Submission to the Commissioner for Children and Young People:

Monitoring OOHC—'Being healthy'

November 2018

The Mental Health Council of Tasmania (MHCT) is a member-based peak body. We represent and promote the interests of community-managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian.

TasCOSS is the peak body for the community services sector in Tasmania. Our membership includes individuals and organisations active in the provision of community services to low-income Tasmanians living in vulnerable and disadvantaged circumstances. Through our advocacy and policy development, we draw attention to the causes of poverty and disadvantage and promote the adoption of effective solutions to address these issues.

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Introduction

Thank you for the opportunity to make a submission in relation to the Out of Home Care Monitoring Program's 2018-19 focus area "Being healthy: preventative strategies, health care services and health outcomes for children and young people in out-of-home care in Tasmania."

The mental and physical health of young people in out-of-home care (OOHC) is critical to their overall well-being. Young people in OOHC typically experience worse mental and physical health outcomes than their peers. This can often be attributed to adverse experiences prior to or during OOHC, insufficient mental health and wellbeing support in care and the on-going impact of exiting OOHC. With the third highest rate of children in OOHC in Australia (9.3 per 1000, only exceeded by the Northern Territory at 11.6 per 1000 and NSW at 10.4 per 1000), Tasmania has a responsibility to ensure that children and young people in OOHC experience the highest standard of care available.[1]

The submissions and advocacy of both MHCT and TasCOSS are strongly informed by the expertise of our members and the lived experiences of the Tasmanians we represent. To inform this submission, MHCT and TasCOSS consulted with member organisations who are familiar with the experiences of children and young people in OOHC, including Life Without Barriers, Kennerley, Catholic Care Tasmania, the Create Foundation, Family Planning Tasmania, and Fostering Hope; with carers, through Fostering Hope; and with a Youth Ambassador for young people in OOHC. These member organisations are at the coalface with children and young people in OOHC and understand the daily impact that mental and physical health issues have on their lives.

While our consultations were organised around the questions proposed by the Interim Commissioner, this submission is organised around our main analytic findings, with additional detail in Appendices A, B and C.

[1] Child Family Community Australia (2018) Children in Care. CFCA Resource Sheet, https://aifs.gov.au/cfca/publications/children-care

Key Issues & Recommendations

Key issues identified through our research and by participants in consultations are:

Tasmania is not consistently assessing or following up on the health of children in OOHC to the standards set out in national frameworks.

Tasmania has a Charter of Rights for Children and Young People in OOHC (The Charter) that stipulates that all children and young people have the right to receive health care when needed, including having a comprehensive health check when they first enter care.[2] This can be completed at either the Royal Hobart Hospital Paediatric Outpatient Clinic (in the south of the state) or by a GP convenient to the carer.[3] In contrast to The National Standards (Appendix C), no targeted timelines appear to exist in The Charter. Participants raised concerns in consultations that in practice this process is often subject to lengthy delays, with some children going up to 12 months without a paediatric assessment. Barriers include:

- Delays in obtaining a Medicare card. During the wait for a Medicare card to be issued, carers may have to pay for medical appointments up front and/or may be unable to apply for benefits.[4]
- Lengthy waitlists at public facilities, which are the child safety system's preferred providers. According to Oral Health Services Tasmania, waiting times for initial dental assessments, while sometimes as little as one week, can extend out to 6 weeks during the busy end-of-year period.[5] While we were unable to obtain current waiting times from the Royal Hobart Hospitals' Out-of-Home Care Clinic, we note that the clinic is held only one day a week from 9:30 to 1 pm.[6]
- Lack or unaffordability of private services, for which (as non-preferred providers) reimbursement may not be available.
- Organisational/departmental responsibility for initiating and coordinating health checks, often resulting in missed appointments, and delayed access to immunisation and allergy records. For adolescents entering care who do not have access to state paediatric services, baselines can be especially difficult to establish.

The delayed access to a comprehensive health check means it can be difficult to organise specialist care for underlying hereditary issues and other disorders. Even though at times a child's extra needs may be apparent to providers and carers, delays in accessing an assessment for a diagnosis can result in inadequate care and support, which can in turn lead to a placement break down. Consequently,

[2] CCYP (nd) Charter of Rights for Children and Young People in Out-of-Home Care. http://www.childcomm.tas.gov.au/wp-content/uploads/2015/06/SmallKidsDemo21.pdf

[3] FKAT Handbook 2018 p. 76. Public hospital assessments do not appear to be available in Launceston or the North West.

[4] FKAT Handbook 2018, p. 36.

[5] Personal communications, Oral Health Services Tasmania facilities in the south, north and northwest of the state, 16 November 2018.

[6] http://outpatients.tas.gov.au/clinics/paediatric_out_of_home_care_clinic

participants stated, providers often end up paying for private consultations to address the issues, without receiving reimbursement.

> "The policy is clear, but the practice isn't."

Recommendation 1: The Tasmanian OOHC system should meet the guidelines for assessment and ongoing management as set out in the National Clinical Assessment Framework and include them in key performance indicators for health services.

The Tasmanian out-of-home care assessment and support system is insufficiently focused on psychosocial and emotional health issues and trauma, particularly complex developmental trauma.

Australia-wide, children in care experience significantly poorer mental health outcomes than children who have never been in care,[7] in many instances stemming from an underlying, and sometimes hidden, history of trauma in the form of physical, sexual or emotional abuse or neglect. The most common health conditions impacting children and young people in OOHC reported by consultation participants were anxiety, depression and anger; poor or no self-regulation; high levels of self-damaging behaviours in the form of self-harm or suicide attempts; eating disorders and unhealthy relationships with food (anorexia, bulimia, binge eating); problem sexualised behavior; Fetal Alcohol Spectrum Disorder (FASD) and the impacts of ice; and developmental delays, particularly emotional (see Appendix B). The National Standards stipulate that the initial health assessment for all children and young people entering OOHC includes psychosocial and mental health assessments, however those we consulted with advised that these assessments are not always comprehensive and nor are they always conducted.

Furthermore, the requirement for a formal mental health diagnosis – which can be hindered by age, waitlists, clinical observation time (typically 4 to 6 months) and lack of available services – before children and young people can access specialist mental health supports and funding can leave children and carers without access to much-needed support for years. Participants suggested that the system should begin with the assumption that every child has experienced trauma, and respond accordingly. This would ensure that all children receive immediate support to address past trauma, as well as to support the often-traumatic transition into OOHC. Early assessment and support for trauma can also help support stable placements, which in turn are associated with better mental health outcomes for children and young people in care.[8]

> "There must be an assumption that all kids come with a trauma background and that they need psychological care as a matter of priority and urgency without an official diagnosis."

[7] https://aifs.gov.au/cfca/publications/outcomes-children-and-young-people-care; https://www.mja.com.au/system/files/issues/206_10/10.5694mja16.00864_adjusted.pdf

[8] https://aifs.gov.au/cfca/publications/outcomes-children-and-young-people-care

Participants in consultations also said that trauma-informed health practice in Tasmania is not as widespread as it needs to be. Many health services, in particular dentistry and immunisation, can be triggering for young people who have experienced trauma, meaning that a 'soft entry' into services is required (necessitating additional time and money for providers). Participants recommended that all government-preferred providers receive education and training around the complexities facing young people in OOHC – and ideally this trauma-informed approach would extend to all health services in the state.

> "One young girl needed three trips to the dentist just to sit in the chair and talk before she felt able to return for the fourth visit to receive actual treatment and care."

Some participants also said that carers need more training around particular trauma-related mental health issues, such as problem sexualised behaviours.

Recommendation 2: Proactive, wraparound therapeutic support for children in OOHC, particularly around complex trauma, should begin immediately and only be removed when it is assessed the support is no longer needed.

Recommendation 3: All preferred provider services should be supported to receive training in trauma-informed care, and carers should be supported to receive additional trauma-related training as required.

Children in OOHC can face long waits for health care.

While there are many excellent health care services in the state, participants said that the overall picture in the state is characterised by:

- *Long waitlists*. For example, the indicative waiting time for paediatric developmental behavior appointments in the south of the state, all of which are classified as non-urgent, is 126 days; the indicative wait for non-urgent paediatric appointments in the north-west is 270 days, with no figures available for the north.[9] The wait for urgent paediatric ear, nose and throat cases in the south, meanwhile, is 356 days, with non-urgent cases waiting 1063 days.[10]

- *Lack of services or support programs at regional or local level.* Participants noted that while the south of the state is relatively well-served, the north has fewer services and the north west fewer still—concerns also expressed in other submissions to this review. For example, the north west lacks services that can address FASD/ice impacts. And not all schools choose to offer general information and support programs such as Family Planning Tasmania's Growing Up Program or Relationships and Sexuality Education.[11]

[9] http://outpatients.tas.gov.au/clinicians/wait_times/wait_times
http://outpatients.tas.gov.au/clinics/paediatric_out_of_home_care_clinic

[10] http://outpatients.tas.gov.au/clinicians/wait_times/wait_times
http://outpatients.tas.gov.au/clinics/paediatric_out_of_home_care_clinic

[11] Family Planning Tasmania, submission to "Being healthy," November 2018.

- *Services in flux*. For example, the Early Childhood Intervention Service is reportedly reforming their intake processes due to a restructure and the impact of the NDIS.

- *Inconsistencies and gaps in eligibility across support services.* For example, participants said, eligibility criteria differs between mental health service providers.

- *Lack of priority for children and young people in OOHC*. Participants observed that external service providers often appear to believe that, because children and young people in OOHC are under the care of the state, separate services will or should exist for them and that they "aren't our responsibility."

The National Standards stipulate 30 days as the required timeframe for children and young people to access health checks. This reflects research that shows the benefits of early screening and intervention for children and young people who have experienced trauma, particularly complex developmental trauma, on their future wellness trajectories and those of their carers. Many felt that where lengthy waitlists exist for public assessment services, it is crucial that the preferred provider system extends beyond government services in order to give children and young people entering OOHC the best opportunity to thrive.

> "They are already so far behind—they should be prioritised."

Recommendation 4: Children in OOHC should receive priority status for healthcare.

Evaluation and research dedicated to effective models of care.

Participants identified that physical and mental health services that come to the home, along with holistic approaches to mental and physical health, have been particularly effective for children and young people in OOHC and their carers. Mobile health services, particularly mental health services, were also recognised as particularly valuable for children and young people in OOHC and the families supporting them. The South Australian Government, for example, has accepted in principle a recommendation to develop a mobile outreach service for children and young people in OOHC.[12] Additionally, participants identified "hub type" approaches that can provide wrap-around support for physical and psychological services for parents, carers and children and young people alike.

Recommendation 5: Focus research on proven models of care for the OOHC system and how they can be applied.

[12] https://www.childprotection.sa.gov.au/sites/g/files/net916/f/a-fresh-start.pdf

Empowerment of children and young people in OOHC is crucial to their mental health.

The Tasmanian Charter of Rights stipulates that all children and young people in OOHC have the right to be consulted and listened to about decisions that affect them, including:

- Being told why they are in out-of-home care.
- Being told what plans have been put in place for their future.
- Having a say in what those plans are and what sort of support will be given to them.
- Having a say about decisions affecting them such as where they go to school, what clothes they wear, who their friends are and how they spend their time.[13]

Participants advised these principles are not always being put into practice. The Youth Ambassador at the consultation emphasised that uncertainty and lack of information provoke feelings of powerlessness and anxiety in children and young people, and that it is possible to have truthful, child-friendly conversations about difficult issues.

> "We come from uncertainty and the lies lead to more uncertainty and poor mental health."

All participants agreed that children and young people should be brought into decision-making, from day-to-day decisions about their care through interactive case and care plans, to overall child safety policy. A few participants, meanwhile, observed that communication silos within the OOHC system, as well as within the health system and other government departments, makes it hard for children's and young people's voices to be heard across the system. This problem is reportedly exacerbated by a focus on obtaining quantitative data for monitoring and evaluation, with only limited opportunities for qualitative assessments of well-being.

The National Standards acknowledge that participation is meaningful when a child or young person is supported in developing skills and confidence to speak out, to give their views and assert their wishes. Participation of children and young people must be encouraged and reinforced through positive experiences of having their contributions taken seriously by workers and by the system as a whole.

Recommendation 6: Ensure children and young people are provided regular and meaningful avenues to be active participants in decisions that affect their lives.

> "Ask [children and young people in OOHC] what data they would like to see collected. How would they define their own outcomes?"

[13] CCYP (nd) Charter of Rights for Children and Young People in Out-of-Home Care. http://www.childcomm.tas.gov.au/wp-content/uploads/2015/06/SmallKidsDemo21.pdf

The Tasmanian OOHC system appears to lack strong mechanisms to support the health of young people transitioning out of care.

The period of transition from OOHC is one of significant mental health risk for young people,[14] as well as a period where there is significant risk that young people will disengage from health services.[15] However, participants could not identify specific measures that are taken to support the health of young people leaving care. In New South Wales, by contrast, young people aged 15-17 years who are leaving care within the next year are given access to a program that fosters increased health literacy, establishes links with General Practice/primary health care, and supports young people's access to their personal medical records.[16]

Recommendation 7: The Health Management Plan of all young people in OOHC should include a transition plan.

[14] https://aifs.gov.au/cfca/publications/supporting-young-people-leaving-out-home-care/supporting-young-people-leaving-care

[15] https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/oohch-program.aspx

[16] https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/oohch-program.aspx

Appendix A: Examples from other jurisdictions

Assessment

Other states have clearer timelines for assessment, more broadly available public health services, and mechanisms for ensuring compliance.

- In Western Australia, a child or young person entering care is to receive an initial medical screening and assessment as well as a comprehensive health assessment across the physical, developmental and mental health domains within 30 working days of WA Health receiving a completed referral from Child Protection and Family Services (CFPS). WA Health staff must send a report on the assessment outcomes, written in a way that can be understood by an average reader, within five working days of the assessment.[17]

- In Queensland, a child or young person entering OOHC will undergo two health checks: a Preliminary Health Check which must be completed within 30 days of entering care and a Comprehensive Health and Developmental Assessment to be completed within 90 days of entering care.[18]

- The South Australian Government has accepted in principle a recommendation to fund initial health assessment clinics at all three of the state's main birthing hospitals, including funding clinics at a level that enables a psychosocial component to be offered at every initial health assessment.[19]

- In Western Australia, successful provision of assessments within the stipulated timeframe is included as a key performance indicator for both Child and Adolescent Community Health and the WA Country Health Service.[20]

Health plans

- In Western Australia, a comprehensive health assessment on a child's health needs, priorities and actions informs the development of a 12 month health care plan and must be written in a way that can be understood by a lay person. Children and young people in care receive an annual review structured around the findings of the health assessment.[21]In New South Wales, on the basis of initial assessments, and in partnership with the child/young person, their carer,

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17 https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Child%20protection/PDF/CACH.CHSH.ChildrenInCareManagingReferrals_updated%2014.3.17.pdf

18 https://www.childrens.health.qld.gov.au/chq/health-professionals/out-of-home-care/

19 https://www.childprotection.sa.gov.au/sites/g/files/net916/f/a-fresh-start.pdf

20 https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Child%20protection/PDF/CACH.CHSH.ChildrenInCareManagingReferrals_updated%2014.3.17.pdf

21 https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Child%20protection/PDF/CACH.CHSH.ChildrenInCareManagingReferrals_updated%2014.3.17.pdf

and/or their case worker, each child or young person has a Health Management Plan developed for/with them. The Health Management Plan identifies their state of health, recommended interventions and appropriate review process. Each local health district has an OOHC Health Pathway coordinator responsible for managing and coordinating referrals across all facilities in their district.[22]

Trauma

- In Western Australia, all processes in the health care planning pathway must include an acknowledgement of issues of trauma and associated effects on physical health, development, social and emotional well-being, and educational outcomes, considered holistically rather than in isolation.[23]
- In South Australia, the Government has:
    - tasked The Department of Child Protection to develop a whole-of-sector therapeutic framework that applies to all child protection service provision in South Australia. The framework will apply to all parts of the child protection system, including early intervention and prevention, investigation, and caring for children in family-based care and non-family-based care. Once this is developed, a model of therapeutic care for all residential care services will be developed.[24]
    - tasked Child and Adolescent Mental Health Services with developing a therapeutic needs assessment panel for children in care whose therapeutic needs are identified in their initial health assessment, and has committed to providing therapeutic support to placements that are identified as being at risk or under stress.[25]
- The South Australian Government has also committed to improving the profile and uptake of trauma training in the education system, and to ensure that the initial orientation training for prospective carers includes training on recognising and managing trauma-related behaviours.[26]

[22] https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/oohch-program.aspx

[23] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Child%20protection/PDF/CACH.CHSH.ChildrenInCareManagingReferrals_updated%2014.3.17.pdf

[24] https://www.childprotection.sa.gov.au/sites/g/files/net916/f/a-fresh-start.pdf

[25] https://www.childprotection.sa.gov.au/sites/g/files/net916/f/a-fresh-start.pdf

[26] https://www.childprotection.sa.gov.au/sites/g/files/net916/f/a-fresh-start.pdf

Appendix B: Commonly reported health conditions

The most common mental and physical health issues affecting children and young people in OOHC reported by the consultation participants were:

- Anxiety, depression and anger. Some participants suggested that anxiety is more visible in young people in OOHC, with depression more often seen and picked up in residential facilities.
- Poor or no self-regulation.
- High levels of self-damaging behaviours in the form of self-harm or suicide attempts.
- Eating disorders and unhealthy relationship with food (anorexia, bulimia, binge eating).
- Problematic sexualised behavior.
- Fetal Alcohol Spectrum Disorder (FASD).
- Developmental delays, particularly emotional.
- Intellectual disabilities.
- Dental problems stemming from poor hygiene and/or poor diet.
- Malnutrition.
- Weight issues.

These are in line with the range of physical and psychosocial problems most commonly faced by children and young people in care Australia-wide. [27]

[27] Moeller-Saxone, K et al (2016) Meeting the primary care needs of young people in residential care. https://www.racgp.org.au/afp/2016/october/meeting-the-primary-care-needs-%E2%80%A8of-young-people-in-residential-care/

Appendix C: National Standards for Out of Home Care

The National Standards for Out-of-Home Care (The National Standards) stipulate that children and young people entering care are to receive an initial health check of their physical, developmental, psychosocial and mental health needs within a specified period of entering out-of-home care.[28] The National Clinical Assessment Framework proposes:

1. A Preliminary Health Check that 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 that 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, in accordance with the needs of the individual child or young person on a case by case basis.

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) 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. There will be a nominated officer/position with the role of Care Coordinator Health (CCH). This role could be provided by the statutory case officer or a health 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.

[28] Child Family Community Australia (2018) Children in Care. CFCA Resource Sheet, https://aifs.gov.au/cfca/publications/children-care