on an honorary basis where they could.

The introduction of Australian Government-funded national health insurance schemes from 1975 with their provision of financial subsidies for both in and out-of-hospital medical services changed the healthcare funding landscape. However Victorian governments' failure to pick up full responsibility for residual health care costs incurred for children in statutory OOHC but not reimbursed through the national insurance schemes, demonstrated an ongoing reluctance to accept statutory responsibility. The Children and Young Person's Act provided that the Secretary may make grants 'to assist CSOs to meet the needs of children requiring protection, care or accommodation' which clearly left CSOs to carry any residual burden.⁹⁹

The 2012 DHS Child Protection Practice Manual encouraged the use of public and private health services for children in statutory OOHC while pointing out that the department, despite having ultimate case management responsibility may not necessarily accept responsibility for the costs associated with health needs assessment or health care for children and young people in OOHC.¹⁰⁰ Current guidance for carers indicates that the Victorian government provides care allowances to reimburse some of the expenses incurred while providing home-based care as a volunteer carer, including a contribution to the cost of meeting children's health needs.¹⁰¹ Any shortfall will then presumably still fall to a parent, CSO, carer or charitable fund. Children in statutory OOHC may have been denied medical assessments, treatments, aids or appliances when no funds were provided.

Responsibilities for consent to medical examination or treatment

Statutory responsibility for authorisation of health assessment and medical treatment for children in OOHC has been diffuse since the Children and Young Person's Act 1989 introduced an alternative to guardianship orders. Under previous legislation the Secretary became the legal guardian to the exclusion of all others until children turned 18 years of age.

The Children, Youth and Families Act 2005 gave the Minister, Secretary or their delegate powers to make medical treatment decisions on the advice of a medical practitioner, when a parent who has retained guardianship cannot be contacted or does not consent.

⁹⁸ Steering Committee for the Review of Government Service Provision (SCRGSP) (2015) *Report on Government Services 2015, Vol E, Health*, Canberra, Productivity Commission.

⁹⁹ *Children and Young Person's Act 1989*, s 58.

¹⁰⁰ Victorian Department of Human Services (2012) *Children Protection Practice Manual*; Definition and purpose of out of home care. Advice 1395, DHS website, (archived).

¹⁰¹ Victorian Department of Health and Human Services (2015) *Financial support guide for home-based carers*. Melbourne, DHHS.

The 2015 DHS Child Protection Manual outlines complex processes for determining responsibility for authorising medical treatment. Statutory authority rests with the Secretary of DHHS but in practice may be delegated through a hierarchy of positions including the Director or Assistant Director of Child Protection, child protection team managers, CSO managers or carers.¹⁰² Mature young people may be able to consent on their own behalf. Some major medical procedures such as sterilisation require authorisation through a court. OOHC case management responsibilities may rest with DHHS staff or with CSO staff. The Victorian Child and Family Services Outcomes Survey 2012 found that 32 per cent of eligible children in OOHC did not have a care team and 10 per cent did not have a care and placement plan.¹⁰³ In 2015 the number of child protection clients of the Department of Human Services without an allocated case manager averaged 16.9 per cent.¹⁰⁴ In previous years this has been as high as 25 per cent.¹⁰⁵ Without an active case manager opportunities to monitor health may have been missed.

In the majority of recent Victorian Children's Court orders parents retained guardianship of children placed in OOHC.¹⁰⁶ At 30 June 2014 approximately 86 per cent of children in OOHC were admitted under a 'care and protection' order rather than a 'guardianship to the Secretary' order.¹⁰⁷ This further diffuses responsibility for consent to medical treatment. Unless the court awards guardianship to the Secretary, parents retain authority to legally 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 parents are unavailable or unwilling to be involved. This is particularly the case as the DHHS Child Protection Manual advises staff that usual practice is to seek parental consent for medical treatment, regardless of whether legislation requires consent or not. Without clear and continuous authority from a parent, health professionals can be hampered in trying to manage child health records and facilitate timely and appropriate health assessment and care. Where parents are unable or unavailable to effectively monitor their child's health then important opportunities for assessment, support and intervention may be missed.

Responsibilities for health needs identification and health care planning

As discussed earlier, departmental heads have not had any particular responsibility to determine the health needs of children in statutory OOHC. However the Department of Human Services recognised that health needs should be considered in case planning and from 2005 adopted an English care plan records system (the *Looking-After Children* records system) which incorporated a focus on health for children in foster and residential OOHC.

Accountability

There have been no agreed national administrative measures for monitoring child health and wellbeing for children in statutory OOHC.¹⁰⁸

Historically CSOs have not been required to publicly account for the way in which the health needs of children in OOHC have been addressed.¹⁰⁹ Nor have Victorian governments developed performance data measures related to children's health needs in OOHC.

¹⁰² Victorian Department of Health and Human Services (2015) '[Child Protection Manual](#)', DHS website.

¹⁰³ Victorian Department of Human Services (2013) op. cit.

¹⁰⁴ Victorian Department of Health and Human Services (2015) *Annual report 2014-2015*, Melbourne, DHHS.

¹⁰⁵ Victoria Parliament, Legislative Council, Standing Committee on Finance and Public Administration (2010) Report on the performance of the Department of Human Services' Child Protection Program, *Inquiry into Departmental and Agency performance and operations, October, Melbourne, The Committee*

¹⁰⁶ Children's Court of Victoria (2015) *Annual Report 2014-2015*, Melbourne, Children's Court of Victoria.

¹⁰⁷ Australian Institute of Health and Welfare (2015) op. cit.

¹⁰⁸ SCRGSP (2015) op. cit.

Quality standards in OOHC in Victoria and health needs assessment

In 2000 there were few recognised practice standards in place and CSOs reported concerns about their resources to fully meet the few standards that did exist. Performance-based measures for home-based care were limited to a small number of broad composite statistical measures such as placement numbers, case allocation, planned and unplanned placement exits and voluntary and permanent placement data.¹¹⁰

The Premier's Children's Advisory Committee and the Victorian Auditor-General were both critical of DHS for its ongoing failure to demonstrate that management of children in OOHC had positive outcomes for child well-being.¹¹¹ In 2005, the Victorian Premier created a new Minister for Children and a position of Child Safety Commissioner to address the concerns. The Child Safety Commissioner developed a statutory *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.¹¹²

Subsequently, registration standards published by DHS for community service organisations (CSOs) included guidance about child health assessment, consistent with the Charter.¹¹³ Those standards were also consistent with the policies of the RACP and the American Academy of Pediatrics. The 2008 standards required that each child have a comprehensive assessment (including medical, dental and mental health) as soon as possible and at least within one month after entering OOHC.

From 1 July 2012 these OOHC specific registration standards were replaced by more broadly based, generic Human Services standards. Unlike the 2008 standards, the generic 2012 standards, which remain current, lack specificity for the OOHC cohort. One of the four current Human Services standards is 'Standard 3: Wellbeing – People's right to wellbeing and safety is promoted and upheld'.

The Protecting Victoria's Vulnerable Children Inquiry found that these standards provided an

...inappropriate or under-developed regulatory framework that governs the relationship between the Department of Human Services and community service organisations... that does not establish appropriate standards or expectations...¹¹⁴

Program requirements

In addition to meeting the generic Human Service Standards, program requirements for children's residential care and home-based care in Victoria currently specify that CSOs providing OOHC services must ensure that children and young people undergo a comprehensive health assessment within 4 to

¹⁰⁹ Victorian Child Welfare Practice and Legislation Review (1984) *Report of the Victorian Child Welfare Practice and Legislation Review*, Melbourne; M. Liddell (2003) Submission to the Senate Inquiry into children in residential institutions, Parliament of Australia, Senate Standing Committee on Community Affairs, *Inquiry into children in institutional care 2003-2005*, Canberra; Cummins et al. (2012) op. cit.

¹¹⁰ Victorian Department of Human Services (2003) op. cit.; Liddell (2003) op. cit.

¹¹¹ Victorian Department of Premier and Cabinet, Premier's Children's Advisory Committee (2004) *Joining the dots: A new vision for Victoria's children. Report to the Premier of Victoria*. Melbourne, Department of the Premier and Cabinet; Auditor-General, Victoria (2005) [Our children are our future: Improving outcomes for children and young people in out-of-home care](#). PP No 123, Session 2003-05, Melbourne, Government Printer.

¹¹² Commission for Children and Young People, Victoria (2008) '[Charter for Children in Out of Home Care](#)', CCYP website.

¹¹³ Victorian Department of Human Services (2011) *Department of Human Services Standards Evidence Guide*. Melbourne, DHS.

¹¹⁴ Victoria, Protecting Victoria's Vulnerable Children Inquiry, op. cit. Vol 1, p. xxxviii.

12 weeks after admission to care and thereafter at least annually.¹¹⁵ CSOs must also ensure appropriate treatment is provided, including medical, dental, auditory, optical, mental health and specialist care.

Availability of child health records in OOHC

The paucity of data management systems and practice in statutory OOHC has been frequently reported over the past 20 years.

CSOs have had contractual obligations to manage a very significant proportion of the steps of care relating to health needs identification and health care planning. The current DHHS Child Protection Manual, revised in late 2015, outlines a comprehensive and complex approach to responsibility for the collection of information about children's health needs and health care planning. For a child entering care in January 2016, and remaining in OOHC for a period of 16 months, staff from DHS and CSOs together with carers would need to complete nine separate assessment and planning records requiring health related-assessment and/or review data. The procedures described in the manual place a substantial burden on CSOs.

Access to health care services

OOHC policies in Victoria have largely relied on the routine engagement of universal health services for children by parents, carers and/or child protection or CSO case managers. Priority access policies have been negotiated in some publicly funded health services. For a small number of children and young people in OOHC a state-wide clinical and counselling support service provides targeted services. Each of these approaches to health care access is discussed below.

Universal health care services

There are several points of care in the universal health service system where some form of health assessment may be made for children or young people in statutory OOHC. These include maternal and child health services (including their enhanced service for disadvantaged families), the Primary School Nursing program and general practitioner services. Child and adolescent area mental health services may assess behavioural and emotional problems and disorders. Multi-disciplinary health assessment may be accessible through state-funded community health services.

A universal Maternal and Child Health Service, jointly funded by Victorian state and local governments offers parents no-cost nurse-led child health assessment and child development advice at ten key ages between 0-40 months of age. While uptake of this voluntary service within the broader community is initially high, covering 94.8 per cent of children at birth, participation reduces significantly over time. Only 60.5 per cent of all one year olds and 50.1 per cent of two year olds were believed to attend recommended health checks at these ages. By age 40 months the rate is officially less than 50 per cent.¹¹⁶ However parent self-reporting of attendance for the 40 month health check indicated a rate of 75 per cent in 2014.¹¹⁷ Attendance rates for children in OOHC are not known.

The Primary School Nursing program provides a free health care and referral service to primary school-aged children. The program attempts to screen all children at entry to primary school, based on parent or carer reports about children's health in the School Entry Health Questionnaire (SEHQ). Screening participation rates have exceeded 82 per cent of all primary school entrants in recent

¹¹⁵ Victorian Department of Human Services (2014) Program requirements for home-based care in Victoria. Interim revised edition, April, Melbourne: DHS; Victorian Department of Health and Human Services (2015) *Program requirements for residential care in Victoria*, April, Melbourne: DHHS.

¹¹⁶ Victorian Department of Education and Training (2014) *Maternal & Child Health Services Annual Report 2013-2014*, Melbourne, DEAT.

¹¹⁷ Victorian Department of Health and Human Services (2015) *Annual report 2014-2015*, Melbourne, DHHS.

years.¹¹⁸ Children who may require further assessment of problems related to health, development or learning may be physically examined by the School Nurse and referred to other services as required. While the SEHQ collects information about children's exposure to abuse, family violence, family alcohol or drug problems or parent mental illness, no population-based health status data is publicly reported from the SEHQ relating to children who have been exposed to these experiences. Neither does the data identify whether children live in OOHC.

Many children entering OOHC may not have experienced continuity of GP care in the past. Parents, case managers or carers may ask a GP to assess or monitor a child's health and development. A carer may take a child informally, within the first few weeks of entry to care, to a local GP or other health professional for a 'check-up'. It appears to be common for children to see the carer's GP rather than a GP who knows the child.

GPs use a standard consultation of less than 20 minutes to determine whether a child has current signs or symptoms of a health condition. Time is only available in such consultations for the GP to deal with currently presented symptoms. A longer appointment time of more than 20 minutes may be requested and repeat consultations are possible which would also attract a Medicare Benefits Schedule (MBS) patient subsidy.¹¹⁹ Many GPs in private practice routinely charge a co-payment in addition to the MBS patient subsidy. Some GPs in private practice may waive a co-payment for a child or young person in OOHC. Carers have been expected to meet any out-of-pocket expenses from the weekly care allowance.

Written reports or records have not been routinely collated or shared which provided information as to the occurrence or outcome of such a 'check-up'. No systematic, aggregated records have usually been kept at a regional or state-wide level to monitor the extent to which health checks occur, the outcome of the health checks or the children's health needs.

The Auditor-General has been critical of the lack of comprehensive and consistent data collection and reporting which could inform governments about outcomes for vulnerable children in Victoria, including those in OOHC.¹²⁰

From a GP perspective, requests to assess the health of children previously unknown to them can be challenging. In the face of increasing clinical demands from older patients the amount of time GPs spend on all paediatric consultations, including those for children with chronic or complex health conditions, has been reducing.¹²¹ Furthermore, GPs face significant medico-legal and other barriers in assessing the health needs of children in OOHC.¹²² The foremost barrier is the lack of child and family medical histories.

Priority access to universal services

Policy and procedural documents distinguish between different types of health care services which may be available to children and young people in OOHC and describe varying access and funding commitments. There have been two important agreements related to education-related health services and a directive guideline relating to mental health service access as shown in Table 5.

¹¹⁸ Victorian Department of Education and Training (2015) *State findings from the School Entrant Health Questionnaire 2012 to 2014*, Melbourne, DEAT.

¹¹⁹ Australian Department of Health (2015) Medicare Benefits Schedule Book, DH website.

¹²⁰ Auditor-General, Victoria (2013) op. cit.; Auditor-General, Victoria (2014) op. cit.

¹²¹ G.L. Freed et al. (2013) Changes in longer consultations for children in general practice, *Journal of Paediatrics and Child Health*, 49(4), pp.325-329.

¹²² Webster & Temple-Smith (2010) op. cit.

The current Department of Education and Training (formerly the Department of Education and Early Childhood Development) documented the department’s *Principles for Health and Wellbeing* as a framework to signify their commitment to improving health, particularly for vulnerable children and to support coordination and collaboration with other organisations.¹²³

An Education and Support Guarantee within the 2011 inter-departmental ‘Out-of-Home Care Education Commitment Partnering Agreement’ signified a commitment ‘to prioritisation of referrals to education-related health and wellbeing services’.¹²⁴ Such services include:

- student support service officers such as psychologists, speech pathologists, social workers or visiting teachers;
- primary welfare officers who can support students with behavioural, mental health or welfare issues;
- student welfare coordinators;
- a program for students with disabilities.

A 2014 agreement gave priority access to free universal early childhood intervention services from birth to school entry for children in statutory OOHC who have a disability or developmental delay.¹²⁵ These services comprise:

- Enhanced maternal and child health services; and
- Free kindergarten program for three-year olds.

The Chief Psychiatrist’s guideline (2011) promotes priority access to triage and assessment by Area Mental Health Services of children and young people in OOHC.¹²⁶ Furthermore the Guideline sets a precedent that exempts children and young people in OOHC from a requirement that they first meet the criteria for a likely diagnosis of mental illness.

Table 5: Victorian agreements relating to health care for children in OOHC

DEPARTMENTS	AGREEMENT
Department of Human Services; Department of Education & Early Childhood Development	Early Childhood Agreement for Children in Out-of-Home Care: A Partnering Agreement between Department of Human Services, Department of Education and Early Childhood Development, Municipal Association of Victoria and Early Learning Association Australia (2014)
Department of Human Services; Department of Education & Early Childhood Development	Out of Home Care Education Commitment: A Partnering Agreement between Department of Human Services, Department of Education and Early Childhood Development, Catholic Education Commission of Victoria and Independent Schools Victoria (2011)
Department of Health	Chief Psychiatrist’s guideline: Priority access for out-of-home care (2011)

Targeted services

The *Take Two* therapeutic developmental service based at Berry Street Victoria was developed with DHS funding in response to an identified need to assist children aged 0-10 years at highest risk of long term psychological damage as a result of physical or sexual abuse. The introduction of intensive therapeutic services was among a suite of strategies introduced in the 2002-03 budget to improve

¹²³ Victorian Department of Education and Training (2014) *Principles for Health and Wellbeing*, DEAT website.
¹²⁴ Victorian Department of Education and Early Childhood Development (2011) *Out-of-Home Care Education Commitment Partnering Agreement*, Melbourne, DEECD, p. 6.
¹²⁵ Victorian Department of Education and Training (2014) ‘Principles for Health and Wellbeing’, DEAT website.
¹²⁶ Department of Health (2011) *Chief Psychiatrist’s Guideline: Priority Access for Out-of-Home Care*, Melbourne: DoH.

service responses.¹²⁷ Service provision commenced in January 2004 and has been ongoing. *Take Two* provides clinical and counselling services for a limited number of distressed children and young people in the child protection system, along with their families and carers. Three evaluation reports of the *Take Two* service are available.¹²⁸

Health needs assessment initiatives

Enhanced models of care are increasingly being developed in the health sector to better meet complex medical, behavioural and social needs. These models of care often begin with active outreach and engagement and initial health needs assessment.¹²⁹

In general, health needs are those that can benefit from health care or from wider social and environmental changes. Health care need is the capacity to benefit from a health service intervention such as health education, disease prevention, diagnosis, treatment or rehabilitation.¹³⁰ Individual health needs assessment can improve detection of health concerns in OOHC¹³¹ and improve individual health service provision.¹³² Assessment can establish the nature and extent of individual health risks and health conditions, and help identify unmet health care needs. Assessment can also identify where ineffective, inefficient or inappropriate health care has been provided. Clinical judgements can then be more easily made about the potential benefits of additional or different health care. The benefits may not be limited to a change in current health status but may include illness prevention, diagnosis, continuing care, rehabilitation or education. They can also include reassurance or support to carers.¹³³

Since 2002, DHS has supported or trialled four different approaches to health needs assessment for children in OOHC. Each of the approaches has been limited to assessment of relatively small numbers of children, either:

- at the first entry to OOHC; or
- in particular age groups; or
- in particular types of OOHC; or
- in a particular geographical area.

Further detail about each of the initiatives is discussed below.

¹²⁷ Victorian Department of Human Services (2002) *An integrated strategy for child protection and placement services*, Melbourne, DHS.

¹²⁸ M. Frederico et al. (2005) *Reflections on complexity: The 2004 summary evaluation of Take Two*, Bundoora Victoria, School of Social Work and Social Policy, LaTrobe University.; M. Frederico et al. (2006) *Give Sorrow Words- A language for healing: Take Two Second Evaluation Report*, Bundoora Victoria, School of Social Work and Social Policy, LaTrobe University; M. Frederico et al. (2010) *More than words- the language of relationships: Take Two Third Evaluation Report*. Bundoora Victoria, School of Social Work and Social Policy, LaTrobe University.

¹²⁹ C. Thomas-Henkel et al. (2015) *Opportunities to improve models of care for people with complex needs: Literature Review*, Princeton N.J., Robert Wood Johnson Foundation and Center for Health Care Strategies Inc.

¹³⁰ J. Wright et al. (1998) Health needs assessment. Development and importance of health needs assessment, *British Medical Journal*, 316, pp. 1310-1313.

¹³¹ S.H. Jee et al. (2010) Improved detection of developmental delays among young children in foster care. *Pediatrics*, 125 (2), pp. 282-289; S.M. Horwitz et al. (2000) Specialised assessments for children in foster care, *Pediatrics*, 106, pp. 59-66.

¹³² S.A. Cooper et al. (2006) Improving the health of people with intellectual disabilities: outcomes of a health screening program after 1 year, *Journal of Intellectual Disability Research*, 50 (9), pp. 667-677.

¹³³ A. Stevens & S. Gillam (1998) Health needs assessment. Needs assessment: from theory to practice. *British Medical Journal*, 316, pp. 1448-1452.

Health needs assessment initiative 1

The first health needs assessment initiative trialled since 1989 was the *Stargate Early Intervention Program*, developed by the Royal Children's Hospital Mental Health Service and supported by funding from DHS.¹³⁴ The program aimed to provide a comprehensive, multidisciplinary health assessment for all children aged 0-17 years within 5-7 days of them entering OOHC in the western metropolitan region of Melbourne in 2002. The comprehensive approach involved interviews with parents and carers, clinical examination of children, completion of standardised health, cognitive and educational screening and a series of assessment consultations with children. Between 2002 and 2003, the program assessed 131 children of a possible 161 children before being discontinued. While successful from a medical perspective, this approach was deemed too costly by DHS to be used for all children entering OOHC.

Health needs assessment initiative 2

In 2006 DHS convened an *OOHC Entry to Care Advisory Group* to provide advice about the development of an alternative sustainable, state-wide system for health assessment and health care planning in OOHC. The advisory group included representatives from paediatrics, general practice, allied health, child protection services, community service organisations and foster parent groups. There was significant debate 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 were GP clinics across Victoria and a significantly greater number of GPs than paediatricians. GPs were 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 services from 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 children and as such was desirable for those in OOHC.

The choice of a primary care setting was consistent with practice in England where looked-after children are seen in general practice for initial health assessments. The Australian Health Insurance Commission at that time advised that routine comprehensive health assessment in general practice for children in statutory OOHC could not attract a Medical Benefits Schedule (MBS) rebate (as a medical report was needed by DHS as to the outcome). DHS accepted that it would need to offer a fee-for-service to GPs in the model being proposed.

The *OOHC Entry to Care Health Assessment* trial project commenced in 2008-09 in the eastern metropolitan region. It involved collaboration between General Practice Victoria, DHS, Berry Street *Take Two* and the Australian Childhood Foundation. The trial was overseen by a DHS project implementation group with representatives from DHS, General Practice Victoria, local Divisions of General Practice, the Australian Childhood Foundation, the *Take Two* Program, and CSOs.¹³⁵

The project recruited and trained a small pool of GPs with a special interest in child and adolescent health to undertake initial health assessments at entry to OOHC and provide written reports to DHS child protection case managers. Socio-emotional assessments were provided by *Take Two* or the Australian Childhood Foundation. GP assessment services were provided on a fee-for-service basis.

¹³⁴ Milburn et al. (2008) op. cit.

¹³⁵ The author was granted observer status on the DHS project implementation group.

This health assessment system design firstly required child protection and general practice sectors to work together in a coordinated and systematic way and to share child health information efficiently and effectively. Secondly, DHS had little experience, at either a policy or practice levels, of collaboration with private general practice in relation to children in OOHC. Indeed, the department developed its first policy on working with general practice in late 2007.¹³⁶ Thirdly, the initiative lacked policy support at the national level. The Australian government (which funds the general practice sector) had no clear national health agenda or policy about health care for children who have been maltreated. Lastly, it was not certain that DHS could successfully engage GPs in the initiative.

An Issues Paper reviewed the interim learning from the pilot,¹³⁷ and recommended that the pilot be continued until at least 100 children had been assessed and processes further refined. The recommendation was not accepted by DHS, owing to unexpected financial pressures in residential care.

In October 2010 DHS advised the collaborative partners in the trial that:

- the cost and complexity of the piloted approach was financially and administratively unsustainable for the child protection sector; and
- the task of resourcing health assessment for children and young people in OOHC had been referred to the Victorian Department of Health.

DHS did not commission an evaluation of the second health assessment initiative. General Practice Victoria published its' own evaluation, which included the perspectives of participating GPs.¹³⁸

The DHS subsequently joined other jurisdictions in representations to the Australian Department of Health urging changes to the MBS so that health assessments by GPs for children in OOHC could be subsidised.

The Australian Population Health Principals Committee (APHPC) subsequently announced a *National Clinical Assessment Framework for Children and Young people in Out-of-Home Care* which signalled a change to national policy and outlined the ways in which MBS patient subsidies could be claimed for health assessment, health care planning and health monitoring activities.¹³⁹ This framework remains current.

Health needs assessment initiative 3

The third initiative rested on an inter-departmental agreement made in 2011 between DHS and the Department of Education and Early Child Development (DEECD).¹⁴⁰ The agreement provided for employment of a part-time Health and Education Assessment Coordinator in each DHS region to

¹³⁶ Victorian Department of Human Services (2007) *Working with general practice; position statement and resource guide*. Melbourne: DHS.

¹³⁷ S. Webster (2010) *Comprehensive health assessment of children and young people entering out-of-home care in Victoria: Issues paper for the Victorian Department of Human Services*. Melbourne, Author.

¹³⁸ S. Tremellen & C. L'Huillier (2010) *Initial health assessments pilot, A report on the role and experience of general practice in the pilot program in the Eastern Metropolitan Region of the Department of Human Services 2008–2009, October 2010*, Melbourne: General Practice Victoria.

¹³⁹ Australian Population Health Development Principal Committee (APHPC), Child Health and Wellbeing Sub-Committee (2011) *National clinical assessment framework for children and young people in out-of-home care*. Canberra: Department of Health.

¹⁴⁰ Victorian Department of Human Services and Victorian Department of Education and Early Childhood Development (2011) *Out of Home Care Education Commitment: A Partnering Agreement between Department of Human Services, Department of Education and Early Childhood Development, Catholic Education Commission of Victoria and Independent Schools Victoria*, Melbourne, DHS, DEECD.

facilitate processes whereby each school-aged young person in residential OOHC (5.2 per cent of the OOHC population in 2013-14) would have an assessment of their educational and education-related health support needs. Assessment included general medical, psychology, audiology and ophthalmology checks. This initiative now has recurrent funding.

DHHS commissioned ACIL Allen Consulting to evaluate initiatives (iii) and (iv) in 2014-15. The evaluation report has not been publicly released.

Health needs assessment initiative 4

The *Protecting Victoria's Vulnerable Children Inquiry* in 2012 criticised the lack of accountability for health needs monitoring in OOHC and recommended that the government adopt stronger measures to ensure that all children in OOHC have their health needs assessed.¹⁴¹

As part of the government's strategic response a fourth initiative was funded by DHS.¹⁴² The aim was to ensure children in OOHC were accessing the full-breadth of universal health services, particularly general practice.

The *Pathway to Good Health* initiative in north-western metropolitan region began assessments for children aged 0-12 years in 2013. The Centre for Community Child Health at the Royal Children's Hospital (RCH) in Parkville was contracted by DHS to develop a clinical pathway, consistent with the *National Clinical Assessment framework for Children and Young People in OOHC*. A *Clinical Advisory Group* (with representatives from the Departments of Human Services, Health and Education, RCH, the Queen Elizabeth Centre, community health services, CSOs, General Practice Victoria and the University of Melbourne¹⁴³) provided input in the design phase. The clinical pathway described how GPs would provide an initial health assessment for each child newly entering care and make a referral to a community paediatrician for a comprehensive health assessment. Medical service providers were from state-funded community health centres, private general practice or the RCH. Medical assessment services were billed via MBS. The *Pathway to Good Health* has also been implemented in the Gippsland region since 2015. This initiative has lapsing, annual funding until the end of 2016.

Summary of OOHC health assessment initiatives in Victoria

Each of the small-scale initiatives trialled since 2002 has tested a different model of health needs assessment for children in statutory OOHC. Each has entailed modestly sized groups of professional staff from child protection and health services working earnestly and creatively at the local level to find a sustainable way forward. A lack of critical data hampered each trial at the start-up stage. In hindsight, three of the four trial models and evaluation designs could have benefited from more adequate preparatory research and development, as well as process evaluation during the conduct of the trial. Three of the project teams reported that they had underestimated the scope of systemic change required, particularly for OOHC services and there were unexpected implementation delays as a result. These four Victorian trial initiatives operated for relatively short periods of between one and four years. Only one initiative now has recurrent funding. Some important new knowledge emerged. However questions such as the optimum length of time or scale needed to develop and evaluate a sustainable, state-wide health assessment model for children in statutory OOHC remain unanswered. Thus the health care needs of these children continue to be largely hidden.

¹⁴¹ Victoria, *Protecting Victoria's Vulnerable Children Inquiry* (2012) op. cit.

¹⁴² Victorian Government (2012) *Victoria's Vulnerable Children – Our Shared Responsibility Directions Paper*, Melbourne, Victorian Government.

¹⁴³ The author was an invited member of the Clinical Advisory Group.

Systemic change to support improved health outcomes

In comparison with currently accepted policy and practice standards in England and the U.S. for health needs identification and healthcare services for children in statutory OOHC, the performance of Victorian governments has fallen short. Furthermore Victorian governments have not yet been able to demonstrate how they have met agreed national health-related quality standards for OOHC. Nor is it clear that those standards can be met in the foreseeable future.

Implementing systematic change to better address health needs in statutory OOHC has widespread implications for both the child welfare and health sectors. Whether some of the key pre-requisites for change can be achieved remains untested. Systemic change will partly depend on:

- the willingness and capacity of the child protection services and CSOs to change their systems of care to increase and sustain a focus on individual child health and the health of the cohort of children and young people in statutory OOHC;
- the type of health workforce personnel assigned (and willing to take on) the responsibility for implementation and how they will be financed and supported to incorporate this into their existing workloads, particularly given blended Australian government, state government and private funding systems;
- the costs of designing, developing and delivering workforce training and ongoing support;
- the extent to which medico-legal issues can be effectively and efficiently resolved;
- organisational capacity to further develop and improve inter-operable communication systems between the child protection services, public and private health services and CSOs.

Two key areas of systemic change will be critical to improved health needs identification and health care for children and young people in statutory OOHC. These include changes in health systems including health records systems, health needs assessment systems and continuity of health service provision. Stronger accountability is the second key area for systemic change.

Health systems

There are five important steps in health care that fit together to strengthen support for better health outcomes for children in OOHC:¹⁴⁴

- The first step is to create and maintain a comprehensive, accessible and current individual child health record;
- The second is early screening for health issues and health risks that need quick attention;
- The third step involves more comprehensive health needs assessment, incorporating assessment of the child's development, physical and emotional health, and addressing concerns the child may have about their health.
- Developing and implementing health care plans is the fourth step;
- Fifthly, access to appropriate treatment and therapy is needed, as well as ongoing health monitoring.

Each of these elements is interconnected and important. Changing current systems for child health records in statutory OOHC, for health needs assessment and for assuring continuity of medical care are first building blocks for systemic improvement.

¹⁴⁴ S.M. Webster (2014) *Fostering health: an Australian health policy and systems study of health assessment for children and young people in out-of-home care*. Thesis submitted for degree of Doctor of Philosophy, The University of Melbourne.

Health records systems

Health professionals need and expect high quality child health histories and effective referral to health services from the child protection and child welfare sectors and they cannot provide optimal care if this does not happen.¹⁴⁵ Health professionals rely on the comprehensive child and family medical history so they can properly assess health needs, diagnose the underlying cause of health problems and plan appropriate treatment. A child's maltreatment history also provides valuable information to enable more effective evaluation of children's health and development.¹⁴⁶ Poor continuity of primary health care provider, dislocation from parents and carers and OOHC placement changes can mean comprehensive child and family medical histories are not readily available.

The development of a more complete child and family medical history records system for children and young people in OOHC is a threshold issue for effective systems change. Cross-sectoral fidelity to the recently revised DHS approach (as outlined in the current DHS Child Protection Manual) will be a significant challenge. The development of more effective processes and protocols for the management, storage, and exchange of health records (including health assessments and health plans) between multiple health service providers and across health and child protection sectors is vital. The Australian government's new national electronic health records system promises to provide a first platform for improving health record quality and accessibility.¹⁴⁷

Health Needs Assessment system

Improved knowledge of the nature and extent of children's health needs is the second building block for systems improvement. Multi-disciplinary approaches are favoured for assessing health needs in OOHC. The more contested issues in Australia are about which professional discipline should provide clinical leadership of comprehensive assessment and what clinical knowledge, skills and experience are the minimum to ensure clinical competence in this complex area.¹⁴⁸ At a national symposium on health in OOHC at the University of Melbourne in 2010, the range of views put forward included:

- Only paediatricians have the necessary knowledge to provide clinical leadership, although not all paediatricians have a special interest or the necessary knowledge to provide clinical leadership in this area;
- Any health professional in a lead role requires particular knowledge and skills in effective responses following the trauma of abuse and/or neglect;
- GPs with a special interest could play a lead role given increased knowledge, training and the ready availability of secondary consultation opportunities with paediatricians and psychiatrists.

As described earlier, recent work by medical colleges in England provides useful direction. Working collaboratively, the colleges have developed a competency framework which spans the key medical disciplines of nursing, general practice and paediatrics. The framework supports multi-disciplinary approaches and provides a platform for workforce development and training.¹⁴⁹

Continuity of medical care provision

From a medical professional's perspective, a comprehensive assessment of a child or young person builds gradually over time within a therapeutic relationship. Every encounter, whether for management of current signs and symptoms of illness, for health prevention activities such as

¹⁴⁵ Webster (2014) op. cit.

¹⁴⁶ J.G. Noll & C.E. Shenk (2015) Introduction to the special issue: The physical health consequences of childhood maltreatment – Implications for public health, *Journal of Pediatric Psychology* 35(5), pp. 447-449.

¹⁴⁷ Australian Department of Health (2016) 'My health record', DH website.

¹⁴⁸ Tarren-Sweeney (2010) op. cit.

¹⁴⁹ Royal College of Nursing, Royal College of Paediatrics and Child Health, Royal College of General Practitioners (2015) op. cit.

immunisation, or for comprehensive health checks, provides a further opportunity to assess and respond to the child's ongoing health and development needs. Medical professionals highly value continuity of health care, particularly for children and adults with chronic or complex conditions. A strong policy commitment to continuity of health care provision for children in statutory OOHC is warranted and would provide a third vital building block for systems improvement. Knowledge is continuing to build from international research about the implementation and advantages of each child in OOHC having a 'medical home'.

Moving forward in the 21st century broad health systems development to address the issues described above would ideally:

- Re-assign responsibility for health records, health needs assessment and health care coordination in statutory OOHC to health authorities. This approach has had demonstrable benefits in the U.S. and England. Primary Health Networks, for example, could be contracted to recruit and support interested and appropriate primary health professionals in the same way that CSOs are currently contracted to recruit and support care-givers.¹⁵⁰
- Isolate specific recurrent funds to the child protection and health sectors to undertake the collaborative work involved;
- De-identify and aggregate the data from child health assessments at both regional and state-wide levels on a regular and ongoing basis to inform health service planning and evaluation. Primary Care Networks have potential to play an important role in collecting and managing health needs data for the OOHC population if commissioned to do so.

Accountability

Why has there been such a low level of accountability for the health of children in statutory OOHC in Victoria since 1989? This paper offers five possible explanations although the analysis is by no means exhaustive.

One possible explanation lies in the historical view that most children in statutory OOHC simply required 'good' substitute parenting. Sir Arthur Rylah, the Chief Secretary, in the Second Reading speech for the Social Welfare Bill in 1960 introduced the idea that it would be sufficient for charitable institutions providing statutory OOHC to act 'as a good parent would'. The philosophy was premised on an expectation that the government would help and encourage charitable institutions to take 'the more normal children' while the state would provide 'special facilities for the care and handling of the more difficult children'.¹⁵¹

The 'good parent' philosophy was enshrined in the Children and Young Person's Act which provided in s. 124 that in placing a child in a community service or secure welfare service the Secretary 'must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would'.¹⁵² However by 1992 state-run facilities for statutory OOHC had closed down and CSOs were increasingly asked to accept children with more challenging and complex needs. The 'good parent' principle survived in the Children Youth and Families Act 2005.¹⁵³ A recent review of residential OOHC caused the Victorian Commissioner for Children and Young People

¹⁵⁰ Webster (2015) op. cit.

¹⁵¹ Sir Arthur Rylah, Chief Secretary (1960) 'Second reading speech: Social Welfare Bill 1960' Victorian Parliamentary Debates, Session 1959-60, p. 2393.

¹⁵² Children and Young Persons Act, s. 124.

¹⁵³ *Children Youth and Families Act 2005*.

to seriously question how well this simplistic philosophy is serving children in the 21st century.¹⁵⁴ The Western Australian government recently signalled a move toward a different view, namely:

Providing healing care to children who have experienced trauma is a different kind of parenting that combines compassion with specialised care. It requires a level of knowledge, skill, time and support beyond that of typical parenting...¹⁵⁵

A second explanation for the lack of attention to child health needs in statutory OOHC was the pre-occupation in child protection practice and public policy with how to respond to the significant increase in child maltreatment notifications and protective orders following the introduction of mandatory reporting in 1993. In 1997 there were 3.4 per 1000 children in Victoria on protective orders, growing to 5.2 per 1000 by 2007. By 2013-14 the rate had further increased to 7.2 per 1000.¹⁵⁶

Thirdly, the low level of accountability may have related to perceptions about the boundaries between parent and state responsibilities and the meaning of the responsibility to 'protect'. The Children and Young Persons Act 1989 set out principles for decision making by the Secretary which held that decisions 'must not be more than was sufficient to protect the safety and wellbeing of the child' in the expectation that the legislation's primary goal would be realised, namely family reunification.¹⁵⁷ However reunification was more often than not an unrealised dream. Two-thirds of children entering care in the five years to 2001 had been in care previously and the overall number of children in care had increased by 21 per cent. By 2004 it was recognised that child protection practice had come to regard placement in OOHC as an end to the problem of protecting children. New understandings subsequently emerged about the need to change child protection practice after recognition that children in OOHC continued to have high needs for support for their wellbeing after placement.¹⁵⁸ The introduction of the *Looking-After Children* case records system from 2003 was seen as a panacea.

Fidelity to administrative systems offers a fourth explanation. The early promise of the *Looking-After Children* records system in OOHC has not brought about the sustainable practice changes that were hoped for. The *Victoria's Vulnerable Children Inquiry* was critical of the fact that case recording systems in some CSOs had not kept up with government standards and the quality of case records was variable. The recent audit of a sample of case files in residential OOHC across several CSOS where serious concerns had been raised about the quality of care, found more than 90 per cent of audited files contained no information about the child's health history, health alerts, hospitalisations or dental care. The most essential information about Health Care Card details was missing in 64 per cent of the files. The Commissioner for Children and Young people formed the view that the *Looking-After Children* records system does not appear to have been implemented effectively by CSOs.¹⁵⁹ Performance measurement for accountability requires data. The availability of aggregated data about children's health needs in statutory OOHC rests fundamentally on accurate and up-to-date health needs assessments and case records. Where these have not been available, reporting and analysis were impossible.

¹⁵⁴ Commission for Children and Young People, Victoria (2015) op. cit.

¹⁵⁵ Western Australian Department for Child Protection and Family Support (2015) *OOHC Strategic Directions in Western Australia 2015-2020: Discussion Paper*, Perth, DCPFS, p. 18.

¹⁵⁶ Australian Institute of Health and Welfare (2015) op. cit., p. 41.

¹⁵⁷ Children and Young Person's Act.

¹⁵⁸ Victorian Department of Human Services (2004) *Protecting children: Ten priorities for children's wellbeing and safety in Victoria, Technical Options Paper*, Melbourne: DHS.

¹⁵⁹ Commission for Children and Young People, Victoria (2015) op. cit.

Fifthly, it is reasonable to expect that medical professionals and health systems experts would have been intimately involved in all aspects of systems design for how health needs can best be addressed in statutory OOHC. However, the Children Youth and Families Act 2005 in s 597 only provides that the Minister for Health *may* make arrangements for the provision of any necessary medical, dental, psychiatric psychological or pharmaceutical services to children in OOHC. The Act does not compel to the Minister for Health to assure such provision. The Cummins Inquiry found that the Victorian Department of Health had given insufficient regard to the needs of vulnerable children, among whom those children in statutory OOHC are considered the most vulnerable.

There are examples where DHS has obtained important clinical input for particular projects such as the health needs assessment trials. There have been specific positive initiatives in the Department of Health such as the Chief Psychiatrist's Guideline on priority access for children in statutory OOHC.¹⁶⁰ However there has been little evidence to demonstrate sustained and widespread clinical engagement at an overall strategic level around OOHC systems planning. The present Ministerial Advisory Committee for Children in OOHC provides the most recent example of this omission. By contrast, the South Australian and New South Wales governments have developed whole-of-government approaches which have entailed significant sharing of statutory responsibilities, and allocation of specific health funding by state health departments.

Arguably it has been unreasonable for Victorian governments to have expected child protection services and CSOs to carry the load of accountability for children's health in OOHC when health falls so clearly within the expertise of the health and medical disciplines and the Department of Health. A five year plan for OOHC in 2014 flagged the establishment of an integrated OOHC Health and Education Governance Group, to comprise senior government representatives, the Principal Commissioner for Children and Young People and CSOs.¹⁶¹ This may well have further developed strategic thinking about children's education-related health needs. However the risk has been that broader health needs and health systems issues would not be addressed.

The administrative amalgamation of the Departments of Human Services and Health from 1 January 2015 has yet to realise a profound change in departmental accountability but may do so in the future. Until and unless there is legislative change, Ministerial responsibility remains diffuse. In September 2015 the government announced a fresh review of child protection, including OOHC.

A final factor which may have contributed to poor accountability is the siloed nature of departmental functioning. The devolution of responsibility to DHS regional offices allowed one type of silo effect. In 2010 the Secretary of DHS reflected that the department lacked a robust system for monitoring how it met statutory obligations at a state-wide level and that reporting and accountability were 'very much a regional responsibility'.¹⁶² Siloed records systems have also contributed to poor accountability. Current health records management systems across health and welfare sectors do not share unique child identification codes. Unique identity codes were only introduced in the child protection system in 2014. There has been little evidence of cross-department data-matching which would have enabled analysis of health services demand from children and young people in statutory OOHC. Questions about rates of presentation to Victorian hospital emergency departments, hospital admissions, maternal and child health services, primary care mental health services and drug and alcohol services or receipt of scheduled immunisations have not been answered. This has been both a by-product of, and a contributing factor to, an ongoing lack of accountability.

¹⁶⁰ Department of Health (2011) *Chief Psychiatrist's Guideline: Priority Access for Out-of-Home Care*, Melbourne: DoH.

¹⁶¹ Victorian Government (2014) *Out-of-Home Care: A five year plan, Victoria's Vulnerable Children-Our Shared Responsibility*, Victorian Government.

¹⁶² Victoria Parliament Legislative Council, Standing Committee on Finance and Public Administration (2010) op. cit., p. 48.

Children in statutory OOHC could benefit if regional health service planners were given responsibility for designing local health needs assessment services. Regional approaches could incorporate health workforce training, serious case review processes and clinical care pathways for children with very complex needs. Health service planning and evaluation could be tailored according to the documented health care needs of children in statutory OOHC in the region.

Effective coordination between the health and child protection sectors is challenging. The workforce in both sectors could benefit from a greater appreciation of the extent and nature of health risks faced by these children. Further supports could assist people to grapple more effectively with medico-legal issues such as consent and privacy. Child protection service or CSO staff are often required to give consent for any immediate medical treatment as well as for further medical tests, treatments or referrals. Careful consideration is needed as to how medical consent processes can be made quick and efficient so that doctors can initiate medical treatments and referrals in a timely way for the child.

Both sectors need to give higher priority to systematically addressing health needs and they need reliable data to help them do so.¹⁶³ Responsibility for following up recommendations from a health assessment can be diffuse. OOHC Health Coordinators can be effective in monitoring that important actions are taken for the child's health across both sectors.

Lessons for overcoming these barriers may be drawn from the more sophisticated systems in the U.S. and England.

Conclusions

An historical review of public policy and programs since 1989 clearly indicates that significant changes will be needed if Victorian governments are to halt the repeated criticisms they have faced for failure to address children's health needs in statutory OOHC. In order to bring about such change, the government would need to:

1. Review and revise the underlying philosophy around what constitutes 'good parenting' by the state;
2. Amend legislation in order to strengthen government responsibility and accountability for identifying the health needs of each and every child ordered into statutory OOHC in Victoria;
3. Re-assign responsibility for health needs identification, health care provision and health care planning for children in statutory OOHC to departments or organisations with a skilled health professional workforce;
4. Register all children in statutory OOHC into a single effective, accessible state-wide electronic health records system;
5. Improve the systems for health needs assessment, health data collection and longitudinal health outcomes measurement for children in statutory OOHC
6. Deliver a measurable and managed framework to actively supporting health care continuity for children in statutory OOHC.

Improved health care and health outcomes for this significant group of children are vital. Doctors and other health professionals need additional authority and support from the Victorian government in order to lead health policy and systems development towards this goal.

¹⁶³ Webster & Temple-Smith (2010) op. cit.

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About this publication

The research report was written by Victorian Parliamentary Library Fellow Dr Susan Webster, from the Melbourne Medical School at The University of Melbourne. Dr Webster is an Honorary Research Fellow in the Medical School's Department of General Practice with a strong research interest in health care systems for children in statutory OOHC. In 2015 she was awarded a PhD for the thesis *Fostering Health: An Australian health policy and systems study of health assessment for children and young people in out-of-home care*. She is involved in ongoing collaborative health policy and systems research relating to how health is understood, methods for determining children's health care needs and systems of health care provision.

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