RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP Submission to the Victorian Department of Health and Human Services consultation into Looking after Children's Health in Out-of-Home Care

September 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Many paediatric Fellows, particularly those who are members of the Chapter of Community Child Health, provide health care for children and young people in out-of-home care and are aware of the difficulties encountered by carers in obtaining comprehensive health care in metropolitan, regional and rural settings. They are also aware of the differences between states and territories in the provision of care.

Introduction

The RACP welcomes the opportunity to provide input to the Victorian Department of Health and Human Services (DHHS) consultation Looking after Children's Health in Out-of-Home Care. The following submission has been structured around the key consultation themes and is drawn from the expertise of RACP Fellows and a range of previously published statements that relate to the matters at hand, including:

- The Position Statement on the Health of Children in Out-of-Home Care 2008
- The Position Statement on Early Childhood: The Importance of the Early Years 2019
- The 2018 Victorian Election Statement
- The Submission to the Royal Commission into Victoria's Mental Health System 2019
- The Position Statement on Sexual and Reproductive Health Care for Young People 2015

All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Child health inequities are differential outcomes in children's health, development and wellbeing that are unjust, unnecessary, systematic and preventable.[1] Many inequities start early in childhood and increase along a clear gradient.[2] This means the greater a child's disadvantage, the worse their health, development and well-being. These gaps widen as children progress across the life trajectory resulting in adverse adult health, educational and vocational outcomes, with increased subsequent premature mortality and morbidity. This can have an intergenerational effect with inequity passed on to the next generation.[3]

While data regarding the health and wellbeing status of children in out-of-home care (OOHC) in Australia are still limited, there is already evidence that this demographic has poorer physical, mental and developmental health compared to their peers.[4] [5] This is largely due to the adverse effects of neglect, abuse and trauma on neurodevelopmental[6] and epigenetic and metabolic pathways, but also because of the effects of disruption to attachment and family structures and ongoing abuse while in care.[7] [8] There is a growing body of literature that illustrates the life-long impact of adverse childhood experiences on chronic disease, health, development and wellbeing.[9]

There is corresponding substantial evidence that shows that investment in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity. Investing in the early years offers the possibility of shifting the trajectory of a person's health over the course of their life and disrupting intergenerational cycles of disadvantage. Early interventions aimed at children, their families, carers and health service and education providers reduce inequities in child health, well-being and development, particularly for disadvantaged children.[10] [11]

The ultimate goal of policy interventions directed at vulnerable Australian children should be a significant reduction in the complex and persistent problem of child abuse, neglect and inequity and an attendant reduction in the number of children in out-of-home care. While we work toward this overarching objective, the RACP would like to offer the following observations and recommendations to the consultation.

---

1 World Health Organization. 2008. Closing the gap in a generation: health equity through action on the social determinants of health. World Health Organization
2 Hertzman, C. 1999. The biological embedding of early experience and its effects on health in adulthood. Ann N Y Acad Sci, 896
3 Nicholson, J. M., Lucas, N., Berthelsen, D., & Wake, M. 2012. Socioeconomic inequality profiles in physical and developmental health from 0-7 years: Australian National Study. J Epidemiol Community Health, 66(1)
4 Nathanson D, Tzioumi D. Health needs of Australian children living in out-of-home care. Journal of Paediatrics and Child Health 2007
5 McLean, K., Little, K. et al. Health needs and timeliness of assessment of Victorian children entering out-of-home care: An audit of a multidisciplinary assessment clinic. J. Paediatr. Child Health, April 2019
6 Teicher, MH et al. The effects of childhood maltreatment on brain structure, function and connectivity. Nature Reviews Neuroscience 2016
7 Yang B-Z, Zhang H, Ma WG et al. Child Abuse and Epigenetic Mechanisms of Disease Risk. American Journal of Preventive Medicine 2013
8 Mehta D, Klengel T, Conneely KN, Smith et al. Childhood maltreatment is associated with distinct genomic and epigenetic profiles in post-traumatic stress disorder. Proceedings of the National Academy of Sciences of the United States of America 2013
9 Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences Study. Am J Prev Med 1998
10 Organisation for Economic Co-operation and Development. What are the benefits from early childhood education? *Education Indicators in Focus*, No. 42, OECD Publishing, Paris 2016
11 Pascoe S, Brennan D. Lifting our game. Lifting Our Game: Report of the Review to Achieve Educational Excellence in Australian Schools through Early Childhood Interventions 2017

National context

The number of children in out-of-home care in Australia remains high. The most recent statistics from the Australian Institute of Health and Welfare show that, as of 30 June 2018, there were 47,756 Australian children living in OOHC. Around 10,000 if them lived in Victoria. The Victorian rate has decreased from 7.2 per 1,000 children at 30 June 2014 to 5.7 per 1,000 children at 30 June 2018, which is significantly less than the total rate across states and territories (8.2).[12]

To improve the health outcomes for children in OOHC on a national level, The Australian National Clinical Assessment Framework for Children and Young People in Out-of-Home Care was developed in 2011 under the auspices of the Australian Government. The Framework was intended to provide a synergistic approach to advocate for proactive, routine, multi-disciplinary health screening, the developmental of tailored health management plans and enhanced access to health and mental health care for children in out-of-home care. The Framework was also to push for enhanced data gathering and communication tools including transferable health records and access to relevant family history.

Despite its commendable intent, persistent barriers and service gaps hinder the successful implementation of the Framework across Australia. These barriers are in part due to the variation in service infrastructure between states and territories, including the availability of community paediatricians and jurisdictional and regional differences in design and funding of services. This problem tends to be especially acute in rural and remote communities, where accessing paediatric health services and mental health services can be significantly more challenging, resulting in poorer outcomes.[13]

Additionally, while the subsequent *Action Plan on Driving Change: Intervening Early* (2015-2018) re-affirmed the shared goal of ensuring that children grow up to become resilient, independent and productive members of society, the Plan included no new Australian Government-led strategies to address the health needs of children in OOHC (for instance, there were no new dedicated funding streams whether through the MBS or other sources for designated multi-disciplinary teams).[14] Going forward, consideration should be given to the introduction of loadings in MBS rebates to incentivise the retention of private practitioner paediatricians and mental health workers and allied health practitioners in rural, remote and regional areas.

Importantly, there is also limited research into the effectiveness of the current child protection policies across the country in general and of the *National Clinical Assessment Framework* in particular.[15] The need for research is especially urgent in light of the persistent national failure to reduce the number of children in out-of-home care.

The College supports renewed efforts to address some of these outlined issues by advocating for the full implementation of the *Australian National Clinical Assessment Framework* through:

- the development and promotion of new models of care (such as integrated models of care to facilitate the establishment of collaborative multi-disciplinary teams),
- the introduction of appropriate Medicare items to better meet the primary healthcare needs of children in out of home care,
- better access to appropriate therapeutic services, including trauma-informed mental health services and educational support,
- mandating greater accountability from responsible service departments across the country, and
- better data collection and analysis to inform future policy development and service improvements.

Victorian context

At the end of June 2018 there were 7,954 children in out-of-home care in Victoria, up from 7,710 in the same month five years earlier.[16] The number of Victorian children in out-of-home care per 1000 children decreased

12 Australian Institute of Health and Welfare. Child protection Australia 2017–2018. 2019
13 Arefadib, N. and Moore, T.G. Reporting the Health and Development of Children in Rural and Remote Australia. The Centre for Community Child Health at the Royal Children's Hospital and the Murdoch Children's Research Institute. 2017
14 Webster, Susan. Children and young people in statutory out-of-home care: health needs and health care in the 21st century'. Parliamentary Library and Information Service, Parliament of Victoria 2016
15 Jones, P. Primum non nocere: Rethinking our policies on out-of-home care in Australia. MJA May 2017
16 Australian Institute of Health and Welfare. Child protection Australia 2017–2018

slightly from 6.0 to 5.7 over this period; however, for 2017–18 Victorian out-of-home care counts excluded children on third-party parental responsibility orders.[17]

A recent review of the health needs and health care of children in out-of-home care in Victoria indicated that for over two decades "public inquiries have repeatedly documented a lack of careful and systematic health needs assessment and appropriate health care provision for children in statutory OOHC". The study raised concerns about the lack of adequate regulatory and legislative changes to "effectively assign responsibility and assure accountability" for the monitoring of health needs and receipt of health care for these children, as well as poor collection and analysis of health needs data to assess longitudinal health outcomes and to properly inform policy. It also criticised the dependency on community support organisations to provide health care coordination for these children, instead of through appropriately resourced health services.[18]

Unsurprisingly, these barriers to effective care delivery result in serious negative consequences for children and young people in OOHC. As reported in *Beyond 18: The Longitudinal Study on Leaving Care* in Victoria published earlier in 2019, participants had lower than average levels of school attainment, low levels of employment, low incomes and high levels of financial stress. There was a high prevalence of responses indicating mental health issues and reported rates of self‑harm and suicidality were two to three times higher than those reported in other studies of Australian youth. Care leavers in the qualitative interviews commonly reported difficulties building or maintaining positive and supportive social relationships.[19]

This is hardly an historical problem. Timely identification and management of health needs for children in OOHC in Victoria continue to be challenging to deliver. A 2019 study in the *Journal of Paediatrics and Child Health* confirmed earlier research by demonstrating that Victorian children in out-of-home care have high rates of physical, mental and developmental health concerns. Immunisation rates were low, particularly for the youngest children (0–2 years). Over 50 percent of studied children had mental health concerns (76 percent of 7–12-year-olds). In children aged 3–6 years, 64 percent had behavioural problems and 77 percent had developmental problems. Timeliness of attendance at the dedicated multidisciplinary assessment clinic for a comprehensive assessment of health needs was poor compared with national recommendations, even within a broader program designed to facilitate timely health checks.[20]

Our obligation to support children does not stop at the age of 18. Every year around 760 young people leave state care in Victoria.[21] Many of these young people experience poor life outcomes: according to a national survey, 35 percent were homeless in the first year of leaving care, 46 per cent of boys were involved in the juvenile justice system, 29 percent of leavers were unemployed[22] and a third of girls got pregnant within 12 months of leaving.[23] Extending care to 21 years, as advocated by the national Home Stretch campaign, would see significant reductions in homelessness, arrests, hospitalisation and alcohol and drug dependence amongst this cohort, as well as improved mental health and physical health outcomes, reduced intergenerational disadvantage and an increase in social connectedness. It is estimated that a dollar invested in the program would bring about an expected return of $1.84 in either savings or improved outcomes.[24]

We commend the Victorian Government's recently announced trial of 250 young people who can now choose to stay in care and suggest the findings and lessons of the pilot be used as the basis for a state-wide program.

17 Third-party parental responsibility order: an order transferring all duties, powers, responsibilities, and authority to which parents are entitled by law to a nominated person(s) whom the court considers appropriate. The nominated person may be an individual, such as a relative, or an officer of the state or territory department responsible for child protection. Australian Institute of Health and Welfare. Child protection Australia 2017–2018

18 Webster, Children and young people.

19 Muir, S., Purtell, J. et al. Beyond 18: The Longitudinal Study on Leaving Care Wave 3 Research Report: Outcomes for young people leaving care in Victoria. Melbourne: Australian Institute of Family Studies 2019

20 McLean, K., Little, K. et al. Health needs and timeliness of assessment of Victorian children entering out-of-home care: An audit of a multidisciplinary assessment clinic. J. Paediatr. Child Health, April 2019

21 Australian Institute of Health and Welfare. Data tables: Child protection Australia 2017–2018

22 Reed, J. Lunn, S. What's the answer? Young people's solutions for improving transitioning to independence from out of home care. CREATE Foundation 2010

23 Cashmore, J. and Paxton, M. Longitudinal Study of Wards Leaving Care: four to five years on, Report of research commissioned by the NSW Department of Community Services. 2007

24 Extending out of home care to 21 years. Deloitte Access Economics. 2016

Key recommendations for all Victorian children in out-of-home care

Considering ongoing concerns over the effectiveness of the services provided to the troublingly high numbers of Victorian children placed in OOHC, the College presents consultation leaders with a range of recommendations for optimal care that apply to **all children** in out-of-home settings.

Please note that these recommendations are drawn from the *RACP Position on the Health of Children in Out-of-Home Care 2008*, which is currently being reviewed and expanded. The updated position is expected to be released in 2020 as the *RACP Health Care of Children in Care and Protection Services* statement. The revised document will address the needs of children across all care and protection services and will consider the health and wellbeing of children of addicted parents, as these children are over-represented in all care and protection settings.

Routine health screening and assessment of all children entering alternative care

- The DHHS must ensure that all children entering care, in line with international recommendations, undergo appropriate assessments in a timely manner. The National Clinical Assessment Framework suggests an initial assessment by a general practitioner, nurse practitioner or an allied health worker within 30 days and a comprehensive assessment by a paediatrician or a multidisciplinary team within 3 months. Staff should be appropriately trained and skilled and the setting must be child-focused and culturally appropriate. The tiered assessments must include the following:
    - General health assessment including a health history of the child and family, physical examination, growth assessment, vision, hearing and dental screening, and an immunisation register check. The health assessment information must be documented to ensure easy access for medical professionals;
    - Developmental assessment incorporating standardised screening tools e.g. Ages and Stages or Brigance, as an adjunct to clinical assessment, and access to formalised assessment. Local systems must be developed to fast track therapeutic developmental services to children with identified deficits. Systems need to be established for liaison with Education representatives; and
    - 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. Local systems must be developed to provide a therapeutic response to identified needs.

Formulation of health plan

- The DHHS must develop and implement a framework for an individual health management plan based on the above assessment including:
    - Identifying a health coordinator for each child and
    - Promoting a follow-up health review to occur within three months of assessment and subsequently at least on an annual basis.

Enhanced care, management and treatment services

- The DHHS and other social and community service providers must work together to ensure that children and young people who are placed in out-of-home care receive similar care, management and treatment to their peers by:
    - Developing local systems to ensure that this group of children is not disadvantaged in their receipt of health care services compared to their peers;
    - Promote the use of fast tracking therapeutic services, given the often, small window of opportunity available due to transient care placements; and,
    - Ensure that such services are provided for all health needs and in particular mental health needs, utilising both public and private therapeutic services as required.

Data collection and access

- The DHHS should develop and resource permanent and easily transferable health records on children who are in out-of-home placements which will be accessible to future health providers and available to parents and carers by:
    - Using electronic health records linked to Community Services files;
    - Ensuring these are stored in a safe manner while at the same time allowing them to facilitate health communication;
    - Recording information that includes a patient hand-held record containing history, relevant family history, health assessment information, treatments and interventions;
    - Evaluating the health needs of children placed in out-of-home care and aggregating this data to monitor and identify the effective interventions; and
    - Improving access to health records of birth parents in a fashion which is consistent with privacy legislation by a) developing a proforma to enable community service workers to collect a satisfactory health history from parents and b) engaging with parents over consent for health treatment of their child at the point of entry into care.

Enhanced communication

- The DHHS should work with health professionals and community service providers to increase the level of communication by:
    - Facilitating effective communication channels between health professionals, relevant government departments and service providers and other key people in the child's life e.g. schools, carers and parents;
    - Establishing specific communication avenues such as community-based inter-agency forums for more complex cases;
    - Listening and responding to children's opinions and ideas as to how their health needs may be best met; and
    - Engaging birth parents in their child's ongoing health planning where possible.

Improved support and training for out-of-home carers

- The DHHS must work to strengthen support and training programs for carers by:
    - Ensuring the provision of therapeutic out-of-home placements by providing adequate support and training for carers and ensuring that out-of-home placements are not overcrowded or in other ways unable to meet the needs of the child; and
    - Developing optimal permanency planning for children in alternative care.

Culturally safe out-of-home care for Aboriginal and Torres Strait Islander children and young people

In 2017–18, Indigenous children were admitted to out-of-home care at a rate of 12.8 per 1,000 children, 9 times the rate for non-Indigenous children (1.4 per 1,000). The difference in rates of admission to out-of-home care for Indigenous and non-Indigenous was evident across all age groups. Rates of discharges from out-of-home care during this period were also higher for Indigenous children (11.2 per 1,000 children) than non-Indigenous children (1.3 per 1,000). In that year, Indigenous children aged less than 1 were 7 times as likely as non-Indigenous children of the same age to be discharged from OOHC, and those aged 10–14 were 10 times as likely.

At 30 June 2018, the rate of Indigenous children in OOHC was 59.4 per 1,000 children, 11 times the rate for non-Indigenous children (5.2 per 1,000). In all jurisdictions with available data (excluding Tasmania), the rate of Indigenous children in out-of-home care was higher than that for non-Indigenous children. This difference between Indigenous and non-Indigenous was evident across all age groups.[25]

In Victoria, as of end of June 2018 there were 89 Indigenous children per 1000 in OOH care, compared to 4.3 per 1000 amongst non-Indigenous children. The rate ratio of Indigenous versus non-Indigenous children in

[25] Australian Institute of Health and Welfare. Child protection Australia 2017–2018

OOHC was 20.5, the highest in all the states and territories and considerably higher than the national average rate ratio of 11.4.[26]

In light of these statistics, it is of great concern for the RACP that there are no publicly funded dedicated paediatric services for Indigenous children in out-of-home care in Victoria. This is despite a recommendation of the *Taskforce 1000* report that[27]:

> 8.1 DHHS, in partnership with VACCHO (…) develop and implement a strategy and practice standard to ensure all Aboriginal children in out-of-home care have a specific Aboriginal children's health check upon entry to care, and then annually, at an ACCHO.
>
> The strategy should ensure that funding for ACCHOs aligns with the initial and future demand for new services and in accordance with the numbers of Aboriginal children in out-of-home care.

We understand the Victorian Aboriginal Health Service, together with the Wadja Unit at the Royal Children's Hospital, Melbourne, is developing a model for providing the health assessments and health care for Aboriginal children in out-of-home care, and we recommend its considered and coordinated implementation.

We also commend Victoria's leadership on Aboriginal self-determination, including its progress towards a treaty, and its commitment to early intervention for vulnerable children, as outlined in the Roadmap for Reform and the Koorin Koorin Balit Djak strategic plans.

The DHHS has the responsibility to improve health access, including to paediatricians, for Indigenous children in out-of-home care in accordance with the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care. This is consistent with *Victoria's Mothers, Babies and Children 2016* (the 55th survey of perinatal deaths in Victoria), which recommended that, as part of a new model of care for the health and welfare of all vulnerable children:

> Staff in non-government community service organisations and community health centres have improved access to consultation with health professionals, especially paediatricians and general practitioners. This requires more paediatricians who are based within community health centres and closer links between community service organisations and the health sector.[28]

The RACP proposes that, in addition to the system-wise recommendations that apply to all children living in out-of-home children (see the section above), the DHHS:

- Commit to long-term planning and investment in social determinants of health to reduce the rate of removal of Aboriginal and Torres Strait Islander children;
- Implement recommendation 8 of the Taskforce 1000 report, ensuring all Aboriginal children in out-of-home care have a comprehensive and specific Aboriginal children's health check at an Aboriginal Health Service, which complies with the recommendations of the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*; and
- Implement recommendation 6 of *Victoria's Mothers, Babies and Children 2016*, improving access to paediatricians, working within community health services, who can provide coordinated and integrated care[29].

The RACP also supports the recommendations of the Secretariat of National Aboriginal and Islander Child Care (SNAICC) included in *Understanding and Applying the Aboriginal and Torres Strait Islander Child Placement Principle – A Resource for Legislation, Policy, and Program Development 2017*. We are in strong agreement with the need to apply the fundamental principle proposed by SNAICC that:

---

[26] Australian Institute of Health and Welfare. Data tables: Child protection Australia 2017–2018

[27] Recommendation 8.1, Commission for Children and Young People, '*Always was, always will be Koori children': Systemic inquiry into services provided to Aboriginal children and young people in out-of- home care in Victoria* (Melbourne: Commission for Children and Young People, 2016), p. 19

28 Recommendation 6, *Victoria's Mothers, Babies and Children 2016* (the 55th survey of perinatal deaths in Victoria), (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2016), p. 29.

29 See RACP Integrated Care discussion paper, Physicians supporting better patient outcomes

"Placement of an Aboriginal or Torres Strait Islander child in out-of-home care is prioritised in the following way:

1. with Aboriginal or Torres Strait Islander relatives or extended family members, or other relatives or extended family members; or
2. with Aboriginal or Torres Strait Islander members of the child's community; or
3. with Aboriginal or Torres Strait Islander family-based carers. If the above preferred options are not available, as a last resort the child may be placed with:
4. a non-Indigenous carer or in a residential setting."[30]

We also support recommendations made in relation to the other four core elements of the placement principle: prevention, partnership, participation and connection.

Safeguarding mental health needs of children and young people in out-of-home care

Children and young people in out-of-home care experience high rates of mental health issues and distress.

RACP paediatricians and adolescent physician members are increasingly being asked to manage the complex trauma, attachment histories, and behavioural and mental health issues of children in out-of-home care.

Both the Australian Government's *National Clinical Assessment Framework* and the RACP's *Statement on the Health of Children in OOHC* call for routine, proactive, multi-disciplinary health screening to establish and plan for ameliorating the complex effects of trauma on these children. Likewise, the Royal Australian and New Zealand College of Psychiatrist's position statement on the Mental Health Needs of Children in OOHC (2015) calls for priority access to multidisciplinary developmental and mental health services for children in out-of-home care.

Despite these recommendations, there are significant and severe gaps in Victoria in the provision of services to children in out-of-home care. As indicated by the recent *Beyond 18* surveys, young leavers of Victorian OOHC displayed a high prevalence of responses indicating mental health issues and reported rates of self-harm and suicidality were two to three times higher than those reported in other studies of Australian youth.[31] Indigenous children who are being removed into care at around 8.2 times the rate of non-Aboriginal children in Victoria[32] have especially high mental health needs. A 2016 audit at the Victorian Aboriginal Health Service of 103 children in OOHC showed that 66 percent of these children had mental health problems; 37 percent had hearing problems and 46 percent had developmental delay.

Persisting service gaps have meant that an alarmingly low number of children, especially Aboriginal children, have received the recommended multi-disciplinary health assessments. Services for these children have been underfunded and poorly targeted and, in the case of Indigenous children, run via mainstream services rather than ACCHOs and thus not culturally safe. Most of such children need prompt and easy access to well-resourced paediatric services. The two paediatric services in Melbourne (one in an ACCHO and one in a tertiary paediatric hospital) who have been seeing the majority of the children have appealed to the Victorian Government to develop, resource and implement an integrated, trauma-informed and culturally safe model of care.[33]

The RACP urges the DHHS to invest in the provision of adequate psychological assessment, psychological, long term trauma informed support and management of medication by psychiatrists for children in child protection system, particularly those in out-of-home care. A comprehensive mental health team of psychiatrists, community paediatricians, general-practitioners, psychologists and youth workers is needed.

We recommend investment in the provision of adequate psychological assessment, psychological, long term trauma informed support and management of medication by psychiatrists for children in child protection

30 Understanding and Applying the Aboriginal and Torres Strait Islander Child Placement Principle – A Resource for Legislation, Policy, and Program Development. Secretariat of National Aboriginal and Islander Child Care. 2017
31 Muir, S., Purtell, J. et al. Beyond 18: The Longitudinal Study on Leaving Care Wave 3 Research
32 Australian Institute of Health and Welfare. Data tables: Child protection Australia 2017–2018
33 Trauma-informed care refers to a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs.

system, particularly those in out of home care. A comprehensive mental health team of psychiatrists, community paediatricians, general-practitioners, psychologists and youth workers is needed.

Our position statement on *The Health of Children in Out-of-Home Care* outlines several recommendations to improve the overall health and wellbeing of children in OOHC including mental health screening using accessible and validated tools and promoting the use of fast-tracking therapeutic services (given the small window of opportunity available due to transient care placements). Over a decade has passed since our position statement was first issued; however, the recommendations remain relevant and we call for urgent implementation of the suggested approaches.

Delivering reproductive and sexual health care and relationship support in out-of-home care

Adolescence and young adulthood are periods of life during which a young person moves through puberty, explores meanings of intimacy and establishes a sense of sexual identity. Young people in all settings and circumstances have the right to age and developmentally appropriate pleasurable and safe sexual experiences; they also have the right to control their own fertility.[34]

Young people often require support to navigate the physical, emotional and social changes that underpin sexual and reproductive wellbeing. They have the right to information, education and clinical care that supports healthy sexual development and informed choices, and minimises the risk of coercion, unplanned pregnancy, sexually transmitted infection and other unwanted or unintended consequences, including emotional, psychological, social and cultural consequences.

Rates of sexually transmitted infection, teenage parenthood, homophobic and transphobic abuse and domestic and sexual violence remain significant concerns for Australian youth. Indigenous youth experience inequities in health status, determinants of health and access to health care.[35] Young people with long-term health conditions or physical or intellectual disability, or who are same-sex attracted or gender diverse, or marginalised due to socioeconomic or cultural factors may require tailored sexual and reproductive health care. These needs need to be taken into consideration in designing and delivering optimal sexual and reproductive health care to young people in out-of-home settings.

The RACP recommends that the DHHS ensure that young people in out-of-home care:

- have access to the services and knowledge needed to optimise their sexual and reproductive health, and to prevent sexually transmissible infections and blood-borne viruses, unplanned/unsupported pregnancy and experiences of sexual violence;
- have access to sexual and reproductive health care that is physically and financially feasible, with options for free health care; and
- have their needs and perspectives relating to sexuality and relationships education and sexual and reproductive health care included in planning, service delivery and guideline development.

The RACP also asks the DHHS and other service providers who work with adolescents and young people in out-of-home care to address sexuality and relationships education curricula and health promotion to ensure that:

- Sexuality and relationships education is received by all young people, is age and developmentally appropriate and focuses on both sexuality and relationships;
- Curricula are accurate and evidence-based, and delivered by trained and supported personnel; and
- Curricula address respectful relationships, sexual and reproductive health, intimate relationships, access to health services, and harm minimisation.

More information on optimal sexual and reproductive health care for young people can be found in the RACP Position Statement on the subject.

34 Williams H, Kang M, Skinner SR. Sexual and reproductive health. In Kang M, Skinner SR, Sanci LA, Sawyer SM. Youth health and adolescent medicine. Chapter 12. IP Communications. 2013
35 Kang M 2013. The health of young Australian people. In Kang M, Skinner SR et al. Youth health and adolescent medicine. Chapter 2.

Concluding remarks

The multiplicity of problems often encountered in out-of-home care for children and adolescents demands a comprehensive and collaborative approach to assessment and treatment.

Ongoing provision of effective best practice care for Victorian children in OOHC should incorporate:

- systematic monitoring
- improved continuity of care
- enhanced information sharing between all parties and
- increased attention to preventative health care, health education and health promotion.

Significantly, the effectiveness of all therapeutic interventions requires ongoing evaluation and is contingent on accurate data collection and ongoing research.

Most importantly, the fundamental goal of all interventions directed at children in care should be to substantially reduce society's reliance on out-of-home care to dealing with the complex problem of child abuse, neglect and inequity in Victoria and Australia. In the words of one commentator, "a child being placed in OOHC should be seen as an indicator that our society needs to do better rather than being accepted as an expected consequence of modern society".[36]

[36] Jones, P. Primum non nocere