HEALTH CARE OF CHILDREN IN CARE AND PROTECTION SERVICES AUSTRALIA

Position statement

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Contents

About the Royal Australasian College of Physicians (RACP)

The RACP represents almost 30,000 medical specialists and trainees from 33 different specialties, across Australia and Aotearoa New Zealand. The RACP trains, educates, innovates and advocates on behalf of medical physicians and trainee physicians. The RACP represents a broad range of medical specialties and is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the community and the medical profession.

About the Paediatrics and Child Health Division (PCHD)

The PCHD aims to improve the health and wellbeing of neonates, infants and children, as well as adolescents and young adults (known as young people) through education and training, research, and policy and advocacy.
The PCHD advocates on behalf of members and is committed to promoting the study of paediatric medicine by encouraging excellence in skills, expertise and ethical standards. The PCHD promotes the health and wellbeing of neonates, children and young people, with a focus on:

- Health promotion.
- Managing disease relating to growth and development.
- Palliative care.
- Social impacts on health.
- Protection, development and behaviour, and public health.
- The rights of children and young people.

Acknowledgements

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Executive Summary

This Royal Australasian College of Physicians (RACP) position statement considers current evidence and proposes strategies and recommendations to deliver effective health care to children and young people who are at risk of entering out-of-home care, are in out-of-home care, or are in contact with care and protection services across Australia. Recommendations are directed to the Commonwealth and State/Territory Governments, as well as providers/workers involved with children and young people, health and care and protection services, across Australia.

The United Nations Convention on the Rights of the Child (UNCRC) and the Charter on the Rights of Children and Young People in Healthcare Services in Australia recognise that children are entitled to special care and protection and that growing up in family environments is essential for healthy development.[2] Australia supports the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the adherence to these documents. The RACP believe that children have a right to realise their individual, national and cultural identity and should not be separated from their families unless it is in the best interest of the child.[3] If this occurs, the continuity of the child's upbringing, including ethnic, religious, cultural and linguistic background, should be considered when finding suitable alternative care.

Each state in Australia has its own child protection system and legal definitions that relate to a child in need of protection. Most jurisdictions define 'child' as up to the age of 16 years with respect to mandatory reporting and to care and protection services provided. Not all adolescents who are at risk of harm are placed in formal out-of-home care (OOHC), which continues until the age of 18 years, often with transition care plans until the age of 21 years.

Medical practitioners must be aware of the requirements of the jurisdiction in which they work. In Australia, the legislative provisions of when a child needs protection varies in each jurisdiction. The Australian Institute of Family Studies, an Australian Government statutory agency, outlines the legislative definitions of 'a child in need of protection' according to the relevant civil child protection legislation of each Australian jurisdiction. RACP members can read more here or contact their relevant jurisdiction department.

Children "involved with care and protection services" is the broader term that also includes children and young people in statutory OOHC, as well as children and young people who are the subject of an investigation or a notification on a care and protection order.[3] While this position statement refers to

children and young people involved with care and protection services, there should be an acknowledgement of those who 'miss out' on care and protection because they are not placed in OOHC.

OOHC is the term used in Australia to describe care provided for children and young people who are not able to live with their biological parents. This is following intervention by statutory child protection authorities or courts, or an approach to the authorities by parents who can no longer care for their child.[4] Anyone can raise protective concerns about a child, with all Australian States and Territories having mandatory reporting laws in place which require certain persons and/or health professionals to report suspected abuse. Removal from family and placement into OOHC is not undertaken lightly and involves the relevant local courts assessing all reports along with any evidence provided by protective workers.

In 2009, the Australian Government released the National Framework for Protecting Australia's Children 2009-2020 to ensure the safety and wellbeing of children and young people. The National Framework has recently been updated to a 2021-2031 version. As part of the initial National Framework, the Australian Government also introduced National Standards for OOHC[5] in 2011. The intent of the National Standards was to establish a set of measures and indicators that would apply nationally so that children and young people in each State and Territory could expect to receive similar base-level support from the care system in their jurisdiction. Standard 5 specifically states that health issues need to be identified and attended to in a timely manner.

The National Standards were followed in 2011 by the National Clinical Assessment Framework (NCAF)[6] which specifies recommended timeframes, components and outputs for health assessments. The NCAF was developed as part of actions and reforms implemented under the original National Framework. Despite this, the limited data available suggest the NCAF components are not being met.

Health status

Children and young people who are involved with care and protection services have been recognised globally as a highly vulnerable group. It is well established in international literature that children involved in care and protection services have poorer physical [7, 8, 9, 10], mental [11, 12, 13, 14] and developmental[15] health outcomes and increased health needs compared with the general population.[16] These children have poorer health outcomes than their peers in large part due to the adverse effect of neglect, alcohol and substance abuse, family violence and other forms of abuse on neurodevelopment,[17] but also from the effects of disruption to family attachment and structures.[18] The experience of racism in the Australian healthcare system also has a hugely negative impact on mental, physical and cultural health and wellbeing of First Nations children.[19] Intergenerational trauma, the impacts of colonisation and systemic racism continues to cause harm and contributes to the over representation of First Nations children in OOHC.[20]

Inequitable life trajectories start before conception and during pregnancy. Pregnancy, birth and early childhood are critical periods for families, especially mothers and infants. They are times of great opportunity to promote healthy growth, learning and development, as well as to reduce vulnerabilities associated with child protection notifications, including the provision of trauma-informed care.[21] While there is no Australian prevalence data for Fetal Alcohol Spectrum Disorders (FASD) in children and young people in OOHC[22], it is likely to be prevalent in this cohort, however it is often misdiagnosed and mistreated.[23] As part of a health assessment process, skilled paediatricians can properly assess, diagnose and facilitate appropriate treatment in line with the Australian Guide to the diagnosis of FASD.

There is a growing body of literature that illustrates the life-long impact of Adverse Childhood Experiences (ACEs) on chronic disease, health, development, and wellbeing.[24] ACEs are traumatic or stressful experiences that occur during childhood that can have negative and long-lasting impacts on a child's life. These impacts can range from poor physical and mental health issues, to increased likelihood of health risk behaviours[25] and should be screened for. Children and young people in OOHC, and those who experience multiple placements within care, can experience profound trauma, distress and a sense of loss and non-belonging. This in turn can lead to distrust of government and societal institutions, a fear of forming secure healthy relationships, increased behavioural problems, poor academic achievement, encounters with the justice system, chronic physical and mental health problems and poorer health and wellbeing outcomes as adults including higher mortality.[26, 27]

Effective care

There are many barriers in providing effective care to meet the health needs, particularly the developmental and mental health needs, of children and young people who are involved with care and protection services. Importantly, there is no clear evidence that clinical assessment alone provides health improvement and, in many cases, recommendations from clinical assessments are not adhered to

or completed.[28] Fragmentation between sectors and providers can lead to discontinuities in health care and leave children and young people feeling frustrated, uncertain and uninformed.

The reality of changing carers, case managers, care placements and health practitioners, who are all responsible for the health of the young person, means that the voice of children as experts in their own lives is critical and necessary.[29, 30] Upholding the United Nations Convention on the Rights of the Child should be fundamental for policy makers and agencies involved with care and protection services. Incorporating the voices of children and young people in decision making will empower them to transition out of care more effectively and work with agencies to better meet their needs.[31]

Adequate service provision and funding is critical; in particular, improved mental health access and support is also critical.[32] Peak child health bodies around the world agree that children and young people entering care and protection services should have routine and timely assessment of their health needs upon entry, with regular review thereafter, to ensure that outcomes are tracked throughout the child's journey in care and their needs are met.[33, 34] Detection and documentation of this assessment is vital to understanding the health needs of a child or young person, however evaluation and follow-up of children and young people is also required to monitor progress. Early investment in strengthening families provides long-term social and economic benefits by interrupting trajectories that lead to health problems, criminalisation, and child protection intervention.[35]

The right to self-determination for First Nations peoples must be a core feature of the health, care, and protection systems. Self-determination empowers communities through culturally centred approaches of decision making and delivery of local solutions. The National Agreement on Closing the Gap and priority reforms provide the strategic driver through a commitment for governments to share decision-making with and increase in policy development. In the area of care and protection services, it is particularly important to include a collective community focus on child rearing and the importance of elder family members to family functioning.[36]

Principles

- Children and young people involved with care and protection services are to be at the forefront of decision making about their health.
- First Nations communities must have self-determination, participating in decision-making concerning the care and protection of their children and young people.
- First Nations solutions should be embedded at each stage of policy development, service planning, design, implementation, and oversight of programs related to care and protection services.[1]
- Prevention, early support, and family restoration programs are essential to help reduce the number of children and families involved with care and protection services.
- Reunification must be at the centre of care and protection services wherever possible.
- Culturally appropriate support must be prioritised by care and protection services.

Recommendations

Health services:

1. Must appoint a healthcare navigator/coordinator for each child/young person entering or involved with care and protection services:
   a. To collect, compile, and organise medical history.
   b. Guide the child/young person and carer/s through the process of accessing health care.
   c. Help schedule any specialty health care.
   d. Support the establishment of continuity of health care.

   (Note: for First Nations children, this person should be from an Aboriginal and/or Torres Strait Islander background).

2. Must ensure that all children and young people entering or involved with care and protection services have a comprehensive health assessment and health management plan (*Note: see the Australian National Clinical Assessment Framework*).

   - These health management plans must be reviewed annually, or at least at significant milestones, by the healthcare navigator/coordinator.

   - The healthcare navigator/coordinator must ensure these health management plans are shared with the child's/young person's family/carers and healthcare team. (*Note: medical information should only be shared with the child/young person's family/carers where it is in the best interest of the child/young person's health, wellbeing and does not interfere with statutory orders in place*).

3. Must ensure health professionals providing health assessments and treatment of children and young people involved with care and protection services are adequately trained:
   a. In trauma-informed assessment and care of children and young people and refer for appropriate and timely therapeutic interventions.
   b. To recognise the uniqueness of each child/young person and avoid negative stereotyping.
   c. In issues surrounding identity, gender identity and sexual orientation to ensure care facilitates the wellbeing of the child/young person and provides a safe space for discussions.
   d. To provide holistic health care that acknowledges child and family models of health needs and the importance of strengths-based holistic wellbeing conversations to support mental health.
   e. To recognise the unique needs of children and young people from First Nations and culturally and linguistically diverse (CALD) communities and provide culturally appropriate therapeutic services.
   f. In substance use disorders and provide support to carer/s affected by these.

4. Must ensure that there are clear and defined processes for obtaining consent and maintaining privacy and confidentiality for children and young people involved with care and protection services.

5. Must ensure health professionals are aware of local provisions for other assessments for children involved with care and protection services and advocate for children and young people to be referred to these, e.g. speech pathology, occupational therapy, dietetics, social work etc.

6. Must ensure the voices of care-experienced children and young people, their carer/s are well represented in research examining their health and the impact of health care services.[1] *(Recommendation 4, pg 78, Kennedy N.)*

Care and protection service providers:

7. Must:
    a. Be culturally safe and provide trauma-informed care.
    b. Consider the need for relational, emotional, and mental health support for carer/s, alongside court processes, to support safe access and reunification.
    c. Ensure adequate supervision and specialist mental health support services are in place to support their care and protection workers.

8. Must ensure care and protection workers are adequately trained in:
    a. Documentation that utilises appropriate language, and the way events are captured are sensitive and empathetic.
    b. How to appropriately communicate and engage with children and young people, and extra care is taken to ensure privacy and confidentiality when communicating personal aspects of these children and young people.
    c. Engaging the carer/s of the child or young person in the child's ongoing health planning where possible.
    d. Supporting young people transitioning out of care to access free or low-cost health care.
    e. Navigating the disability system.

Both the Australian Government and State/Territory Governments:

9. Must develop health and care and protection services with First Nations communities, supporting and investing in the strengths of First Nations peoples to lead on child wellbeing, development, and safety responses for First Nations children.

10. Must commit to and invest in prevention, early intervention, and support programs to reduce the number of children and carer/s involved with care and protection services and the risk of statutory intervention.

11. Must commit to and invest in First Nations community-led providers for comprehensive proactive support that address the needs of First Nations children and their carer/s.

12. Must appoint Aboriginal and Torres Strait Islander Children's Commissioner roles in each jurisdiction.[1] *(Recommendation 1, pg 77, Kennedy N.)*
    - The Commissioner's must review existing policies, programs and services in their jurisdiction to ensure the promotion and continued improvement of cultural safety and equity of access to health and care and protection services for First Nations children, young people and their carer/s.
13. Must invest in specialised multidisciplinary services for vulnerable children and young people to deliver integrated primary health, specialist, and mental health care using the principles of integrated care, including through First Nations Organisations and community hubs.[1] *(Recommendation 4, pg 78, Kennedy N.)*
14. Must commit to and invest in services in rural and regional areas and for families with mental health issues and substance use disorders, including pregnancy education and support.
15. Must implement a nationally consistent framework for young people leaving care up to the age of 21 years to ensure they have access to the health and services they need, including mental health outreach and substance use support programs.
16. Must commit to, and invest in, Target 12 under Closing the Gap, which aims to reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45% by 2031.
17. Must provide adequate financial assistance and other supports to young people leaving care to meet their living and housing needs.

The Australian Government:

18. Must implement a nationally consistent and equal approach to payment and support services for both foster carers and kinship carers to support equitable access to health care and support services.
19. Must develop a framework that includes national health indicators to measure and evaluate interventions for the health and wellbeing of children and young people in the care and protection system, with annual reporting on these indicators to be undertaken by the Australian National Children's Commissioner.[1]
20. Must develop a reporting framework that specifically addresses the health needs of First Nations children and young people involved with care and protection services. This information should be included in annual reports on child protection provided by the Australian Institute of Health and Welfare.[1] *(Recommendation 3, pg 77, Kennedy N.)*
21. Must develop specific Medicare item numbers for initial comprehensive and follow-up health assessments delivered by health care workers for children and young people in care and protection services.
22. Must commit to and invest in implementation of the National Clinical Assessment Framework in all jurisdictions to strengthen government responsibility and accountability for identifying the

health needs of every child and young person involved with care and protection services, including those transitioning from care to independence.

- This should be co-designed with children, young people, carers and service providers with a special focus on the needs of multicultural communities and the Aboriginal community-controlled sector.[1] *(Recommendation 2, pg 77, Kennedy N.)*

23. Must commit to and invest in full implementation of the Safe and Supported National Framework for Protecting Australia's Children 2021-31.

The State/Territory Governments:

24. Must implement a systems-approach to prioritise access to health care for children and young people involved with care and protection services.

25. Must explore and implement a single and easily transferable health care record system that can be shared with health professionals and those who care for the child/young person. This record system should interact with the Australian Government's My Health record system.

26. Must ensure mandatory reporting of Standard 5 of the National Standards for OOHC in their jurisdiction to address health inequity for children and young people involved with care and protection services.

27. Must undertake a training needs analysis to understand the current and potential gaps in care and protection service providers/workers knowledge and capability in recording of data and system usage. This should be used to inform development of jurisdiction training programs.

28. Must commit to and invest in adequate training programs and support services for foster carers and kinship carers.

Glossary of terms

ACCHOs	Aboriginal Community Controlled Health Organisations
ACEs	Adverse Childhood Experiences
CALD	Culturally and Linguistically Diverse communities
CAMHS	Child and Adolescent Mental Health Services
Children involved with care and protection services	In Australia this includes children and young people who are the subject/s of an investigation or a notification on a care and protection order and/or in statutory out-of-home care.[3]
Cultural care plan	Also known as a cultural support plan. An individualised, dynamic written plan or a support agreement that aims to develop or maintain children or young people's cultural identity through connection to family, community and culture.[37]
Culturally safe care	Provision of care that is safe for Aboriginal and Torres Strait Islander people. This means there is no assault, challenge or denial of their identity and experience. Cultural safety is about shared respect, shared meaning and shared knowledge.[38]
DLD	Developmental Language Disorder
ECEC	Early Childhood Education and Care
FASD	Fetal Alcohol Spectrum Disorder
First Nations	The RACP acknowledges the strength and diversity of First Nations peoples. The term First Nations will be used respectfully throughout to refer to both Aboriginal peoples and Torres Strait Islander peoples.
Foster care/households	Foster carer households are private households containing one or more foster carers who have received authorisation from the relevant department or agency to enable a child to be placed in their care.[39]
GP	General Practitioner
Health management plan	An individualised, comprehensive health record that documents a person's comprehensive health history,

	identified health needs, relevant referrals and a schedule of future assessments or therapy/treatment.[40]
Kinship care	The carer is a family member or a person with a pre-existing relationship to the child/young person. A First Nations Kinship carer is a person with a biological bloodline and/or cultural connection to the child. Consideration of who is kin to a child is also the decision and responsibility of family and those with cultural authority for the child.[41]
NCAF	National Clinical Assessment Framework
NDIS	National Disability Insurance Scheme
OOHC	Out-of-home care. Court ordered statutory care. This is the term used in Australia to describe care provided for children and young people (aged up to 18 years) who are not able to live in the family home. Living arrangements include foster care, relative or kinship care, family group homes, residential care and independent living.[4]
Residential care	Residential care is round-the-clock care provided by a group of qualified workers, who are paid to support the safety and wellbeing of the children and young people in a 2-, 3- or 4-bedroom home.[4]
Self-determination	Self-determination is an 'ongoing process of choice' to ensure that First Nations communities can meet their social, cultural and economic needs. It involves practices and processes that incorporate not only self-governance and shared decision making, but also rights to express and pass on culture, language, and relationships with Country.[42]
Trauma informed care	A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.[43]

Children and young people involved with care and protection services

Most children and young people who enter care and protection services do so because they are deemed to be at risk of significant harm because of potential exposure to family violence, child abuse and/or neglect. In Australia, rates of children admitted to OOHC are highest for children under one year of age[3] (refer to Figure 1 below) with many parents of children and young people who enter care living with multiple, complex issues that research shows commonly co-occur and compound.[44]
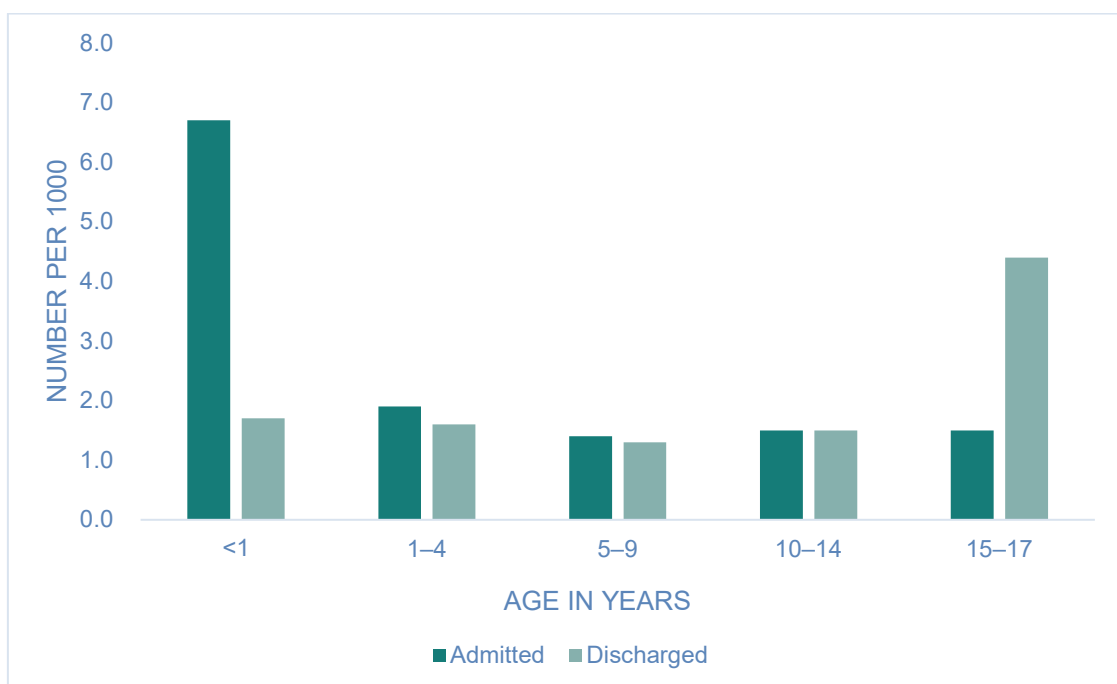

Figure 1: Children admitted to, and discharged from, out-of-home care, by age group, 2021–22 Australia.
Source AIHW Child Protection Australia 2021-22

Within Australia, 3% of all children aged 0-17 years have contact with care and protection services each year.[3] Where a claim of abuse or neglect is substantiated, emotional abuse is the most common, followed by neglect, physical abuse and sexual abuse.[3] Children from very remote areas in Australia are almost four times as likely as those from major cities to be the subject of a child protection notification.[3]

In 2019, the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability heard that, on average, 12% of children in OOHC were reported as having a disability.[45] Data from 2021–22 on disability status was only available for 71% of children in OOHC, as at 30 June 2022. Of these children, about 29% were reported as having a disability.[3] As the data available does not accurately reflect the disability status of children in OOHC, it is difficult to adequately plan and support the health needs of children in OOHC.

Young people with experience with care and protection services are also more likely to parent young and have children removed. Having a child removed has been linked to the exacerbation of housing instability, interpersonal violence, excessive alcohol and drug taking, mental health issues, the entering of unhealthy intimate relationships, and repeat pregnancy.[44]

Children and young people from culturally and linguistically diverse (CALD) communities can face greater challenges when navigating the health system, particularly those who are unaccompanied minors seeking asylum, or are deemed refugees. Low proficiency in the English language can also isolate people from CALD backgrounds from accessing necessary and appropriate services.[46] Health, care and protection services must be aware of the cultural differences that can act as barriers to access and should use interpreter services to communicate appropriately with these community groups.

First Nations children

In Australia, First Nations children and young people are at a significantly greater risk of entering the care and protection system than non-Indigenous children (refer to Figure 2 below). Evidence indicates that First Nations children are eleven times more likely than non-Indigenous children to be placed in OOHC and this inequality begins in infancy.[47, 48] There are a wide range of intergenerational impacts that underpin this, including colonisation.[49]

The number of First Nations children entering the care and protection system has been increasing across every State and Territory in Australia. In 2020-21, First Nations children were 5.5 times more

likely than non-Indigenous children to be reported to child protection authorities, 10.2 times more likely to be subject to a child protection order, and 10.4 times more likely to be in OOHC (including on permanent care orders).[20]

Evidence also shows that First Nations children are less likely (14.8% compared to 20.6% respectively) than non-Indigenous children to be reunified with their birth families.[50] In 2020-21 only about 16% of First Nations children for whom reunification was a possibility, were restored to their family home.[51]
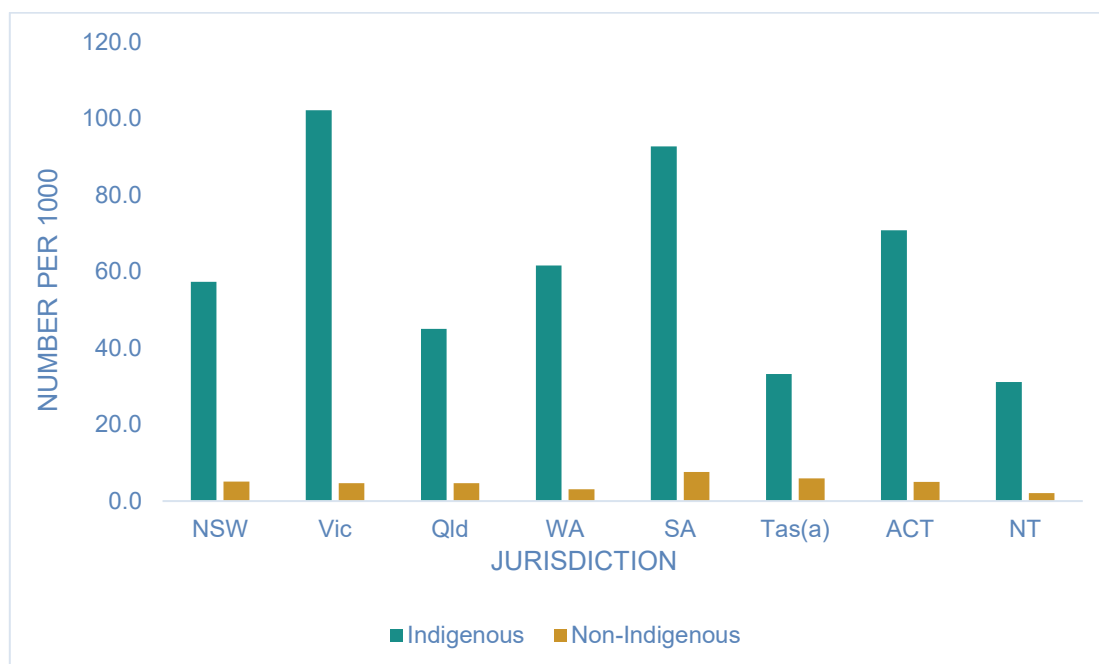

Figure 2: Children in out-of-home care, by Indigenous status and state/territory, 30 June 2022 Australia. Source AIHW Child Protection Australia 2021-22

There are a wide range of intergenerational impacts that underpin this including:

- Systemic and institutional racism,
- Intergenerational trauma,
- Poverty and socioeconomic disadvantage, and
- Lack of access to safe and stable housing.

The cultural strengths of First Nations child-rearing practices contribute to creating safe and nurturing environments for children.[52] But despite these strengths and the committed effort of most First Nations peoples to care for children, First Nations communities experience entrenched disadvantage that requires a whole of community and society response to redress the issues.[50]

The views of care experienced by children and young people

The United Nations Convention on the Rights of the Child recognises that children and young people have the right to express their views and have the opportunity to be heard in decisions affecting them. Young people need to be at the centre of decision making. Institutions and policy makers that have an open dialogue with young people can create meaningful change through the development of new processes and shifting of attitudes.[53]

The CREATE Foundation in Australia found many children and young people in care report feeling safe and secure in their placement, however placement type is a factor affecting their experience in care.[54] Those children and young people in residential care reported feeling less supported and less satisfied than those in home-based care. Respondents from residential care also reported difficulties in obtaining freedom to socialise, accessing health services and were less likely to have a say in their placement.[31] This disparity in experience highlights the need for equitable access and opportunities for all children and young people in care and greater synergy between residential and home-based care. Data strongly indicates that children and young people living in home-based care have better developmental outcomes than those living in residential care with paid, rostered staff.[51]

Shared decision making

Children and young people repeatedly cite participation in decision making as a core part of their wellbeing and experience in care.[55] Despite this, many report feeling unprepared for changes in placement and not included in decisions affecting them.[31] Consultation with children and young people in care identified key needs such as improved communication with carers, improved family contact processes, increased assistance in transitioning to independence, enhanced cultural support and fewer

placement changes.[31] Being provided with the space and time to respond to questions and have tailored communication options (phone call/written responses) facilitates effective conversations and decision making.[56]

> *"[It would help] to say one question and give me time to actually respond and not just keep going over the top of you"* [56]

Interaction with health professionals

Children and young people have identified the importance of health professionals having a clear understanding of trauma and appropriate questioning about family and parents.[57] This extends to health professionals paying attention to visual stimuli, understanding the connection between body and emotions, and recognising the potential impact of the physical presence of professionals and family members. Specialist trauma informed counselling and support to develop coping strategies including self-soothing by connecting with nature, art and music, and letting off steam have been highlighted as helpful tools.[57] Health professionals can provide training to caregivers on how to best support the mental health and health needs of young people who have experienced trauma and need support, care and treatment.

The importance of communicating directly with children and young people in a respectful and developmentally appropriate way is critical. Having continuity in care will also help with engagement and feelings of safety. Health care should include sexual health support and education. Avoiding negative stereotyping, being mindful of cultural and spiritual needs and being mindful of the environment and context of conversations is also important. All caregivers and health professionals involved with children and young people need to be trained in issues surrounding identity, gender identity and sexual orientation to ensure care facilitates wellbeing and provides a safe space for discussions. Young people have the growing autonomy to give consent to their own medical treatment, be afforded confidential health care and be given full access to health information and care regarding sexual and reproductive health.

The Australian Research Alliance for Children and Youth (ARACY) have developed The Common Approach, a prevention-focused and flexible way of working to help health professionals have quality interactions with young people and their families that emphasises the importance of regular, informal, preventative, strengths-based holistic wellbeing conversations.

Health status of children and young people

Children and young people in OOHC are more likely to have chronic health problems such as abnormal vision, hearing loss, speech difficulty and emotional or behavioural problems.[16, 58, 59] Children and young people in OOHC also commonly experience greater rates of physical health concerns such as asthma, eczema and constipation,[16, 58] and 17-32% of children in OOHC are behind on important immunisations.[58, 59] Mental health concerns are also evident in children across Australia, with up to 62% of children in OOHC experiencing mental health concerns.[58, 60, 61] Lack of routine health checks along with undiagnosed and/or untreated health conditions are more common in this group of young people. Improved health care is an important defence to help reduce these poor outcomes and break the cycle of health and social disadvantage.

Children and young people in OOHC often present with complex psychopathology related to exposure to perinatal risk including FASD (e.g. maternal drug and alcohol use during pregnancy) and ACEs including insecure, disorganised and disrupted attachment relationships, and the cumulative effects of childhood maltreatment, including exposure to trauma, as well as prior experiences with carers. Australian and international studies show a high prevalence of emotional and behavioural disorders in children in OOHC care. Up to 60% of Australian children in OOHC are identified as having developmental concerns, including developmental delays,[13, 49] and 48-61% are diagnosed with behaviour problems.[49, 62] Developmental delays are also common, including speech and language delays/disorders, cognitive development and gross and fine motor skill development.[59, 63]

What effective provision of care should look like

Health care service requirements

The health status of children and young people entering care and protection services highlights the needs for equitable, holistic and culturally safe health care services to meet their needs. In Australia, about 46,200 children aged 0-17 years were in OOHC, as at 30 June 2021, with 31,400 of those children (68%) having been in OOHC for 2 years or more.[64] For children and young people to receive adequate health care, health services must be available and easily accessed. In Australia, there are significant gaps in the mental health system with some communities such as rural, regional and remote communities lacking available services.[65] There are also often poor linkages between health services, primary care/general practitioners (GPs), specialist services (e.g. paediatricians, psychologists, psychiatrists) and First Nations health services.

Both the care and protection and health systems can be complex to navigate, especially concurrently. Barriers have frequently been reported at every step involved in accessing health care, including receiving necessary paperwork, such as child Medicare numbers or eligibility;[66] obtaining past medical history, including immunisation records; lack of clarity around roles, responsibilities and authorisation of adults and agencies involved;[67, 68] gaining appropriate authorisation or consent for health care; insufficient availability of services;[69] bureaucratic delays, and the challenges of navigating complicated health and disability systems such as the NDIS.[67, 70] Radical change is needed within services and systems and between sectors to deliver the health care that children and young people involved with care and protection services need at the right time and in the right place.

Institutional racism is also present in the health system and leads to a systemic failure of health services in Australia to meet the health needs of First Nations children.[71] Institutional racism can be present even when measures have been taken to address and eliminate interpersonal racism.[67] It has an impact on the way health care is delivered, resulting in First Nations peoples receiving both less, and lower quality, health care.[71] Institutional racism must be acknowledged and addressed in the health system and cultural safety training undertaken regularly by staff. Health professionals and health services must understand differences in culture, address their own personal cognitive bias and build relationships with First Nations communities to build cultural safety.[71] The cultural determinants of health provide many of the solutions for First Nations health equity and should be embraced within the health system. This must include increased investment in First Nations led place-based health initiatives and supporting and building the First Nations health workforce. Embedding First Nations holistic definitions of health and wellbeing and cultural expression in health service delivery is also critical.

Having a 'Medical Home' with a team of specialised multidisciplinary health professionals ensures continuity of care and helps build relationships.[1] Health professionals must also be adequately trained;

having clinical and support staff sharing core training is one option to provide consistent care.[1] Effective health care also involves the comprehensive assessment and gathering of all information, including from family and carers, and ensuring all information moves with the child/young person. Regardless of a change of location or placement, the child/young person's health care information must be easily accessible and transfer with them.

Primary health care

GPs are trained to recognise and respond to a range of health challenges, to triage effectively, and to initiate appropriate referrals within local service systems. As such, the capacity of general practice/primary care to offer continuity of health care is pivotal in changing health trajectories in this population group.[72]

The 2011 Australian National Clinical Assessment Framework for Children and Young People in Out-of-Home Care highlights GP participation as fundamental to establishing continuity of care for these children and young people.[73] A consistent health professional who is familiar with the child/young person, their family/carers and their medical and social history, is important to promote a trusting relationship and to improve adherence with health care. A strong consistent relationship also helps the health professional to identify changes in the child/young person. Health professionals and health care coordinators should facilitate timely completion of health care recommendations and ensure completion of primary health checks. Support should also continue beyond reunification with family.

While GPs are best placed to assess, triage, manage and coordinate care, they need to be supported to do so. This includes consideration of specific MBS items but also strengthening pathways and communication with other health professionals, particularly acute care and other specialists.

Developmental needs

Significant numbers of children in care have undiagnosed, unrecognised, or untreated, developmental delays and/or disability.[74] These children need timely assessment and referral for therapy/treatment.[75] Such therapy/treatment needs to be appropriately funded to attract qualified, trained, and experienced health professionals. There is a lack of services available, particularly for those living in rural or remote areas, or who are no longer eligible for early intervention services. Early identification of learning delay/disability is integral to a child receiving adequate support at home and school, as well as ongoing assessment over time as level of impairment, type of impairment and needs change as the child develops. Increasing demands for services, cost of early childhood education and care (ECEC) and lack of learning support officers means some children are not receiving the support they need in their early learning and schooling years. Many carers may underestimate the health needs of a child or young person in care therefore, training is required to ensure carers can identify issues early and seek appropriate help.[76]

Developmental Language Disorder (DLD) is also common amongst children and young people in care. A study looking at the literacy, language and communication abilities of young people leaving care found that 90% of the care leavers' language abilities were below average and over 60% met the criteria for DLD.[77] Incorporating speech pathologists in the health assessment and management plan for a child/young person can improve identification rates and enable appropriate care to be provided. Additionally, investment in universal access to quality ECEC can have long-lasting impacts on learning, behaviour, and health.[78] Part of this investment needs to include building the capability of ECEC educators to respond to children in trauma-informed ways.

Children with trauma exposure often present with neurodevelopmental diagnostic challenges due to the overlap of behaviours.[79] Additionally, many developmental and mental health conditions will evolve over time, which is why health surveillance is important to be ongoing, not only at the point of entry into care.[6] Children involved with care and protection services not only need access to early intervention support, but they also need timely access to comprehensive interdisciplinary/multidisciplinary diagnostic/developmental services.[10] Resourcing for these services is already stretched with inappropriately long waiting times, with a study indicating the average wait time from parents first noticing concerns to receiving an assessment was 3.5 years.[80] There is a critical need to improve and fund access to developmental and diagnostic assessment and therapy, audiology, speech-language therapy, and primary and secondary paediatric mental health services, especially for vulnerable families.

Mental health

Health professionals need to appropriately manage the complex trauma, disrupted attachment histories, and behavioural and mental health issues of children and young people involved with care and protection services. The disruptions experienced by a child as part of a placement process can often

compound pre-existing conditions.[81] Children with FASD present with higher rates of mental health comorbidities compared to the general population[23] and it is important that health professionals understand this comorbidity on assessment and with ongoing health care.

Evidence suggests children and young people in OOHC are almost five times more likely to display suicidal behaviour than peers with no OOHC involvement.[82] As such, there is a clear need for evidence-informed services and interventions to enhance children and young people's mental wellbeing. Children involved with care and protection services need special attention and priority access to comprehensive health and developmental assessments, as well as multidisciplinary mental health care that can address their complex health, psychosocial and developmental needs within the context of their placement and the care and protection system.[76] A shortage of mental health professionals highlights the need for partnerships between multidisciplinary healthcare providers and child and adolescent mental health services (CAMHS), as well as schools and the education sector, to help form a network of care and support for children, young people and their families/carers. There must be adequate CAMHS service provision to meet population needs, including mental health therapy to address trauma.

Areas for improvement

Nine areas have been identified for improvement, noting that these have been identified in the current context of the care and protection system in Australia:

1. Health assessment and management plans, with appropriate follow-up
2. Culturally safe care
3. Trauma informed care
4. Prevention and early engagement with support services
5. Transitioning out of care
6. Integrated care and accessible health care records
7. Accountability, acknowledging State/Territory and National variations
8. Reporting, data and research
9. Care and protection system and care and protection workers

Efficient and effective implementation of solutions will require collaboration with relevant sectors, including the health sector, as well as all levels of government, and other related agencies to devote resources to enhance delivery of care, such as telehealth.

The RACP recognises that at present there are shortfalls in resources, particularly in remote and rural locations. The RACP calls on the Australian Governments to implement early intervention policies and strengths-based models of care that aim to keep families together and commit to ensuring that health needs of this cohort of children and young people are assessed and addressed in a timely manner.

1. Health assessment and management plans, with appropriate follow-up

Health assessments

When children enter care and protection services for the first time, details of their medical and family medical history, along with an intuitive parental appreciation of the child's health and wellbeing, may be unavailable. An initial health assessment should therefore build a complete picture (social, emotional, educational, physical, and developmental) of the needs of the child to ensure access to the right services as early as possible. Differentiating between FASD and other disorders is also important. The initial health assessment should be completed by a paediatrician but may be completed by another health professional depending on local resources. With many children entering care and protection services before the age of 1 year, there must be emphasis on long-term follow up to ensure that emerging health issues are identified early and managed appropriately.

In 2021-22, 42.5% of Australian children in OOHC had been in OOHC for 5 years or more[3] (refer to Figure 3 below). Implementing a health assessment annually, or at critical stages of development, will ensure that ongoing health needs of children in care are met. The National Clinical Assessment Framework (NCAF) provides a good framework for the initial assessment.
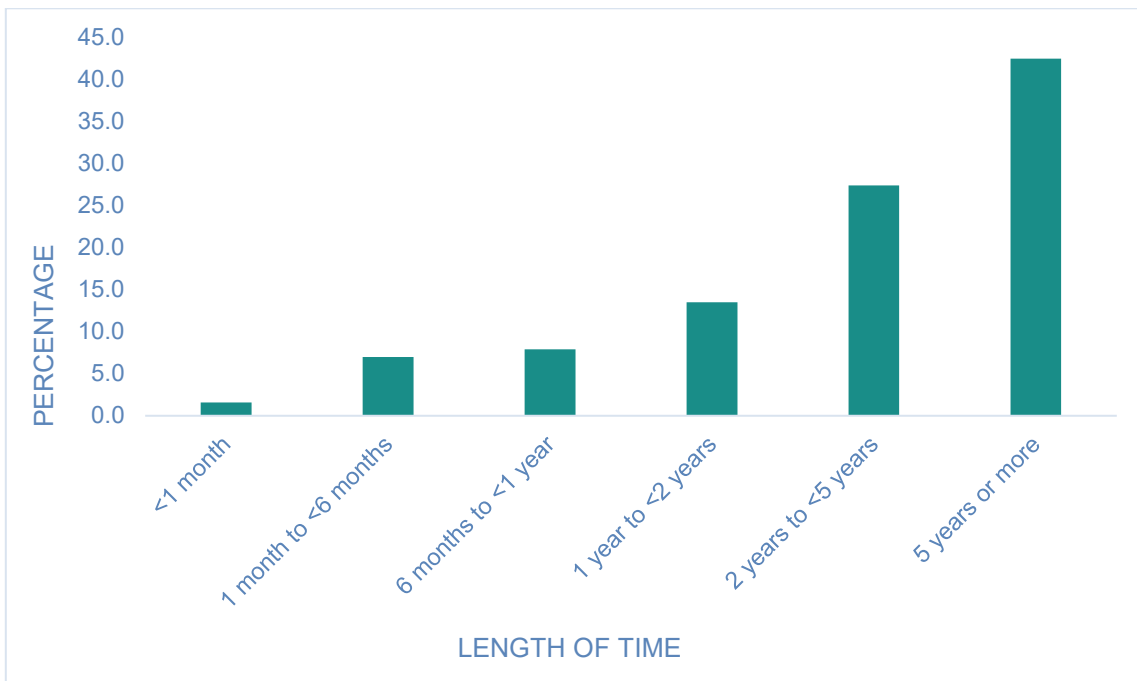

Figure 3: children in out-of-home care, by length of time continuously in care, 30 June 2022 Australia
Source AIHW Child Protection Australia 2021-22

The NCAF recommends:

1. A **Preliminary Health Check** should be commenced as soon as possible and ideally no later than 30 days after entry to OOHC to determine areas of immediate concern.
2. A **Comprehensive Health and Developmental Assessment** should be completed within 3 months of placement.
3. **Further specific assessments and management**, following the Preliminary Health Check and/or the Comprehensive Health and Developmental Assessment, where additional screening may be undertaken in accordance with the needs of the individual child or young person on a case-by-case basis.
   - **General health assessment**: including a health history of the child and family, physical examination, growth assessment, vision, hearing and dental screening, and an immunisation register check.
   - **Developmental assessment**: incorporating standardised screening tools (e.g. Ages and Stages Questionnaires, ASQ Trak, Griffiths, Bayley's or Brigance), as an adjunct to clinical assessment, and access to formalised assessment.
   - **Mental health screening**: using accessible and validated tools (e.g. Strengths and Difficulties Questionnaire, Achenbach Child Behaviour Checklist (CBCL) and Teacher's Report Form (TRF) or Conners Assessment Forms). Infants and toddlers must be assessed for attachment disorders.
   - **715 Health Assessment:** for First Nations Peoples.
4. Development of a **Health Management Plan**, including a personal health record. The Health Management Plan should be integrated with other management plans (e.g. educational plans, cultural care plans) into a single management plan for the child or young person.
5. **Follow-up monitoring** in accordance with the clinical needs of individuals to ensure that existing issues are being appropriately addressed and new and emerging issues are identified and addressed.
6. **Case coordination**. There will be a nominated officer/position with the role of Care Coordinator Health. This role could be provided by the statutory authority case officer or a healthcare case manager and should be responsible for ensuring required health and development assessments occur, referrals to specialist services are made, and that there is continuity of information and services following placement change. Ideally this is done with some co-location of health professionals with the statutory authority to facilitate cross-sector collaboration.

Although the NCAF recommends appropriate assessments and practice, this has not been implemented consistently across the country. States and Territories are responsible for implementation and Australia has limited data on the timeliness of health care service utilisation.[83] An analysis of children and young people entering care in Victoria showed that a minority of children are accessing health care services according to National and State standards, with very few accessing in a timely manner.[83]

The Out of Home Care Health Pathway Program in New South Wales aims to assess children within 30 days of entering care, with six-month checks with children under five years of age, and annual checks for older children. Resourcing can impact the success of these assessments taking place though.

In 2021, the Australian Government released Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031. This builds on the previous framework and sets out the next 10-year strategy to improve the lives of children, young people and families who are experiencing disadvantage or who are vulnerable to neglect and abuse. The Framework was developed with First Nations peoples and will be delivered by 2- and 5-year action plans and will align with other national initiatives.
(Note: *At the time of writing this document, it is not yet known if the Standards and NCAF will be updated or superseded*).

Health management plans

A health management plan is an individualised, comprehensive health record that documents the child or young person's comprehensive health history, identified health needs, relevant referrals and a schedule of future assessments or therapy/treatment.[6] Carers and children should be provided with information about the child's health and be involved in planning processes about their care in a contextually appropriate manner in accordance with the child's age, capacity, and level of development.[32] Health management plans must be reviewed regularly to ensure that they remain relevant to current needs.[6] The information must also then be provided to carers and the health care team.

The development of more effective processes and protocols for the management, storage, exchange and confidentiality of health care records, including health assessments and health management plans, between multiple health service providers and across health and care and protection services is vital.[84] In this way, treatment can become better directed and modified as needed, while also providing young people with more opportunities to inform and contribute to their own care. The factors that contribute to children entering care and protection services are often directly related to family/carers ability to ensure that the health needs of the child are met.[35] Children reunified with their families are therefore at risk of disengaging with the healthcare system. It is essential that a child's/young person's health management plan and information is shared with their family/carers and ongoing support is in place.

Healthcare navigators/coordinators can improve health outcomes, health literacy and access to health services for children and young people in care. Health navigators coordinate health and developmental assessments for children in care, ensure referrals are made to appropriate health services, and coordinate health professionals. This can help ease the burden on the young person[85] –

> "*You don't have to reiterate your experiences, it's more encouraging and it's less traumatising. I've had old support workers contact on my behalf and take me to new services, it makes such a difference.*" [85]

The RACP strongly supports the role of healthcare navigators/coordinators and the important role they have improving health experience and outcomes for children and young people. Where health system navigation is difficult, having appropriate system navigators in place will assist with the delivery of appropriate health care. Employing dedicated First Nations healthcare navigators who can act as cultural brokers within the health system would ensure children and families have access to culturally safe support.

2. Culturally safe care

For First Nations children, young people, and their families, it is essential that all services are culturally safe and that upholding the right to self-determination is a core feature of any system. A culturally appropriate health service is one which considers language(s), beliefs, gender, and kinship systems; delivers care in a manner which respects these factors; is free of discrimination and racism and takes account of the need for trauma-informed care.[86, 87]

Data sovereignty and recognition of the kinship structure within community is critical for First Nations populations. All levels of Government must financially recognise kinship care along with the importance of sharing of information with carers to benefit the health care of a First Nations child.

Many of the strengths of traditional First Nations family life and child-rearing practices are supported by evidence that could be applied in cross-cultural settings, including collective community approaches to raising children, issues of child autonomy and independence, the contributions of elderly family members in family and community life and the role of spirituality in family functioning.[20] Investment is needed in research and targeted interventions that support First Nations families to use and reclaim child-rearing practices that may have been lost due to cultural disruption and suppression.

All children and young people should be cared for by extended family, or within close geographic proximity to their family, to maintain connection to their culture.[20] Children and young people have the right to access a Cultural Care Plan that includes connection to language, culture and family members –

*"**I want to find out if I have a cultural support plan so I can get help finding more info about my culture and where my family was from**."* [31]

Indigenous-led solutions are showing the way in providing high quality care for children. In Queensland and Victoria, Aboriginal family-led decision making is proven to improve decision making processes and keep significant numbers of children with their families. The Northern Territory and Queensland have Kinship programs that aim to keep children connected to family, community and culture.[20] Understanding how culture can help to deliver positive outcomes for children and young people may also help service providers in their work with non-Indigenous families.[52]

There must be a demonstrable commitment to supporting meaningful partnerships between Governments and First Nations peoples and communities. Governments should take steps to ensure that the quality, culturally safe services required to realise these rights are accessible and available to all First Nations families. For example, the South Australian and the Australian Capital Territory governments have established independent Aboriginal and Torres Strait Islander Children's Commissioner roles with stronger powers to conduct inquiries, provide advice, monitoring and advocacy for First Nations children. These roles should be established in all jurisdictions.

3. Trauma informed care

There is a lack of services available for children and young people who have experienced trauma, especially in rural and remote areas, and a lack of understanding of the impact of trauma amongst health professionals, educators, and carers.[88] When entering care, children and young people go through their own unique cycle of grief.[89] Children are often unable to express their grief verbally and tend to show their feelings and thoughts by their behaviour.[90] The way they express themselves will vary enormously depending on their age and stage of development.

Exposure to trauma is also common in children who have been placed in care, and the effects of this trauma can be severe and long lasting. Brain development can be impaired, insecure attachments can result and self-destructive behaviours can develop.[91, 92] Trauma-related outcomes reported in children and young people in the OOHC system are also key risk factors for suicidal behaviours, with evidence suggesting that children and young people in OOHC are five times more likely to display suicidal behaviour than peers with no OOHC involvement.[82]

In Victoria, it was found that 74% of young people had not offended before being placed in OOHC. Over half (61%) of the young people who experienced residential care and who offended committed their first offence either during or after their first residential care placement.[93]

Children and young people report the importance of acknowledging the trauma they have experienced –

"There just needs to be an understanding that this is a child who has experienced things that most people will not experience for most of their life." [32]

Consequently, trauma-informed policies and services are needed, along with trauma-specific care, ideally early in life, before the emergence of consequences such as poor performance at school, risky behaviours, mental illness, and teenage pregnancy occur.[94]

Trauma-informed services respond to the impact of trauma on children and adults, families and communities. Values and principles of trauma-informed services can include awareness of trauma impacts, person-centred safety, cultural competency, cultural safety, enabling an individual's control, enabling healing, and providing integrated care.[86] Paediatricians and health professionals should understand and be comfortable working in trauma-informed models of care.[71] Appropriate education and training must also be provided to all health professionals working with children and young people, including identifying and appropriately responding to the signs of child abuse and neglect.
Health services must also recognise the potential to retraumatise children and young people in care and be equipped to ensure safety. This can be via training for health professionals to reduce racism and discrimination and acknowledging biases. Although the development of trauma-informed services is critical, children and young people who are survivors of trauma also require individual therapeutic care. There is no single way to provide such care. Documented experience suggests that approaches informed by First Nations culture shows promise for supporting healing and recovery.[94]

In New South Wales, the KARI Aboriginal Multi-disciplinary Assessment Clinic aims to improve the health and wellbeing outcomes for Aboriginal children, young people and adults engaged in KARI Programs. The service has been expanded to provide individual assessment and therapy, group therapy through playgroups, and school readiness programs, as well as carer education and training. In addition, the clinic focuses on trauma-informed practice, cultural connectedness, and community capacity building. A review of children in KARI care, who had remained in stable care, found that cultural engagement appeared to be a major factor in Aboriginal children's positive developmental health and wellbeing; supporting the need for trauma-informed and culturally embedded therapy and supports, individualised for each child in care.[95]

In Queensland, New South Wales and Victoria, The Pyjama Foundation runs a trauma-informed program that carefully matches a child in OOHC with a dedicated mentor. Currently the program is supporting more than 1,000 children nationally. On average, these mentors, often referred to as Pyjama Angels, remain in the child's life for an extended period and become a "significant adult" in the child's world. These mentors meet the unique needs of the child, and build a relationship that remains, if possible, through movement in care arrangements. In a study undertaken by the CREATE Foundation in 2021, many young people identified their Pyjama Angel as a "significant adult" in their life.[54] In the report it concluded that it was critical for the positive life outcomes of young people transitioning out of care to be able to both identify and have a thoughtful dialogue with a significant adult in their lives.

4. Prevention and early engagement with support services

Research has highlighted the importance of a prevention approach to health care and how this can help families alleviate the pressure on the care and protection system.[96] There are several factors that place stress on the family such as poverty, poor housing, poor mental health, disability, substance abuse, intimate partner violence, or children with high needs.[97] Early, specialist support that is culturally appropriate and meaningful can support families and prevent the need for formal care and protection services.[98]

Structural barriers and disparities in accessing preventative support services also contributes to the number of children involved with the care and protection system. For example, many children experience homelessness as an outcome of family violence.[99] The lack of family support services means there is limited scope for at-risk parents to get the support they need to build safe and resilient families for their children.[50]

Early support for mothers is crucial in changing future health outcomes. Currently there are inconsistencies between State/Territory mandatory reporting requirements in relation to the safety of unborn children.[100] It is essential that early preventative supports are available to women where there is a reasonable likelihood that following birth a child will be at risk of abuse, neglect or death due to actions of the mother or a person with whom the mother resides in order to improve health outcomes of children and reduce the risk of statutory intervention.[101] Children are at high risk of maltreatment if their mother experienced harm as a child.[102] Assisting survivors of childhood maltreatment provides a crucial opportunity to help prevent further child abuse and neglect.[94] Children who have been abused are also at greater risk of entering the youth justice system. In Australia, 53% of those under youth justice supervision in 2020–21 interacted with the child protection system in the last 5 years with almost 30% the subject of a substantiated notification for abuse and neglect.[103]

There is also a lack of drug and alcohol residential treatment facilities for women with children, which means that children are at risk of being removed from their parents and placed in care.[104] Parents sometimes leave treatment programs early or do not attend due to their fear of the impact on the wellbeing of their children.[104] Research shows there are benefits with programs that allow dependent children to remain with their mother during treatment.[105]

There are also a significant number of children that "fall through the gaps" as they do not meet requirements for acute mental health services but would benefit from mental health input. There needs to be a focus on early/preventative support prior to children and young people reaching crisis. Often children with "behavioural difficulties" are not referred to mental health services and therefore there is little support offered for these children. There may also be a disconnect between paediatricians and

psychiatrists and greater collaboration may be helpful.[106] A comprehensive health assessment should be completed when a child/young person is in first contact with a community service. This would provide support at an earlier point with early identification and referral and may help prevent ongoing mental health issues.

In Australia, historical trauma, and unconscious bias impact the health of First Nations families. Aboriginal Community Controlled Health Organisations (ACCHO)-led support services are alternate referral pathways to assist families in meeting their needs. These organisations can work with service providers and families to address challenges in a culturally safe environment.[50]

First Nations women are less likely to access antenatal care in their first trimester or avoid accessing care due to distrust and fear of non-Indigenous services, and experiences of institutional racism.[20] Existing First Nations-led maternal support programs have proven that empowering mothers to make informed choices has resulted in significant and sustained improvements in maternal and infant outcomes.[107] The Birthing in our Community (BiOC) Program is an example of a culturally responsive model achieving outstanding results for First Nations mothers and infants. The program integrates midwifery services of the Mater Mothers' Hospital with the cultural knowledge of the Institute for Urban Indigenous Health and Aboriginal and Torres Strait Islander Health Service Brisbane. Through the program First Nations mothers access a culturally sensitive wrap around support team from early pregnancy to six weeks post-birth. An evaluation study found the program reduced participant rates of pre-term births.[108]

5. Transitioning out of care

The transition from adolescence to adulthood is a significant social and developmental stage, as well as a period of substantial brain development.[109] Young people leaving the care system are more vulnerable and face this transition without the same social support systems or family safety-nets as their peers. [110] Stability of care and emotional security during time in care are significant predictors of young people's outcomes.[110]

The absence of careful planning and ongoing support post-care can contribute to poor outcomes experienced by many care leavers, particularly for those with chronic health conditions. Sadly, many young people who leave the care system experience homelessness and mental health struggles.[111] Through a post-care survey, the CREATE Foundation found that 17% of young people were homeless on leaving care and 46% were entirely dependent on Centrelink.[54] Young people have reported feeling confused with the leaving process, next steps, and lack of access to financial support. One young person stated:

> "*There is no clear pathway to leave care. There is no possible way to plan a secure, safe exit from care [when] you have no idea where you're going until your birthday!*" [54]

Young people leaving the care system have reported a range of different health setbacks when accessing appropriate health services, such as lacking official identification or medical documents that are required to access health services, or having to organise health care appointments on their own with little help or knowledge.[30] Many often struggle to obtain a full record of their own medical history, which can interfere with obtaining appropriate health care in adult life, highlighting further the need for comprehensive health care records that travel with the child/young person.

Improving health literacy skills can empower young people to be actively involved in their health, health care and the health system, resulting in better health outcomes.[112] Young people have expressed a need for assistance with finding suitable services to meet their health needs,[54] including access to affordable medications and dental health services. Health professionals can provide information to young people prior to leaving care and begin conversations early to better equip the person for leaving the care system. A transition checklist that ensures the young person is provided all information and documentation they need well before leaving care would be useful. Additionally, a young people leaving care must have their language, literacy and communication needs identified and appropriately supported.

To overcome such barriers, the United Kingdom has implemented a strong cross-departmental strategy to improve outcomes for young people leaving care. The 'care leaver strategy' includes measures spanning health, education, employment, financial support, housing, and the justice system.[113] Australia could implement a similar strategy.

A 2020 inquiry by the Victorian Commission for Children and Young People in Australia found that nearly all the young people covered by the Commission's in-depth file review, who did not have stable housing at the time they left care, had a suspected or diagnosed intellectual disability. [114] The report also found almost half of the young people who left care between 2006 and 2014, were admitted to hospital with acute mental health problems and one-quarter were involved in the youth justice system.[114]

Age of leaving care

Research suggests that the leaving care transition period needs to be flexible, gradual and well planned. Planning and preparation for transition should begin at age 15 years, not a short time before the young person is due to leave the care system.[115] For First Nations young people, this transition should have a strong focus on supports to build a connection to culture and community during and after care. Many young people identified the need for ongoing support past 18 years of age:

> *"When young people turn 18, [the department] should still be supporting the young person, as they transfer from foster care/refuge, etc., into independent living."* [54]

Young people with experience in the care and protection system are more likely to parent young with fertility rates among young people in, or leaving care, higher than the general population.[55] Many young mothers report feeling a sense of pride and purpose with motherhood, however transitioning out of care and managing adult responsibilities can place additional stressors on the young parent. Extending the age of leaving care and working with the young person to identify supports required can reduce these pressures.[54] Existing supports in place for the young parent must continue with holistic and ongoing programs implemented to ensure that parents maintain independence and security.[55]

Programs in the United Kingdom and the United States of America found that giving young people the option to stay in care until the age of 21 found participants were twice as likely to be in full-time education at age 19 years,[116] and had improved housing and employment outcomes.[117] These young people were also less likely to be involved in the criminal justice system or have children at an early age.[118] As of November 2022, all Australian jurisdictions have extended care to age 21 years in some form. However, a nationally consistent approach is required with clear, accessible information on support provided to each young person.[119]

6. Integrated care and accessible health care records

Integrated care aims to deliver care that is person-centred, provided by a multidisciplinary team and connects parts of the health system that can be difficult to navigate.[120] Successful integrated care is founded on a set of values and principles that focus on collaboration, transparency, coordination and shared responsibility and accountability.[121] Integrated care is particularly important for children involved with care and protection services who often require support from professionals from a wide range of services. Once health assessments have taken place, children in care should receive the highest priority in access to health services to achieve better outcomes in their health, education and wellbeing.

Systemic barriers to integrated care that may impact the care of children and young people involved with care and protection services include the division of funding structure associated with place of delivery service, the need for innovative and flexible funding and care delivery models that incorporate blended funding, disparate clinical governance and compliance arrangements, referral arrangements that are not fit for multidisciplinary care, as well as workforce pressures.

Telehealth/virtual care is a key component of integrated care and can significantly improve accessibility and quality of health care for children and young people in the care and protection system, particularly for children/young people living in rural and remote areas. It is important to ensure children and their carers have access to appropriate information and communication technology (ICT) that allows them to participate in telehealth/virtual care appointments.

Protocols for information collection and sharing must recognise confidentiality issues and comply with the relevant jurisdictional privacy legislation. However, change of placement, caseworker, primary health practitioner and/or school contributes to poor communication and difficulties with information transfer. Children and young people have reported that their right to privacy and confidentiality had not been respected –

> *"I might have disclosed something to someone who have said they would keep it confidential… and then a couple of days later, someone from the care team comes up and said, 'I heard you said this.*" [32]

In the case of foster carers, issues sometimes arise regarding what health care information they are entitled to access regarding a child/young person. This may be due to confidentiality and privacy reasons, but also, they may not be the listed next-of-kin, person responsible, or Guardian. This contributes to difficulties with health care decision-making, particularly if the young person is unable to provide informed consent.

Ensuring young children have the best possible start to life requires children and families to have equitable access to quality services and supports. One solution increasingly recognised around the world is to ensure that health professionals are aware of existing services and build connections between these services to meet the diverse needs of families. This approach is gaining momentum around Australia with models of care being developed that aim to integrate variations of health, education, social care (including legal and financial), and social support within co-located child and family-focused hubs. [122]

The location of these hubs should be planned with a place-based approach, taking into consideration the unique context of the community.

ACCHOs have been established in Australia from the 1970s to address not only access to health, but to provide holistic, culturally safe care to First Nations communities. In many ways, ACCHOs have pioneered integrated care in Australia. However, because of jurisdictional gaps in funding, few ACCHOs are funded to provide the comprehensive, specialist care that reflects the health needs of the First Nations population.[1]

A South Australian initiative, *Investing in their future,* provides a framework for children in care to receive improved access, or a dedicated service response, to a range of culturally appropriate services and initiatives to assist them in reaching their full potential, such as health and dental services, therapeutic support, learning and education, recreational activities and support for transitioning to independence.[123]


7. Accountability, acknowledging State/Territory and National variations

There is no formalised national leadership in Australia with accountability to improve the health and wellbeing of children involved with care and protection services and no way to measure compliance and ensure children receive the health care they need. The RACP therefore strongly supports the role of the National Children's Commissioner in Australia. This role is vital in upholding the rights to health, safety and wellbeing of all children and young people. The Commissioner can provide national oversight and direction on child protection matters and report on outcomes and most importantly, be a champion for children and young people. The Commissioner should be given powers to make adequate national and jurisdictional regulatory and legislative changes to effectively assign responsibility and assure accountability for the monitoring of health needs and receipt of health care for children and young people involved with care and protection services.

However, there also needs to be adequate national and jurisdiction regulatory and legislative changes to effectively assign responsibility and assure accountability for the monitoring of health needs and receipt of health care for children and young people in care. There also needs to be appropriate responsibility and accountability for the collection and analysis of health needs data to assess longitudinal health outcomes and to properly inform policy. A review in Australia criticised the dependency on community support organisations to provide health care coordination for children involved with care and protection services, instead of through appropriately resourced health services.[124]

There is often a high level of mobility and transience for children and young people in the care and protection system and they are vulnerable to falling between the cracks. There needs to be a robust state-wide service, with electronic health care records, where information can be easily transferred, or maintained, so children and young people can receive the health care they need, even if they move location. For example, mental health service boundaries can mean children have to change service if they move, which is extremely disruptive to their continuity of care, and if they move between jurisdictions, it is difficult to transfer between services. Services must meet a state-wide standard with national oversight to ensure consistent and seamless service delivery.

The Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031 is intended to facilitate compliance by the States and Territories with the National Standards for OOHC . This is largely influenced by existing community-based paediatric services, the partnerships between statutory bodies, community service organisations and health services. However, implementation and resourcing of the National Standards for OOHC is largely left to the States and Territories which has resulted in considerable state-by-state variation in services for children in the care and protection system.[1] The National Framework is not supported by specific Medicare rebates, or other specific Commonwealth funding.[1] There is no publicly available data reporting on compliance with Standard 5 (health issues need to be identified and attended to in a timely manner),[83, 125] meaning there is no way to measure compliance and ensure children receive the health care they need.
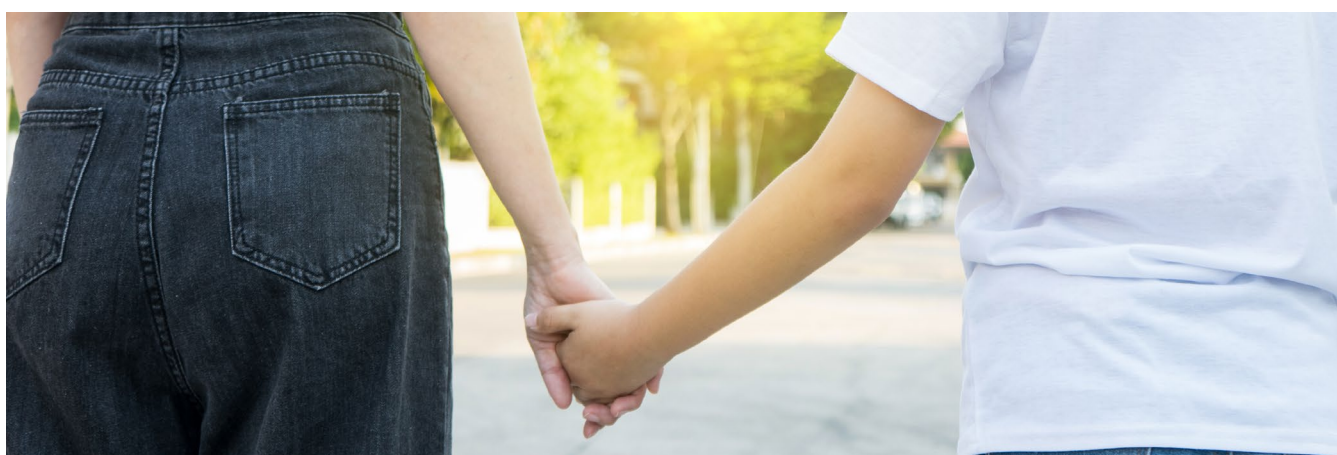
8. Reporting, data and research

The current system relies on blunt instruments to indicate success. These instruments include access to accommodation and access to education/training. There are no measures to reflect what a child needs to be as close to the 'norm' as is possible and it does not reflect current knowledge regarding trauma and healing. If a scientific approach is taken, success should be measured against physical and psychological (emotional/cognitive) development norms. Measurement of progress of this cohort of young people should be against national standards/expectations of the general population.

To better respond to the health needs of children involved with care and protection services, more accurate and publicly available disaggregated data is required to provide an in-depth understanding of their background, demographics, experiences and outcomes. Lack of compliance with government data quality standards, data controls and workload stressors by jurisdictions impact the ability to capture accurate and timely information.[126] Strengthened focus on the collection and recording of data by case workers would improve understanding of the intellectual and physical needs and any risks of children in care. Improvements are also required in recording regional and site level data to support better decision making for frontline staff.[127]

Despite growing recognition of the importance of listening to the voices of children and young people, the voices of care-experienced young people, as well as their carers and families, are not well represented in research examining their health. The inclusion of these voices in health research and the provision of services is a vital part of understanding and subsequently addressing possible barriers children face to improving their health outcomes.[30]

It is generally accepted that children with a disability are over-represented within the care and protection system. Little research has been conducted to identify the prevalence of children with a disability within OOHC. Child protection authorities do not apply a uniform definition of disability and do not routinely capture information about a child's experience of disability within data collection frameworks.[126]

In Australia, there is limited data to enable ready comparison across jurisdictions.[83] Accurate measurement of performance against the National Standards, both within and between jurisdictions, is dependent on the collection of consistent and comparable information of data items across jurisdictions. There has been little evidence of cross-department data-matching, which would have enabled analysis of health service demand from children and young people in statutory OOHC.[128] While the Australian Institute of Health and Welfare provides some national data on care and protection services this is reliant on jurisdictions accurately recording and providing the information and it includes no data on health care or health service use. Care and Protection workers must be provided trained to improve knowledge and capability in recording of data and system usage.

A review of the Victorian Department of Families, Fairness and Housing data system found that adequate controls were not in place to ensure data is of high quality.[126] Incomplete, inaccurate and inconsistent data may be preventing the Department from using the data to monitor children's progress in OOHC.

In New South Wales, data collection is via the Ministry of Health and the Out of Home Coordinators in each of the Local Health Districts. Data is collected and shared but relies on the Coordinators being advised when a child moves to a different health area.

9. Care and protection system and care and protection workers

It is essential that those involved with care and protection services are well informed of their roles and responsibilities and protocols in place, with reunification being the primary service goal. With many children and young people more likely to share concerns and needs with their carer, it is essential that adequate training is provided, and supportive and clear processes are in place for all involved.

Carers have an important role in facilitating health care but also face logistical difficulties such as transport, time spent at appointments, meeting with care and protection service workers, and even more so for carers with multiple children in their care. Mental health services are often needed but also often the most difficult to arrange, along with paediatric services.[66] Children and carers in kinship care arrangements often have less financial support, less training in health needs and less institutional support. It is reported that First Nations carers often experience many of the same challenges as non-Indigenous carers; however, these were sometimes compounded by limited financial resources, living

remotely, experiences of systemic racism and workers in the OOHC workforce exhibiting a lack of culturally safe practices.[129]

The safety of children in care is paramount. Sadly, abuse in care is not uncommon. In Australia, 1,200 children were the subject of substantiation of abuse in care in 2021-22.[20] It is essential that carers are appropriately trained, assessed, and monitored on an ongoing basis to ensure the safety of children and young people in their care. Following a survey of foster and kinship carers in New South Wales, it was found that 40% received no information or training related to caring for a baby and only 33% received information on developmental trauma.[130]

Care and Protection workers are regularly exposed to stressors and experiences that can impact their mental health, such as trauma from exposure to child abuse and death, hostile treatment from child and/or carers and organisational stress from increased overtime hours and lack of support for complex cases.[131] Adequate supervision, appropriate case load and clear support pathways must be in place to ensure that workers don't experience burn out or experience mental health impacts.

An audit into the Victorian child protection system found that unreasonable workloads had created workplace stressors that were harming the mental health of Child Protection Practitioners.[131] Workplace stress was a key cause of staff turnover and WorkCover mental injury claims and payments.

Along with improved access to mental health supports, for those working within the system, consistent trauma-informed training and accessible work health and safety and legal support is required. An adequate case load for social workers is also imperative so that staff are not over capacity and are able to deliver effective care. Services must also be flexible and provide different options to suit the child's needs.[76]

Structural reform and transformation at the systems level is needed to enable the First Nations community-controlled sector to design and deliver programs to improve the cultural safety and responsiveness of the child protection continuum. Cultural competence training for all people involved in care and protection services is crucial for the ongoing support of First Nations families with children and young people in care. All health professionals and carers must have adequate cultural safety training and effectively communicate the health needs of the child and young person across multiple services and platforms. The impact of complex factors such as exposure to family violence, drug and alcohol-related issues and chronic undiagnosed and untreated mental health issues contributes to the disparity of First Nations children in care. Limited understanding of these impacts can perpetuate the removal of children and limit the reunification of those that are placed in the care and protection system.

Where to from here?

The RACP supports full implementation of the Safe and Supported National Framework for Protecting Australia's Children 2021-31. The Framework is to be delivered by 2- and 5-year action plans with a clear focus on family, community, and culture, increased early supports that extend beyond child protection services, focus on healing trauma for families and communities and community-led approaches to prevention and early intervention.[132]

The Keeping Kids Safe and Well: Your Voices 2021 report released by the National Children's Commissioner will inform the action plan of the Safe and Supported Framework. Listening and responding to children/young people and their views is a key aspect of the report. Ensuring children and young people have a voice in policy development and are in the centre of decision making when determining their care is vital.

Reunification must be at the centre of care and protection, and it is essential that early and culturally appropriate support is prioritised by all levels of government. Understanding the strengths of family and community, and working with First Nations communities to build relationships, will foster positive decision making and ensure family and communities are leading change.

People with care experience consistently express the importance of connection to culture. Where possible, First Nations children are to be placed with extended family, kin or broader First Nations community.

> *"There needs to be a greater focus on the government to look at different ways children are supported to remain at home, particularly for First Nations children through better family finding and exploration of kinship options."* [85]

Self-determination must also be at the core of care and protection. It is not enough to consult with First Nations communities; decision-making must lie with First Nations families, organisations, and communities. In Australia, embedding the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) will strengthen the connection of children and young people to their community, culture and country. As such, service development and provision should be led by First Nations health organisations.[85] The ACHHO sector is crucial in delivering effective, culturally safe care and must have long-term secure funding to continue to grow maintain capacity.[133]

The RACP recognises the incredible strength and resilience of so many children, young people and carers who are, or have been, involved with care and protection services.

Protecting children and young people is everybody's business and requires a whole system, government, and community approach to ensure that our children are well cared for and achieving their potential. Harnessing the strengths of family, cultural identity and shifting our policies and systems to be family- and person-centred and responsive to the child/or young person's needs is the key to success and change.

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