

**HEALTH of CHILDREN in
“OUT-OF-HOME” CARE**

Paediatric Policy

**The Royal Australasian College of Physicians
(RACP)**

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TABLE OF CONTENTS

Acknowledgements.....	3
Executive summary	5
Recommendations.....	6
Introduction.....	10
Health status and developmental needs of children entering out of home care ...	14
Health service requirements for Children in Care	15
Psychological needs	16
International systems and policies	18
Identified barriers to effective care provision	20
Models and effectiveness of ‘out-of-home’ care	22
The way ahead	24
References.....	25

Executive summary

Children in “out-of-home” care are a vulnerable and at-risk group in the population. This group of children are likely to have poorer physical, mental and developmental health than their peers. Existing data regarding the health status of this population in Australia and New Zealand is limited. The College currently relies largely on overseas data and has identified this as a major research gap.

There are many gaps and barriers in providing effective health care for children living in out-of-home care. This document identifies models of care that demonstrate some solutions to these problems.

This document outlines the best available evidence from the research literature surrounding children in out-of-home care and proposes strategies to deliver effective health care within Australia and New Zealand. The key proposals involve the following:

- Ensuring that physical, developmental and mental health assessments are performed on all children who enter into out-of-home care;
- Encouraging ongoing monitoring of needs by identified health care co-ordinators;
- Ensuring appropriate timely access to therapeutic services;
- Developing a transferable health record system;
- Improving training and support for foster carers;
- Coordinating a health care centred approach between all agencies involved with this group of children, including Community Services and Education;
- Encouraging governments to adequately fund the implementation of the suggested recommendations; and,
- Collecting aggregated data and ensuring evaluation of programs.

Efficient and effective implementation of these recommendations requires utilisation of local health systems and resources. The College and individual Paediatricians need to advocate with Community service departments in each jurisdiction, and at the Federal level, to assist in provision of optimal care for this group of vulnerable children. The College recognises that at present there are shortfalls in resources, particularly in remote and rural locations, to fulfil these recommendations.

Recommendations

Considering what is known about the health and social needs of children and young people in out-of-home care placements, the College suggests the following recommendations for the best optimal care. In addition, it is recognised that the most efficient way to implement these recommendations is in partnership with key stakeholders including relevant government and non-government organisations.

1. *Routine health screening and assessment of all children entering alternative care.*

That the College advocate for all children entering care, in line with international recommendations, to have a comprehensive assessment within 30 days of placement. Depending on local resources this care may be provided within a specialised clinic, by an individual Paediatrician, a General Practitioner, or Nurse Practitioners or by Aboriginal Health workers. Staff should be appropriately trained and skilled and the setting must be child-focused and culturally appropriate. The assessment 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;
- Mental health screening using accessible and validated tools e.g. Strengths and Difficulties Questionnaire, or Achenbach Child Behaviour Checklist (CBCL). Infants and toddlers must be assessed for attachment disorders. Local systems must be developed to provide a therapeutic response to identified needs.

2. *Formulation of health plan*

That the College, through the Paediatrics & Child Health Division, work with community services in the relevant Australian and New Zealand health

jurisdictions to develop a framework to implement 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.

3. *Enhanced care, management and treatment services*

That government departments including Community Services, Health and Education, Child Youth and Family Services (New Zealand), and the relevant Australian and New Zealand health jurisdictions, 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.

4. *Data collection*

That the College encourage governments to 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 past history, relevant family history, health assessment information, treatments and interventions; and,

- Evaluating the health needs of children placed in out-of-home care and aggregating this data to monitor and identify the effective interventions.

5. *Improved access to health records of birth parents*

That the College assist Community Services workers to have access to health records of birth parents in a fashion which is consistent with privacy legislation by:

- Developing a proforma to enable these workers to collect a satisfactory health history from parents, and engage with parents over consent for health treatment of their child at the point of entry into care; and,
- Entering into discussions with Privacy Commissioners, or similar bodies, to explore the availability of this information to Community Service workers.

6. *Enhanced communication*

That the College, with other health professionals and Community Services, in the relevant Australian and New Zealand health jurisdictions, advocate increasing the level of communication by:

- Facilitating effective communication channels between health professionals, Community Services Departments and other key people in the foster 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 foster 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.

7. *Improved support and training for foster carers*

That the College, with Community Services in the relevant Australian and New Zealand health jurisdictions, advocate strengthening support and training programs for foster parents by:

- Ensuring the provision of therapeutic foster placements by providing adequate support and training for foster carers and

ensuring that foster 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.

Implementation of recommendations

In order to implement these recommendations, all Paediatricians working with children in out-of-home care, must assist with the utilisation of existing health systems and if necessary, development of new ones. Dialogue and communication with other key agencies, particularly Community Services Departments (Australia) or the Department of Child Youth and Family Services (New Zealand), who have the statutory role and often guardianship for these children, will be necessary. The National Plan for Foster Children, Young People and their Carers has proposals to assist with some areas e.g. research and training.¹

Introduction

Children and young people in out-of-home care have been recognised globally as a highly vulnerable group of children with increased physical, mental and social health needs and with associated limited access to resources. As such, they are a group of children for whom Paediatricians and The Royal Australasian College of Physicians (RACP) have a responsibility in advocating for provision of improved health services catering for physical, emotional and social needs.

This document aims to deal specifically with children and young people in foster care or residential care on statutory court orders, but may be equally applicable to children on statutory orders in kinship placements. It aims to overview the extent and nature of health problems and offers recommendations for Paediatricians and others working with these children and young people to address these problems.

Types of alternative care in Australia and New Zealand

Out-of-home care encompasses a variety of living arrangements for children and young people other than living with their parents. Arrangements include foster care, kinship placements and residential care. These placements can be instigated either by voluntary arrangement or via a court order.

There are no national data on the reasons for placement out-of-home.^{2 3} The majority of children in out-of-home care will have been the subject of substantiated child protection notifications and will also be on care and protection orders of some kind. A small number of children will be placed voluntarily, usually on a temporary basis, with alternative carers if families are unable to care adequately for them.

Numbers of children involved and demographics

In 2004-05 there were 12,531 children admitted to out-of-home care in Australia.⁴ Family and Community Services data for 2003-04 uses different population definitions and reported 9,214 children admitted to out-of-home care.^{5 1} This was a decrease from the 12, 819 admitted in 2002-03. Indigenous children are 6.5 times more likely to be placed in out-of-home care than non-Indigenous children.⁶

Trends in numbers of children in out-of-home care showed that in 30 June 2005 there were 23,695 (4.9 per 1,000) children aged 0-17 years in out-of

¹ In this case defined as care outside usual home by a person other than a parent, whether or not for fee, and if on a court order being for a period of more than 14 days, and excluding relative care except on court

home care in Australia.⁷ The number of children has increased steadily between 1996 and 2005 with an increment of 70 per cent in that period. The majority of children (94 per cent) were in home-based care with only four per cent in residential care and one per cent in independent living. Since 1996 there has been a trend of increased use of placements with relatives and kin or foster carers, and decreased use of placement in residential care.⁸ This is reflected in 2005 with the numbers of children aged 0-17 years accounting for 57 per cent in foster care and 42 per cent in relative or kinship care.⁹

In Australia, the majority of children (84 per cent of out-of-home children) were on court orders with state variations ranging from 70 per cent in Western Australia to 100 per cent in Northern Territory.¹⁰ Since 1997, there has been a steadily increasing trend for children to be placed on orders in all jurisdictions except Tasmania and the Australian Capital Territory.

For children subject to court orders, gender distribution was equal. Twenty four per cent of children were aged less than five years with three per cent younger than 12 months. Thirty three per cent were between 5-9 years, 32 per cent 10-14 yrs, and 8 per cent were 15-17 yrs.¹¹

Child protection orders are of three broad categories. Guardianship orders involve the transfer of legal guardianship to an authorised department or in some jurisdictions transfer to an individual. This involves transfer of responsibility for the child's long-term welfare including education, health, religion and financial matters.

Custody orders place the children in the custody of a third party giving them responsibility for the day-to-day requirements of the child but leaving guardianship responsibility with the child's parents.

The third type of order is a supervisory order where the relevant community services department has some responsibility for the child's supervision, but care is provided by parents and guardianship or custody is unaffected.

Of children on orders across Australia at 30 June 2005, 90 per cent were guardianship or custody orders and 9 per cent of orders were temporary or interim.¹² However, of children admitted into care during the same period 33 per cent were on interim or temporary orders indicating shorter term changing placements. Current policies are to reunite and support families and most children are eventually returned home.

The majority of children (51 per cent) were in out-of-home care for less than two years but 22 per cent had greater than five years in continuous out-of-home care.¹³

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are over-represented within the population of children in alternative care. At 30 June 2005 there were 5,678 (26.4 per 1000) Aboriginal and Torres Strait Islander children aged 0–17 years in out-of-home care. This rate is 6.5 times the rate for non-Indigenous children in out-of-home care. These rates vary between jurisdictions from 8.9 per 1,000 in Northern Territory to 40.7 per 1,000 in Victoria.¹⁴

Aboriginal and Torres Strait Islander children have been shown to already have a heavier health burden compared with the general population.¹⁵ This includes social, emotional, and mental health problems in addition to the increased rates of illness and death related to almost all disease and injury categories.¹⁶ ¹⁷Hence, Aboriginal and Torres Strait Islander children coming into out-of-home care suffer an adverse double-effect on wellbeing. This is further exacerbated by the known difficulties of the Indigenous population in accessing services and receiving culturally appropriate services.¹⁸

Aboriginal and Torres Strait Islander peoples see the separation of children "from land and kin" as a form of abuse in itself and disruption of cultural ties and identity can result in life-long harm and trauma as recognised in "the stolen generation".¹⁹

All jurisdictions have adopted the Aboriginal Child Placement Principle either in legislation or policy. This outlines preference for the placement of Aboriginal and Torres Strait Islander children, firstly, with their family, alternatively within their Indigenous community and as a third option, with other Aboriginal and Torres Strait Islander people. Factors such as availability of Indigenous carers affect achievement of this goal. At 30 June 2003, 77 per cent of Aboriginal and Torres Strait Islander children had been placed according to these principles.²⁰

The Northern Territory Government (Australia) has developed a framework that attempts to increase the capacity of Indigenous people to develop and support local initiatives by advancing the social, cultural, and economic wellbeing. Strategies used to combat violence and enhance family cohesion work with Indigenous controlled family support centres to assist them to increase recruitment, training, career development and retention of Indigenous employees in Child Protection Units.²¹

Out of home care in New Zealand

New Zealand data are similar to Australian but not directly comparable in that orders refer only to custody or guardianship of the Chief Executive, (equivalent of Australia Director General) and do not include supervisory orders. At 30 June 2004, 5071 (4.4 per 1,000) children were in care placements in New Zealand. ²²As with Aboriginal Australians, Maori children are over-represented making up 45 per cent of the total. Kinship placement is the preferred policy of the New Zealand Child protection services, and is therefore prevalent with 36 per cent of children in care placements living with carers who are defined as family or Whānau (Extended family). Average length of stay in care has been increasing and is currently almost three years.

Health status and developmental needs of children entering out of home care

There is clear evidence from studies conducted in the United States and the United Kingdom that children entering foster care have a high prevalence of acute and chronic health problems and developmental disabilities, and subsequently have a broad range of health care needs.^{23 24 25 26 27}

There are multiple reasons for vulnerability in these children including their high prevalence of abuse and neglect, their greater likelihood of disadvantaged backgrounds, and their increased biological weighting e.g. with parents with mental health and drug abuse problems. These factors also contribute to fragmented health care.

Early studies from the United States reported only 13 per cent of children entering care had a normal physical examination, 50 per cent had multiple abnormalities, most frequently involving growth and development.²⁸ More recent studies^{29 30 31} report similar findings. Many children entering care (25 per cent) had failed a vision screen, 15 per cent failed a hearing screen, and 23 per cent of children under 5 yrs had suspected developmental delays.³² Over half of the children over three years required referral for dental or mental health services. Children under three years had an increased incidence of poor growth. Other studies have documented rates of developmental delays in preschool aged children entering foster care ranging from 20 per cent to 60 per cent.³³ Furthermore, children entering care are less likely to be fully immunised.³⁴

Australian data is at present limited but suggests a similar pattern of high needs. The Kari Clinic Pilot Program, a New South Wales (Australia) program for Aboriginal and Torres Strait Islander children, observed high levels of language delays or disorder (63 per cent) and reported 37 per cent with oral health problems.³⁵ A Victorian (Australia) pilot program reported nearly two thirds of children and young people in out-of-home care required medical or allied health follow-up.³⁶ A screening program conducted in New South Wales (Australia) with children in foster care found that a fifth of the 80 children failed hearing tests with a similar number failing vision tests. Half of this group of children were found to have delayed speech development and had not reached their usual developmental milestones.³⁷

Health service requirements for Children in Care

This section of the document highlights the extra health care services required to meet the needs of children in-out-of-home care. The importance of providing the best available care to children in-out-of-home care is essential in order to prevent problems. The effectiveness of clinical interventions for children in care has not been well researched. It is not appropriate to extrapolate findings on the effectiveness of treatments from children in the general population as their problems are different.

Entry into care does not necessarily ameliorate these health problems. There are data suggesting that children in care have ongoing unmet health needs such as poor uptake of immunisations and inadequate oral health care.^{38 39} Developmental disabilities remain prevalent (reported in up to 60 per cent) as do chronic medical conditions (45–76 per cent).^{40 41}

Studies examining children already in care highlight the frequent lack of available information about past medical history and accurate information about current health status.⁴² This deficit is particularly marked in those who have experienced multiple placements and presumably lack of continuity of health care. Perceived confidentiality issues may also impact on outcomes by limiting information sharing between health providers, carers and child protection agencies.

To date there is limited published data relating to the health and developmental status of children in out-of-home care in Australia or New Zealand. However, similar high needs and obstacles to providing optimal care are most likely to be present.

Psychological needs

The high prevalence of psychological and mental health problems of children in foster care has also been well documented. There are multiple causes including environmental, social, biologic and psychological risk factors.⁴³

There is good evidence about the need for infants to establish secure attachment with their primary caregiver and about the long-term impacts of abnormal early attachment.^{44 45 46} Chronic physical abuse and emotional neglect can cause insecure, avoidant and ambivalent attachment to primary adult care takers and subsequent poor relationships with new caregivers.⁴⁷

Children who have been placed in foster care have experienced parent-child separation and the subsequent breaking and making of attachments. Feelings of rejection, guilt, anger, abandonment and shame are common responses to loss of family and neighbourhood.⁴⁸ Children may blame the system and show destructive externalising behaviours. While these behaviours may test a foster parent's ability to nurture and place the stability of the placement at risk, the response of a carer can be crucial to the child's emotional wellbeing.

The process of re-unification with natural parents can further destabilise the child, and access visits need to be positive and aimed at strengthening relationships and improving interactions. The visitation process can be a negative experience, resulting in deterioration in behaviour and stress on the child as well as on their developing relationship with the foster parent.⁴⁹

The disruption experienced by a child as part of the placement process can often compound pre-existing conditions. Even for children who have been harmed severely thus making removal necessary, removal from parents is rarely a positive experience.⁵⁰ A therapeutic foster placement that is nurturing, caring and accepting is essential, rather than one that is overcrowded, unsupportive and transient.

From the above understanding, it is therefore not surprising that a large proportion of children in alternative care have been found to have mental health problems. Many studies have reported high incidence of moderate to severe mental health problems. In the United States, 70 per cent of children placed for at least a year in alternative care reported moderate to severe mental health problems.⁵¹ Another United States study found 84 per cent of a foster care sample had developmental or psychological problems.⁵² Emotional, self-regulatory, relational and behavioural abnormalities were most prevalent in school age children.

United States children in out-of-home care have 10-20 times the utilisation rates of mental health services.⁵³ Seventy-five percent of this is accounted for by adjustment, conduct, anxiety and emotional disorders,⁵⁴ and in a group of

children older than three years, 15 per cent reported suicidal ideation and 7 per cent homicidal ideation.⁵⁵ A baseline for comparison is a New Zealand study of children which reported up to 30 per cent by 21 years admitting to suicidal ideation.⁵⁶

It has been observed that foster parents and social workers tend to under-report psychological problems (33 per cent compared with 84 per cent found following careful assessment)⁵⁷ hence the need for screening and careful assessment as well as effective intervention.

In the longer term, adult longitudinal studies identify that those who have been in care during childhood, have significantly higher mental health, educational and vocational problems than the general population.⁵⁸

Mental health, socialisation and self esteem were assessed in a prospective study of children in court ordered foster and kinship care in Australia. This study reported that these children were at high risk of mental health problems.⁵⁹ The study recommended further research into providing effective health services that focus not on discrete disorders but rather a more holistic and complex view of mental, social and emotional aspects of care.

Children in care in Australia are over-represented in the juvenile justice⁶⁰ system and in prisons.⁶¹ In New South Wales (Australia) an inmate health survey reported that 23 percent of women and 21 percent of men had been in care before they were sixteen years old.

There is a clear need for evidence based services and interventions to enhance children and young peoples mental wellbeing.

International systems and policies

Given this recognition of a high level of health, developmental and psychological needs of children in alternative care, recommendations have been developed for management of these problems.

In the United States the Child Welfare League of America and the American Academy of Pediatrics⁶² recommended that all children entering foster care have an initial physical examination before or soon after placement, focussing on identification of acute and chronic conditions requiring expedient treatment. All children should then receive comprehensive physical, mental health and developmental evaluations within one month of placement. In addition all children should be assigned a consistent source of health care.

In the United Kingdom regulations under the Children Act (1989) recommend a statutory annual health assessment (biannual if under 5 years of age).⁶³ The initial health assessment includes information gathered from the child, social worker and parent / carer about current health status as well as personal or family history which may aid in identification of genetic risk or infection risk. The child receives a physical examination including assessment of hearing, vision and growth, and developmental assessment (preschool age) or functional school report (school age).

Unfortunately, in both countries uptake of these assessments has been poor⁶⁴⁶⁵ and while assessments have been helpful in identifying health problems and needs, there has been a disappointingly low rate of action on recommendations.⁶⁶⁶⁷

More recent *Quality Protects* initiatives in England and *Children First Initiative* in Wales (1998) have increased resources and performance monitoring via the *Framework for Assessment of Children in Need and their Families* which aims to improve life health chances of children in care.⁶⁸ The 2002 guidance *Promoting the Health of Looked after Children* has further formalised a framework for delivery of services and health promotion for children and young people in the care system.⁶⁹

In Australia and New Zealand, to date there is no unified response or specific policies or recommended standards of health assessment interventions for children in out-of-home care. In Victoria (Australia) a feedback / complaints project⁷⁰ conducted by the Advocate for Children in Care (the Advocate) established the *Minimum Standards and Outcome Objectives for Home-based Care in Victoria & Minimum Standards and Outcome Objectives for Residential Care in Victoria*.⁷¹ These sets of standards require a medical and dental examination within one month of entering out-of-home care.⁷² This service is provided by General Practitioners using the *Looking After Children (LAC) program*.

The different jurisdictions have a range of systems and initiatives to address the health needs of children and young people in care. These have been comprehensively researched in the *Report card on Health 2006*.⁷³ This report highlights the need to further develop a framework for health care and particularly highlights the need for a national research capacity around health of children in out-of-home care.

Identified barriers to effective care provision

While recognising the needs of these children it is also necessary to acknowledge and address the barriers to intervention. The American Academy of Pediatrics reports that the health care of children in alternative care is frequently compromised by insufficient funding, poor planning, lack of access, prolonged waits for services, poor co-ordination and lack of adequate communication.⁷⁴ The same could be said for many children in alternative care across Australia.

There are recognised barriers to adequate medical care for foster children. They often experience multiple moves usually with no provision for permanent and accessible health records. There is frequently a lack of specific health policies and utilisation of health services occurs in an ad hoc manner. Resource shortages within both health and child support agencies discourages routine screening and support and promotes crisis management. Lack of permanency plans for children in care further exacerbates the above concerns.^{75 76}

Children placed in kinship care may receive even less support and therefore receive fewer services despite similar levels of need.⁷⁷ Ethnic differences can add further to inequitable service provision as some cultures are less inclined to acknowledge mental health issues and actively seek support.⁷⁸ Aboriginal and Torres Strait Islander peoples have difficulty with both access to and availability of culturally appropriate services generally, let alone for the subgroup of children or young people in care.

Absence of information about birth families, birth history and early health issues is commonplace and problematic, and an important function of any health assessment is searching for and collation of what information is available.⁷⁹ In Victoria (Australia) the *Looking after Children* project which aimed to overcome problems of collation of essential information reported poor compatibility with this new set of information and previous records.⁸⁰

Communication between different groups such as health professionals, child welfare workers, foster carers, and biologic parents is often very poor. Medical information and recommendations need to be transferred to everyone involved in the care of children in out-of-home care. Certain parties may be left out of the loop to the long-term detriment of the child. In the case of foster carers, issues sometimes arise with regards to confidentiality and what health information they are entitled to know.

Change of placement in care often results in change of primary health practitioner and change in school and contributes to poor communication and difficulties of information transfer. Change of caseworker has a similar effect.

Instability in foster care placement in the United States was associated with increased mental health costs during the first year in care and this was especially so among children with increasing health costs.⁸² This study again raises the importance of early interventions that target health care resources for these children.

There is often ambiguity in who has responsibility for co-ordinating health needs whether it is the foster carer, the case worker or the medical provider. These children need a strong advocate and health care co-ordinator to ensure that health care needs continue to be met over time.

Models and effectiveness of ‘out-of-home’ care

Previously mentioned models indicate that there is no question that children entering foster care have multiple needs, the question that remains is how to provide complex services to these children in a timely and cost-efficient manner.

Foster care clinics - community based multi-disciplinary clinics

A number of centres in the United States^{83 84 85 86} have developed multidisciplinary community based clinics to provide services to children in foster care. These services have included assessment, usually incorporating standardised screening and assessment tools, health care co-ordination, and often treatment of identified problems. Program evaluations demonstrated that these clinics were more effective in identifying developmental and mental health problems but no more effective in detecting medical and educational problems than community health providers.⁸⁷ However, children in these clinics were more likely to receive recommended services.

Given the high prevalence of developmental and mental health problems in children and young people in out of home care, assessment for Australian or New Zealand children should incorporate the principles of developmental surveillance.⁸⁸ Screening tools must also be used with adequate psychometric properties e.g. Ages and Stages Questionnaire or Brigance Screen, and Strengths and Difficulties Questionnaire or Achenbach CBCL, with ready access to diagnostic tests.

This multi-disciplinary clinic model may be effective in identifying developmental and mental health problems and linking to services, there is still paucity of clear evidence as to effectiveness of various interventions with this population.⁸⁹

Family support programs

It is recognised that in parallel with assessment and treatment of a child's specific needs by professionals, interventions must be ecologically based incorporating the significant others in the child's life such as foster carers, parents if possible, and educational staff.⁹⁰

Given the nature of the attachment difficulties in abused children it is to be expected that issues may play out within a foster placement and within a school setting, and that carers need awareness and special skills to support these children.

Foster parents have to face multiple and seemingly incompatible expectations. They must make emotional investments into nurturing a child who may be

difficult to live with, and to simultaneously support eventual reunion with birth parents and separate easily when the time comes.

Access, while extremely important, can be very stressful for all. Children can become anxious before and may be aggressive or tantrum after. Birth parents may act inappropriately, yet foster carers are expected to deal with the child's reactions and to support the biological parents and ongoing visits.

Various publications address the importance of adequate services and training for foster carers ⁹¹ and the association of such services with better placement and behavioural outcomes for children. ⁹²However, in the United States fewer than one third of carers reported being well prepared to foster.⁹³ Short-term training and supports for foster carers did not impact on children's psychopathology however carers perceived benefits for themselves.⁹⁴

Support services can provide a range of interventions for children and their carers. ⁹⁵ ⁹⁶ This can include education for caregivers eg on effects of early trauma and management of common behavioural problems, guidance in individual or group settings, peer support, and respite care for young children and case management. Relative carers may have greater needs but may receive less support than foster parents. ⁹⁷ ⁹⁸

Over and above the mainstream fostering services there have been trials of "specialised" foster care where there is enhanced pay, and training and regular mental health services. These services have been shown to provide improvements in the children's psychopathology but are expensive. ⁹⁹

Recruitment and training of foster carers are major issues in all Australia and New Zealand. Training is minimal and many foster carers are under-resourced to manage the complexity of the problems, both physical and emotional, that they encounter.

Permanency planning

Children who have experienced abuse with family disruption and who have poor attachment have a heightened need for permanency, security and emotional constancy. Lack of placement stability and multiple moves is unfortunately very common. While the goal of placement is usually to work towards the child being safely reunified with biological parents, there are some children for whom this is not possible and for these children permanency planning at the earliest possible time is essential to stop drift within placements.

The way ahead

Efforts to improve outcomes for these children and young people in Australia and New Zealand must address the existing barriers. The frequent multiplicity of problems mandates a comprehensive and collaborative assessment and treatment approach. Ongoing health care should incorporate systematic monitoring with improved continuity of care and information sharing between involved parties, and attention to preventative health care, health education and health promotion. The effectiveness of therapeutic interventions requires ongoing evaluation and is contingent on accurate data collection and ongoing research.

The recommendations in this document are a framework to allow these goals to be achieved.

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