

# HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE IN STATE CARE

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## Introduction

This chapter reviews health needs of children and young people in State care and outlines what is required of health services to meet these needs. The aim of this chapter is to inform health service providers of some of the key issues to be addressed in developing and expanding services for children and young people in State care. The voices of children and young people who have experienced State care are included where possible, highlighting the importance of their participation in service development and provision. The chapter is not an itemised catalogue of evidence for best practice in relation to specific health conditions; this information is provided elsewhere through clinical networks and guidelines referred in NZCYES reports. This chapter presents some key aspects that will be important to deliver high quality child-centred services to some of the most vulnerable children in New Zealand.

Children and young people in State care have experienced a lack of nurturing care, and this lack can have a serious impact on their health. Most of these children and young people live in out-of-home care; that means they live with members of their whānau or extended family, or in foster care with people to whom they are unrelated.<sup>1</sup> Children in out-of-home care live very complex lives. They experience divided loyalties to the people they live with, who provide the day-to-day care and protection they need, and also to their birth families for whom they may have strong but ambivalent feelings.<sup>2</sup> These children need intensive support so that they have the chance to develop a sense of stability and to enjoy the same opportunities and outcomes as other New Zealand children.<sup>3</sup>

The complex experience of children and young people in State care has important implications for health services. For health service systems to enable continuity of care, they need to take account of changes in caregivers and in domicile which can occur multiple times for some of those children in State care.<sup>4</sup> Strong co-ordination between District Health Boards (DHBs) is important so that when children or young people move they do not have to start again from the beginning of a health assessment process. Within DHBs it is important for child health services and child and adolescent mental health services (CAMHS) to work together to meet the needs of vulnerable children and their whānau. Effective services for children and young people in State care involve multiple government agencies, including health, education and justice, as well as non-government organisations. Information sharing between agencies and organisations is an essential part of ensuring that the needs of children and young people in State care are prioritised and met.<sup>3</sup>

More than half of the children and young people in State care have Māori recorded as their primary ethnicity.<sup>5</sup> Processes to embed a high degree of cultural competence and confidence are required to meet the needs of all children and young people in State care.<sup>3</sup> In this chapter, the principles of the Meihana model have been used as a framework to present findings from the international scholarly literature about the health needs of children and young people in State care. The Meihana model acknowledges physical, spiritual, psychological and family dimension of health and wellbeing, as well as the role of the services and systems and the physical environment in contributing to the health outcomes.<sup>6</sup> International experience has been drawn upon to identify possible ways forward from the perspective of the health sector.

The chapter concludes with a description of the child protection process in New Zealand and why and how children and young people are taken into State care. In any one year, about 5000 children and young people in New Zealand are in the custody of the Chief Executive of Child, Youth and Family. They have been through a formal assessment and investigative process and found to need statutory care and protection.<sup>1</sup> Further detail from recent reviews is also included with an overview of the proposed changes to the child protection system.

## Experiences of children and young people in State care

Children and young people who enter State care have been exposed to a lack of parenting ability and in particular, a lack of nurturing care, which impacts significantly on their wellbeing. The report of the Modernising Child, Youth and Family Expert Panel described a marked difference between the intentions of

New Zealand's child protection system and the nature of the actual experience described by young people. Although the experiences of the young people differed greatly, themes of chaos, disruption, a sense of loss and abandonment came through very strongly during the interviews with them. Their subjective experience was dominated by negative emotions such as anxiety, powerlessness and grief. To them, the system lacks humanity and struggles to keep children and young people safe, let alone helps them recover from the impact of abuse and neglect.<sup>7</sup>

Transition into State care often meant that there were abrupt changes in young people's lives, for example, separation from their siblings, living in a different geographical location and having to change school. Few young people reported any support to help them manage the trauma and emotional impact of being removed from their family or being moved from placement to placement.<sup>7</sup> Finding a sense of family in an environment where they feel accepted and loved is critical for young people. Caregiving arrangements need to be well matched to the young person's age, gender and stage of development. A key mark of effective caregivers is that they identified a strength area or a source of happiness and supported the young person to excel at something.<sup>7</sup>

The expert panel heard from 19 young people about their experiences in the New Zealand care and protection system. The key messages from these young people are shown in **Box 1**.<sup>7</sup>

Box 1. Main things told by young people to the Modernising Child, Youth and Family Expert Panel

<p><b><i>We need more nurturing and love</i></b> The young people told us the system often did not provide them with the nurturing and love they required. They felt their caregivers should provide more than food, shelter and supervision – they should also provide an environment where children and young people could learn, grow and heal.</p> <p><b><i>We want a say in what happens to us</i></b> The young people felt they did not have a voice in important decisions being made about their futures. They felt people involved in the process were not being honest and transparent about the decisions that were being made. This left them confused, anxious and disempowered.</p> <p><b><i>We have experienced trauma and need help to make sense of what has happened to us</i></b> Young people described being expected to transition into new environments frequently with little support. Young people commented that they need to be empowered to make sense of what they have been through and the reasons why things have happened to them.</p> <p><b><i>We crave belonging and being part of a family who bring out the best in us</i></b> Finding a sense of family is critical for young people. Young people were concerned that if others knew they were in care then they would also know that they did not belong to anyone. Many reported the life-changing impacts of finding 'the one' adult who understood and supported them.</p> <p><b><i>We want to strengthen our cultural identity and connection</i></b> Young people talked of the value of cultural connections, especially in relation to building their sense of identity and wellbeing. They felt this was not well recognised or supported, and adults did not understand the importance of connection and undervalued it.</p> <p><b><i>We do not stop needing help, support and nurturing just because we turn 17</i></b> Some young people felt very unprepared, stressed and vulnerable when they age out of the care system at the age of 17. For some young people leaving care, the only option is going back to the unsafe environments they were initially removed from.</p>
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Source: Modernising Child, Youth and Family Expert Panel. 2015. Interim report.<sup>7</sup> (pp. 8-9)

The messages from young people who met with the Expert Panel were consistent with what the Children's Commissioner heard from children and young people in the custody of the Chief Executive of Child, Youth and Family (in CYF care) through surveys and focus groups. Those in CYF residences were generally positive about their experience but experiences were more variable for those in-kin and non-kin out-of-home care. Some described overwhelmingly negative experiences including abuse in foster homes, separation from siblings, constant change, "Bible bashing", depression, alcohol and drug use.<sup>5</sup> The messages by children and young people in the 2016 *State of Care* report can be summarised as follows:<sup>8</sup> (p. 7)

- **We need to feel like we belong.** Children and young people wanted help to manage relationships with family, opportunities to learn about and connect with their culture, and to be able to enjoy their childhoods with a range of activities, a positive school life, and no stigma attached to being a "CYF kid."
- **Involve us, listen to us, and communicate with us.** Children and young people wanted to be given a voice in decisions that affect them, involved in care plans and transition planning, and communicated with clearly and respectfully.
- **Social workers have a big impact on our lives.** Children and young people spoke in detail about their interactions with social workers. Their comments highlighted that, as the chief interface between the child or young person and CYF, the social worker plays a critical role in determining whether the child has a positive or negative experience in the care and protection and youth justice systems. A child in non-kin foster care stated "[My social worker is] kind of like family now; like a friend now."

## Health needs of children and young people in State care

There has been limited research on factors associated with wellbeing of children in care in New Zealand, with a tendency to rely on international research to inform policy and practice.<sup>9</sup> Recent reviews have found that current systems in CYF and in the Ministry of Social Development (MSD) are not set up to measure and record the most important information about children in care. Reviews have also found that there is poor integration between MSD and other government agencies, including health.<sup>5</sup> Nevertheless it is recognised that families of children who are referred to CYF have often experienced high levels of long-term need and disadvantage, often including combined effects of long-term unemployment, low income, unaddressed physical and mental health needs, addiction disorders and family violence.<sup>7</sup>

Gateway assessments have been provided since 2011 for children and young people who may be at risk of coming into CYF care, entering care or already in care.<sup>10</sup> Gateway assessments are managed by DHB co-ordinators, after referral of children by CYF, and include assessment by health professionals. The Expert Panel observed that health needs were identified frequently among the children and young people who had completed a gateway assessment. For every ten children or young people who completed a gateway assessment:<sup>7</sup>

- Three had a mental health need
- Five had emotional needs
- Three had developmental needs
- Six had learning needs
- Three had dental needs
- Four had needs as a result of parent or caregiver alcohol or drug addiction.

Research in other countries has shown that children and young people in State care are a very vulnerable group with relatively high levels of unrecognised or unmet health needs.<sup>11</sup> Children in State care have been classified as a population of children with special health care needs in the USA and in the UK.<sup>12</sup> Understanding and recognition of the health needs of children and young people in State care is important so that plans are in place for them to receive health care wherever they are placed, and to appropriately review the services in place for them.<sup>11</sup> In addition to their important health care needs, children and young people in State care experience barriers in accessing appropriate and continuous care that can worsen their prognoses.<sup>13</sup> In this chapter the concept of *te waka hourua*, or the double-hulled waka, is used as a framework to present findings from research about the health needs of children and young people in State care.<sup>6</sup>

To date there has been inadequate research about the long-term outcomes of foster care. By long-term outcomes researchers are referring to what happens among young adults who were in State care as children. This group is referred to as having ‘aged out’ of care. Prevalence studies on specific populations of young people who have aged out of foster care show high rates of clinically significant mental health problems (54%), chronic medical illness (30%), unemployment (19%–37%), poverty (33% live at or below the US poverty level), lack of health insurance (33%–50%), and homelessness within one year of leaving care (22%–36%). High school completion rates vary and completion may occur years after leaving care. One study of young adults who lived in foster care during adolescence found a prevalence of post-traumatic stress disorder (PTSD) twice that of combat veterans. Although these prevalence studies of high-risk adult populations are not representative and therefore cannot be used to indicate ‘cause and effect’, they do provide a measure of the ongoing health problems affecting young people who leave State care as they transition to adulthood.<sup>12</sup>

It is difficult to compare information about children and young people in State care in different countries, mainly due to different approaches, organisational structures and definitions of formal out-of-home care.<sup>7,13</sup> In many countries the categories are broader than that used in New Zealand for children and young people in CYF care, for example many jurisdictions include children and young people in voluntary placements with family or friends and not only those formally in statutory care. Also, in many jurisdictions monitoring and surveillance systems continue to follow young people after they have left State care. Despite these limitations, the literature suggests that all children who have contact with child welfare services share similar risk factors associated with a higher likelihood of poor long-term outcomes whether in out-of-home care, kin care or remaining with parent(s).<sup>12</sup> The following terms can be considered as synonyms in this part of the report, bearing in mind that they may describe slightly different population groups dependent on national definitions: looked-after children and young people; looked-after and accommodated children; children in care; and children and adolescents involved in the child welfare system (CWS). Children in foster care refers to out-of-home care in a family with kin or non-kin carers, and children in kinship care refers to out-of-home care within a child or young person’s extended family.

## Te waka hourua

The concept of te waka hourua is a key component of the Meihana model, which has been developed to enable health practitioners to develop a broader understanding of Māori patients and their needs.<sup>6</sup> The principles of the model are not unique to Māori, and in this section are applied more widely to all children and young people in State care. Importantly, statistics show that over 50% of children and young people in CYF care identified with Māori as their primary ethnicity and this model is therefore directly relevant to them.<sup>5</sup>

Te waka hourua was the traditional mode of transport used in the migration of Māori from Hawaiki to Aotearoa (New Zealand). The two hiwi (hulls) represent the child or young person and their family or whānau on a journey to health and wellbeing. The hiwi are joined by five crossbeams:<sup>6</sup> (p. 108)

- Tinana: Physical health and functioning
- Hinengaro: Psychological and emotional wellbeing
- Wairua: Beliefs regarding connectedness and spirituality
- Taiao: Physical environment including home environment and neighbourhood
- Iwi katoa: Services and systems that provide support within the health environment

The journey toward health and wellbeing of the child or young person and their whānau or family is also impacted by nga hau e wha, the four winds, that represent wider societal and historical influences. The forces of colonisation, racism, internal migration from traditional iwi land, and marginalisation have significant influence on the journey and are important components of clinical assessment.<sup>6</sup>

The concept of nga roma moana, or ocean currents, reflects the way in which each specific child or young person, and their whānau, relate to te ao Māori (the Māori worldview), including use of te reo Māori, tikanga Māori including karakia and prayer, whānau roles and responsibilities, and specific geographical and genealogical connections, or whenua.<sup>6</sup> When health practitioners identify aspects of Te Ao Māori that are important to a child or young person and their whānau it can help all involved to share more freely in the clinical setting and thus facilitate better care.<sup>6</sup> Health practitioners can also provide more culturally appropriate services when they become familiar with specific cultural principles and integrate these within clinical practice.<sup>6</sup>

## Whānau

Whānau may refer to biological family and/or other key support people.<sup>6</sup> Occurrence of child abuse strengthens rather than diminishes the importance of the whānau: “Parental rights often tend to be seen as secondary to the interests of whānau ... to ensure that future generations are protected.”<sup>14</sup> (p. 73) Many young people with experience of the New Zealand care and protection system indicated to the Expert Panel that they “wanted to remain in the very environment they were removed from. They could not understand why the offending adult(s) remained at the home while the child was the one taken away.”<sup>7</sup> (p. 41)

*I just thought it took only one call for me and my sister to be uplifted without a question, without even coming in to meet my dad or anything. I mean I understand now he drank a lot and my mum and dad used to fight but we were never hit, we were never mistreated, we got our food, we went to school sometimes, and I can understand why they took us away now, but being a young kid and being taken away, you think oh my gosh my parents are like awesome, they're like the best. Female, 19, about experience in CYF care<sup>7</sup> (p. 41)*

It is of critical importance that children and young people in out-of-home care find a sense of family in an environment where they feel accepted and loved. A key mark of effective caregivers is that they identified a strength area or a source of happiness and supported the young person to excel at something (such as cheer-leading, music, sport, dance, bike repairs).

*... But if you put them in something they enjoy and something they're good at, they will be able to see the potential in themselves. I loved it because I got involved in sport. I was so involved in sport that I didn't have time to rebel and then with that family I started to see the importance of school and education because the oldest daughter she was actually my best friend and because she was in my class I was always hanging out with her. I would always do my work, and she was just like a really good role model even though she was my age. I graduated high school because of them. Female, 17, about experience in CYF care<sup>7</sup> (p. 43)*

A competent, caring, nurturing, stable foster or kinship placement can be very important in supporting and advocating for the health and wellbeing of a child or young person. For children who have suffered severe neglect and abuse, placement in non-kin foster care or kinship care can be an important opportunity for intervention and healing.<sup>12</sup>

## Tinana

Childhood trauma and adversity contribute to development of a number of health issues, and the ongoing loss and uncertainty in out-of-home care may exacerbate rather than ameliorate problems.<sup>12</sup>

Children and young people in State care have at least the same health needs as other children. The New Zealand Health Survey estimates that 17% of all 0–14 year olds and 24% of Māori 0–14 year olds have medicated asthma.<sup>15</sup> It is reasonable to expect similar prevalence amongst children and young people in State care. It is important to identify allergies, especially for those children who have anaphylaxis, as the carers need to be aware of substances/foods to avoid and to receive advice on management.<sup>11</sup>

There are, however, other health conditions more prevalent among children and young people in State care than among other children, including incomplete immunisation status and developmental disorders, as well as substance use, early sexual initiation and teen pregnancy among young people.<sup>11,12</sup> In the US, studies suggest that 30–80% of children who enter foster care have at least one physical health problem and at least one-third have a chronic health condition. These health problems are commonly undiagnosed and untreated before the child enters State care.<sup>12</sup> The authors also noted particular health issues for adolescents in foster care, who were at high risk of having untreated mental health conditions as well as educational, physical and reproductive health and psychosocial needs. Around 50% of young people in foster care had chronic medical problems unrelated to behavioural concerns.<sup>12</sup> Young people in care are a diverse group who may have come into care as a result of behavioural issues such as school truancy or petty criminal activity, or may have grown up in State care. This research identified that whatever the circumstances, most young people in State care have experienced neglect or abuse at some point in their lives. Those entering foster care as adolescents report high rates of exposure to violence, substance abuse and school failure with low literacy levels. Those who have positive peer relationships and adult mentors seem to fare better than those without. By age 18 years, 93% of youth in foster care reported being sexually active and almost half of these youth reported sexual initiation before the age of 16 years. Compared with peers not in foster care, foster care youth were approximately 2.5 times more likely to experience a pregnancy by age 19 years. Youth in foster care are more likely than youth not in foster care to report unintended pregnancy and less likely to use regular contraception. Repeat pregnancies among youth in foster care occur in almost half of all young women, compared with less than one-third of their peers not in foster care. Young adults in foster care are almost twice as likely as their peers to have experienced “forced sex”.<sup>12</sup> (p. e1148) Youth in foster care not only experienced substantial health issues, but also experienced difficulties transitioning from adolescence to adulthood with higher rates of unemployment, poverty, and homelessness than youth not in foster care.<sup>12</sup>

A comprehensive audit of a representative sample of 237 looked-after children in the London Borough of Hillingdon (LBH) in the 2014–2015 year found that 79.5% of the children and young people had at least one physical, mental or behavioural health need, 17% had a physical or mental impairment which had a substantial and long-term effect on the ability to undertake normal daily activities (recognised disability), and 3% had extremely complex needs. Prevalence of allergy and of overweight/obesity were comparable to prevalence in the general population. While it is encouraging that looked-after children were not more overweight than the local population the authors note that healthy diet and exercise continues to be important. Health needs of looked-after children and young people in LBH differed by age group, with higher prevalence of physical health needs, including developmental needs, at younger age groups and higher prevalence of mental health needs in older age groups (See **Box 2** for further details).<sup>11</sup>

Box 2. Physical health needs by age group of children and young people in State care, representative sample of looked-after children, London Borough of Hillingdon (United Kingdom) 2014–2015

**< 1 year:** 87% of looked-after children in this age group had one or more health needs. 56% had experienced antenatal substance misuse/neonatal abstinence syndrome; 32% had neurodevelopmental problems; 19% had congenital abnormalities.

**1–4 years:** 78% of looked-after children in this age group had one or more health needs, with 10% having complex needs. 14% had suffered antenatal substance misuse/neonatal abstinence syndrome; 53% had neurodevelopmental problems, 21% had some toileting difficulties; 21% had both physical and emotional problems.

**5–9 years:** 61% of looked-after children in this age group had one or more health needs. 42% had neurodevelopmental problems or speech and language difficulties.

**10–15 years:** 62% of looked-after children in this age group had one or more physical health needs. 1.5% had congenital abnormalities; 7% had dental problems, such as caries/orthodontics/enamel loss; 11% had gastrointestinal problems; 12% had skin problems, mostly acne; 4% presented with various injuries.

**16–17 years:** 66% of looked-after children in this age group had health needs, with half of these having only one health need. Symptoms included: skin conditions (17%); musculoskeletal (16%); gastrointestinal, including liver disease (13%); ear nose throat (12%); respiratory (10%); dental issues (4%); neurodevelopmental difficulties (9%); gynaecology, including pregnancy and female genital mutilation (7%).

Source: Health needs audit for looked after children and young people in the care of the London Borough of Hillingdon<sup>11</sup>

## Hinengaro

To provide appropriate treatment for children, the importance of the role of childhood trauma in the emergence of child mental health problems needs to be understood. Children who have experienced trauma, especially those who have lacked appropriate caregiving and treatment, may develop depression over time or may have comorbid mental health problems.<sup>12</sup> Bronsard et al's systematic review and meta-analysis of eight epidemiological studies across different countries demonstrates the complexity of mental health screening and care in children and young people in the child welfare system (CWS). For these children and young people externalised and internalised mental health and emotional disorders are associated and complexly entangled.<sup>13</sup> The authors found that almost half (49% pooled prevalence) of children and adolescents in child welfare systems met criteria for a current mental disorder, a prevalence almost four times higher than in the general child and adolescent population.<sup>13</sup> They also cite the clear association between attachment insecurities and vulnerability to mental disorders and posit that the central role of child-to-parent attachment in a child's development may explain the high prevalence of mental disorder observed in their work. Adverse experiences of children and adolescents in the CWS, including maltreatment and serious neglect, reduce the likelihood of creating secure attachments that are crucial for developmental health. Multiple placements and temporary or disrupted relationships with caregivers can also potentially prevent the formation of secure attachments by these children and adolescents.<sup>13</sup> Multiple placements and maltreatment during the time of placement may contribute to worsening of pre-existent externalised mental disorders or promote emergence of such disorders. Externalised disorders were the most prevalent mental disorders in the meta-analysis: 27% of children and adolescents met the diagnostic criteria for a disruptive disorder including 20% with conduct disorder (10 times higher than child and adolescent population prevalence) and 12% with oppositional defiant disorder (three times higher than child and adolescent population prevalence). The estimated 11% prevalence of attention deficit hyperactivity disorder (ADHD) among children and adolescents in the CWS was three times higher than that of their peers. The prevalence of internalised disorders such as anxiety disorder (18%) and depressive disorder (11%) was also three to four times higher than the prevalence of these disorders in the general child and adolescent population. Limitations to this systematic review included heterogeneity of results, possibly influenced by factors such as differences between countries in interpretation of symptoms, and patterns of child welfare provision, and the small number of epidemiological studies describing children and young people in State care.

Szilagyi et al's data suggest that children in foster care are prescribed psychotropic medications at a rate three times that of other Medicaid-enrolled children in the US and they have higher rates of polypharmacy. Once psychotropic medications are prescribed, children in foster care are likely to be kept on them longer than children who are not in foster care. Treatment with psychotropic medications may not address the underlying trauma and attachment issues at the root of challenging behaviours. Factors that may contribute to the apparent overtreatment with psychotropic medications include caregiver demand for medication to manage disruptive behaviours, lack of understanding of childhood trauma, lack of paediatric mental health resources, and misdiagnosis of trauma symptoms as other mental health conditions, such as attention deficit hyperactivity disorder.<sup>12</sup> Szilagyi et al note that psychotropic medications should be prescribed for children and young people

in State care only after a mental health evaluation and trauma assessment by a child mental health expert and only for a specific mental health diagnosis. The medication should be appropriate to the diagnosis, initiated at the lowest appropriate dose, and increased slowly while monitoring for efficacy and adverse effects. Polypharmacy should be avoided whenever possible.<sup>12</sup>

Child health professionals may need assistance from mental health professionals trained in trauma-informed care to correctly assess and diagnose mental health problems in children and young people in State care. The American Academy of Pediatrics recommends a mental health evaluation within 30 days of out-of-home placement, ideally by a child mental health professional trained in trauma-informed care. Periodic reassessment of mental health should occur whether or not a child is receiving mental health services because of the many uncertainties and transitions that can occur in their lives. Trauma-informed, evidence-based therapies include parent-child interaction therapy, child-parent psychotherapy, and trauma-focused cognitive behavioural therapy. A shortage of appropriately trained and experienced mental health professionals is a barrier to all children who might benefit from these interventions being able to access them.<sup>12</sup> Within New Zealand this highlights the importance of child health services and child and adolescent mental health services (CAMHS) working closely together and facilitating cross-referrals when indicated. Adequate CAMHS service provision is a prerequisite to such collaborative working.

## Wairua

Atwool noted the following with respect to carers:

Recognition of their vital role in supporting children in short-term and long-term placements and ensuring they are in a position to answer questions and contribute to a child's search for meaning is an essential prerequisite for improved practice. All caregivers (including those offering short-term care) need to be equipped to support children in keeping an ongoing record of their time in care through the use of memory boxes, life story books and digital records. Provision of back-up storage in case records are lost or destroyed is also needed.<sup>16</sup> (p. 10)

Children and young people in State care expressed a clear need for help to manage relationships with family as well as opportunities to learn about and connect with their culture.<sup>8</sup> Young people reported a wide range in the help they needed to build or maintain cultural connections. One young woman (age 17) reported that her caregiver "didn't understand and she wouldn't let me go to kapa haka practices and she couldn't see why it was important to me."<sup>7</sup> (p. 44) Such connection is essential for their wellbeing, is an integral part of clinical assessment and of providing child-centred care. Life story work is an inclusive term that emphasises the process of providing children with access to a coherent story of their life.<sup>16</sup> Life story work, adapted to suit a child's interests and needs, can contribute to bolstering self-esteem and a sense of identity. Children and young people find that a coherent life story helps them to learn about themselves, their families and their past, and to manage emotions, particularly emotions associated with negative experiences. There is currently a rather haphazard approach to such work in Aotearoa New Zealand which may contribute to poor outcomes.<sup>16</sup> Understanding their own 'health history' is an essential part of growing up securely. Inconsistent record keeping can lead to wrong decisions by professionals and adversely affect the child or young person.<sup>4</sup> Ensuring that a comprehensive health record is available to the child, young person and their caregivers, as part of the life story record is a positive contribution that health services can make to children and young people in State care. Health practitioners can ask to see records of the child's lived experience to date, and also ensure that important medical information is included and available to the child or young person as well as to any future caregivers.

## Taiao

The underlying model on which New Zealand approaches care and protection is reflected in the direct questions asked of the child or young person and their caregivers about their home environment, neighbourhood and safety.<sup>6</sup> In the UK, Bilson (2016) suggests an alternative approach to the forensic child protection model that is common in the UK, USA and New Zealand. Such an alternative approach would aim to improve the conditions of families and communities, enabling them to enhance the wellbeing of children, rather than relying on agents of child protection to seek out harm. A community orientation would embrace approaches that focus on increasing neighbourhood cohesion to promote the wellbeing of children and families, evidence-based delivery of early childhood education that increases social capital, and also advocate for increased incomes for poor families that, in itself, has been shown to increase the wellbeing of children.<sup>17</sup> In New Zealand, many of the families of children who are referred to CYF live in areas with high deprivation scores.<sup>7</sup> Reducing social

inequalities overall, and breaking the link between deprivation and extreme interventions by promoting good child development, could become a central goal of child protection policy and practice.<sup>18,19</sup>

Although it is rare, children may experience further abuse or neglect in foster homes.<sup>12</sup> Biehal et al's review found that it was difficult to come to clear conclusions about the extent of maltreatment in foster care.<sup>20</sup> Some studies reported either the total number of substantiated or unsubstantiated allegations of maltreatment per foster carer or foster family, whereas others reported the number of children experiencing maltreatment or incidents of maltreatment, with no indication of the proportion of children or foster carers involved in multiple incidents. There were also differences in the data sources used and reporting bias may result from children being unwilling or unable to report abuse. These factors need to be borne in mind when considering the following results on the extent of maltreatment in foster care. Five US studies of incidence found that between 0.27% and 2% of fostered children per year were known to have experienced maltreatment. Some of the variability in reported incidence may be due to local variations in thresholds for investigation or in recording policies. Separate studies from Baltimore, England and Scotland found that allegations of maltreatment were made in relation to 3–4% of foster homes per year, and substantiated in less than 1% of all foster homes. Biehal (2014) further notes that it is important to distinguish maltreatment in foster care from maltreatment by foster carers. Although foster carers are responsible in the majority of cases of maltreatment, perpetrators also include other children (including other fostered children, siblings of the child experiencing maltreatment, foster carers' own children or other unrelated children) and partners of foster 'mothers' (mothers may be unaware of the abuse). Fostered children may also be reabused during contact with their parents.

## Iwi katoa: Health service implications

An integral part of the assessment process is to identify whether children, young people and whānau have had appropriate access to health services and systems.<sup>6</sup> The Expert Panel heard that health services

“... do not prioritise work with vulnerable children ahead of their general accountability for universal services, despite the fact that vulnerable children are harder to reach and have more complex needs. If we are to have the same high level of aspiration for vulnerable children as we do for all other New Zealand children then we need to establish specific targets for children in the care and protection and youth justice system and hold social sector agencies to account for the achievement of these targets.”<sup>7</sup> (p. 11)

Health services are key actors in the planned legislative and operational changes to the New Zealand care and protection system as children and young people in State care will need access to appropriate services to address health concerns. Health services will need to ensure that health needs of children and young people in State care are actively prioritised, and respond appropriately to the full range of children's and young people's needs.<sup>5,8</sup> In addition to evidence-based best practice, children in State care have health service needs related to the context in which they live and grow.

## Foundational principles and values

The National Institute for Health Care and Excellence (NICE) in the UK has articulated a group of principles that apply to all services for children in State care, including health services:<sup>4,21</sup>

- Put the voices of children, young people and their families at the heart of service design and delivery
- Deliver services that are tailored to the individual and diverse needs of children and young people by ensuring effective joint commissioning and integrated professional working
- Develop services that address health and wellbeing and promote high-quality care
- Encourage warm and caring relationships between child and carer that nurture attachment and create a sense of belonging so that the child or young person feels safe, valued and protected
- Help children and young people to develop a strong sense of personal identity and maintain the cultural and religious beliefs they choose
- Ensure young people are prepared for and supported in their transition to adulthood
- Support the child or young person to participate in the wider network of peer, school and community activities to help build resilience and a sense of belonging
- Ensure children and young people have a stable experience of education that encourages high aspiration and supports them in achieving their potential

## Participation in health care decision-making by children and young people

The Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Bill has a renewed emphasis on the participation rights of children and young people.<sup>22</sup> The participation rights of individuals in their health care is well established, including the importance of securing the participation of children in decisions which affect them.<sup>23,24</sup> Being child-centred is a way of elevating the interests, wellbeing and views of children. The overarching reason to be child-centred is to make sure decisions by health services and health professionals do not harm children and, in fact, support them to thrive. Services seeking to become more child-centred can seek the views of children and young people and ensure that their opinions and views are taken into account when decisions are made.<sup>25</sup> The Children's Commissioner's guidance for agencies to become child centred describes the following core principles of child-centred thinking necessary in both top-down leadership and bottom-up practice:<sup>25 (p. 3)</sup>

- The best interests of the child should be an important consideration in all decisions
- Children should have the opportunity to have a say in decisions that affect them
- Decisions should ensure that children are not discriminated against
- Decisions should support, and not prevent, children to live, grow and achieve their full development
- Instituting child-centred thinking requires adoption at all levels of the organisation, including leadership commitment, training of staff and embedding in operations
- Any assessment of how children may be affected needs to be made at the beginning of a decision making process so issues can be addressed in the ultimate decision

## Identifying children in need of care and protection

In practice, it is very difficult for CYF to restrict its role to a narrow statutory scope when health, education and welfare services are either insufficient or poorly aligned to the needs of vulnerable children and their families.<sup>7</sup> Within current legislation as well as the proposed amendments, health services have a major role in identifying child abuse and neglect and lodging appropriate reports of concern. The New Zealand Clinical Network for Child Protection (the Network) provides a source of expertise on issues of child abuse and neglect across the country and acts to assist in the co-ordination of services to abused and neglected children and young people.<sup>26</sup> New Zealand DHBs have a memorandum of understanding with Child, Youth and Family that recognises the expertise of DHB staff in the recognition and management of child abuse and neglect to guide effective practice. This MoU can be accessed from the Network webpage.<sup>26</sup>

The National Institute for Health and Care Excellence (NICE) in the UK has developed a pathway that provides an integrated view of guidance, standards and indicators relevant to looked-after babies, children and young people.<sup>4</sup> There is also a specific pathway with information and resources about attachment difficulties in children and young people; although attachment difficulties are not specific to children in State care they do affect almost all children and young people in State care. It is essential that all professionals working with children in State care understand the complex issues affecting the lives of these children and young people, including discrimination and its impact, and recognise the importance of culture, identity and education in achieving a state of wellbeing.<sup>4</sup>

## Information sharing and collaboration

It is generally accepted that effective child protection requires responses from health, education, justice, police and non-government organisations. For example, in New South Wales, the 'Keep them Safe' initiative involved expanding responsibility for responding to children at risk to increase the involvement of health, education, Police and other government agencies, as well as the non-government sector.<sup>7</sup> New Zealand is one of the few jurisdictions that does not have information-sharing settings in relation to vulnerable children in its care, protection and youth justice legislation.<sup>3</sup> The Expert Panel noted that New South Wales and Scotland have recently introduced major changes to information-sharing settings with some common features:

- Changing the threshold for information exchange towards promoting safety, welfare and wellbeing of children and young people and away from averting threats of serious harm
- Enabling greater information exchange between a much broader range of people involved in the lives of children and young people and their families than just those directly employed by the care and protection service
- Accompanying information-sharing duties with duties to collaborate with other professionals

The Children, Young Persons and Their Families (Oranga Tamariki) Legislation Bill includes provision for an information sharing framework that will include health services. This may be in response to the Expert Panel's observation that health services and other agencies are not prioritising services for vulnerable children ahead of

a general accountability for delivery of universal services. Although there is clear government policy for every child in State care to receive a comprehensive health and education assessment, CYF data indicate that only five to six out of every 10 children in State care have a completed assessment, and there is little record of how many of these children have accessed required services to meet assessed needs.<sup>7</sup>

## **Healthcare staff knowledge skill and competence**

In England, providers of health services are expected to identify a named doctor and nurse for looked-after children. These named professionals coordinate the provision of services for individual children and also provide advice and expertise for fellow professionals.<sup>27</sup> To fulfil their role and responsibilities in respect of looked-after children, all health staff need access to appropriate training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.<sup>4</sup> Those in specific child health service roles also need the skills and competences to undertake health assessments, contribute to healthcare planning, ensure clinical governance arrangements to assure the quality of services for looked-after children, and coordinate care for each young person. The high prevalence of mental health conditions among children in State care, and the shortage of mental health professionals, calls for strong collaboration between paediatricians and mental health partners, including psychiatrists, psychologists, and developmental and behavioural paediatricians, among others. One promising model for the care of children in foster care is integrated paediatric and mental health care services in the paediatric medical home setting.<sup>12</sup>

The concept of a medical home was first mooted in the US in the 1960s among paediatricians who cared for children with chronic health conditions. At that time a medical home was a primary care practice for children that offered central coordination of specialists involved and a way to keep all information and data about the child in one place.<sup>28</sup> A medical home may contribute to mitigating the impact of adverse events on the wellbeing of children, and provide support which enhances family and child resilience.<sup>29</sup>

## **Primary prevention of child abuse and neglect**

Bilson's<sup>17</sup> suggested alternative approach to the forensic child protection model common in the UK, USA and New Zealand aims to improve the conditions of families and communities, enabling them to enhance the wellbeing of children, rather than relying on agents of child protection to seek out harm. A community orientation would encompass approaches that focus on increasing neighbourhood cohesion to promote the wellbeing of children and families, evidence-based approaches to early years education that increase social capital, and advocacy to increase incomes of poor families that on its own has been shown to increase the wellbeing of children.<sup>17</sup> Reducing social inequalities overall and breaking the link between deprivation and extreme interventions by promoting good child development are policy goals that foster good practice for health as well as for education and other services.<sup>18,19</sup> Neighbourhood-based strategies for child maltreatment prevention can be effective in low- and high-resource communities leading to a reduction in child maltreatment for children aged under six years.<sup>30</sup> Although the authors observed that mechanisms related to successful interventions differed in different communities, they noted that the final outcomes always included improved child safety.

## **Parenting interventions and support of caregivers**

Akin et al<sup>31</sup> reviewed the implementation of evidence-based parenting interventions with substance-affected families involved with the child welfare system in five United States (US) counties using the following framework:

- Process factors including staff selection, training, coaching, and performance assessment
- Provider factors such as health service providers' attitudes toward evidence-based practice, which may in turn be affected by individuals' education level and professional status
- Innovation factors including logistical issues such as transport availability and the congruence between the planned intervention and the culture, values, and methods of the organisation implementing it
- Client factors which include the complexity of clients' presenting concerns as well as environmental barriers they may encounter
- Organisational factors ranging from the culture, climate, attitudes, and values of an agency to its policies and procedures
- Structural factors in the broader operating environment of organisations, including workforce issues, court systems, and interagency collaboration

Successful uptake of an evidence-based parenting intervention was associated with interactive and supportive staff training, well-balanced staff composition, programme flexibility that allowed for adaptation to local conditions and client circumstances, a focus on family skill development rather than clinical therapy and peer support among participants. Strong leadership at executive and management levels, particularly where there was

a person dedicated to the coordination and implementation of the programme, was critically important for successful uptake. Community partners' donations of space, volunteers, food, and prizes helped successful programmes but varied between sites. Lack of adequate funding was a key barrier to effective implementation, and was associated with reliance on volunteer input and minimal capacity to make allowance for staff absences or staff turnover. Another barrier was difficulty in finding a time that worked well for families. Barriers experienced in rural communities included lack of transport, maintaining a minimum number of participants, and securing community partners.<sup>31</sup>

Many children in foster care have emotional and behavioural difficulties and some carers may respond poorly to these challenging behaviours.<sup>20</sup> Training in childhood trauma for caseworkers and foster parents has improved in recent years, and ongoing support for foster parents by well-educated professionals is important so that they have the opportunity to develop specific skills in parenting the traumatised child.<sup>12</sup>

## High quality data

Accurate and up-to-date personal health information has significant implications for the immediate and future wellbeing of children and young people during their time in care and afterwards.<sup>4</sup> Deficiencies in available data have been noted in New Zealand (see **Monitoring State care in New Zealand on page 14**).<sup>5</sup> There is an urgent need to improve the range and quality of information on the needs of children, family/whānau and caregivers. Reliable information on the range of indicators is required to measure whether we are making a difference in the lives of children. Better and more accessible information is required on child and family risk factors, and evidence-based practice needs to be implemented by front-line health workforce and other agencies. This is likely to require some investment in the data infrastructure, information technology and workforce skills and training.<sup>7</sup>

## Child protection processes in New Zealand

Since first introduced in 1925, child welfare legislation in New Zealand has demonstrated a strong preference for non-institutional foster care over institutional care.<sup>9</sup> The current legislative framework is the Children, Young Persons, and Their Families Act 1989.<sup>32</sup> Family preservation is a key principle underlying this Act, and the Act sets forth the family group conference (FGC) as a mechanism to provide for the participation of family, whānau, hapu, iwi, and family group in decision-making about the care of a child or young person.<sup>9</sup> Under this Act, the welfare and interests of the relevant child or young person shall be the first and paramount consideration<sup>32[Section 6; Section 13]</sup>. The guiding principle for determining the welfare and interests of a child or young person is that children and young people must be protected from harm and have their rights upheld.<sup>32[Section 13]</sup> Under the current Act a child is a boy or girl under the age of 14 years. A young person is defined as a boy or girl of or over the age of 14 years but under 17 years, but does not include any person who is or has been married or in a civil union.<sup>32[Section 2]</sup> From 1 April 2017 the upper age limit of the statutory definition of young person will be increased to 18 years.<sup>33</sup> In the 2015/2016 year, ahead of this amendment to the Children, Young Persons, and Their Families Act, 1989, the Ministry of Social Development began providing increased advice and assistance to support young people aged 15–20 years who have been in statutory care.<sup>33,34</sup>

Child, Youth and Family (CYF) is a service arm of the Ministry of Social Development with legal powers to intervene to protect and help children who are in need of care and protection.<sup>5</sup> The full definition of a child or young person in need of care and protection, as contained in the Children, Young Persons, and Their Families Act, 1989, is provided in **Box 3**.

**Box 3.** Definition of a child or young person in need of care and protection, Children, Young Persons, and Their Families Act, 1989 Section 14.

- (a) the child or young person is being, or is likely to be, harmed (whether physically or emotionally or sexually), ill-treated, abused, or seriously deprived; or
- (b) the child's or young person's development or physical or mental or emotional wellbeing is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable; or
- (ba) the child is a subsequent child of a parent to whom section 18A applies, and the parent has not demonstrated to the satisfaction of a social worker (under section 18A) or the court (under section 18C) that he or she meets the requirements of section 18A(3); or
- (c) serious differences exist between the child or young person and the parents or guardians or other persons having the care of the child or young person to such an extent that the physical or mental or emotional wellbeing of the child or young person is being seriously impaired; or
- (d) the child or young person has behaved, or is behaving, in a manner that—
  - (i) is, or is likely to be, harmful to the physical or mental or emotional wellbeing of the child or young person or to others; and
  - (ii) the child's or young person's parents or guardians, or the persons having the care of the child or young person, are unable or unwilling to control; or
- (e) in the case of a child of or over the age of 10 years and under 14 years, the child has committed an offence or offences the number, nature, or magnitude of which is such as to give serious concern for the wellbeing of the child; or
- (f) the parents or guardians or other persons having the care of the child or young person are unwilling or unable to care for the child or young person; or
- (g) the parents or guardians or other persons having the care of the child or young person have abandoned the child or young person; or
- (h) serious differences exist between a parent, guardian, or other person having the care of the child or young person and any other parent, guardian, or other person having the care of the child or young person to such an extent that the physical or mental or emotional wellbeing of the child or young person is being seriously impaired; or
- (i) the ability of the child or young person to form a significant psychological attachment to the person or persons having the care of the child or young person is being, or is likely to be, seriously impaired because of the number of occasions on which the child or young person has been in the care or charge of a person ... for the purposes of maintaining the child or young person apart from the child's or young person's parents or guardians.

Families become known to CYF when someone who is worried about the safety and wellbeing of a child and their family makes a report of concern to CYF. Reports of concern come from a variety of sources including the Police, health, education and social service providers, family members and friends, and concerned members of the public.<sup>5</sup> Notifications about a child are first received by a National Contact Centre social worker who decides whether the concerns meet the threshold for CYF action. If so, the notification is recorded as a report of concern. If not, the notification remains a contact record only.<sup>7</sup> The following process for managing reports of concern is described by the Office of the Children's Commissioner<sup>5</sup> (p. 8)

When CYF receives a report of concern, they undertake an initial safety and risk screen about the child and family's situation, and decide whether any further action is required to make sure the child is safe. In many cases, no statutory intervention is required; the family may simply need some advice, or to be connected with the right support services.

In more serious cases, CYF care and protection teams work with the family to identify issues and find a solution, which could include a formal investigation with Police. When it is established that a child is in need of care and protection, a family group conference may be held where the child's family/whānau and other key people agree on a plan to keep the child safe and identify the support they need.

A child or young person comes into statutory CYF care through a formal declaration by the Family Court that the child or young person is in need of care and protection, which can occur only after a family group conference (FGC) has been held. An interim Custody Order can be put in place without delay if a child or young person is in immediate danger.<sup>35</sup> The child or young person is then in the custody of the Chief Executive of CYF, and a CYF social worker files a report and plan for their care and protection with the Family Court.<sup>35</sup> The law allows that the child or young person may be placed with:<sup>32</sup>

- a parent or guardian of the child or young person; or
- any other person who previously had the care of the child or young person; or
- any member of the child's or young person's family, whānau, or family group; or
- any person approved by a social worker.

If it is not practicable or appropriate to place the child or young person with any of these specified persons the child or young person may be placed in a residence.<sup>32</sup>

## Children and young people in Child, Youth and Family care

Child, Youth and Family (CYF) data show that as at 30 June 2016 there were 5,312 children and young people in New Zealand who were in in CYF care. Of these 5,312 children and young people, 578 (11%) were aged under two years; 869 (18%) were 2–4 year olds; 1,538 (29%) were 5–9 year olds; 1,193 (22%) were 10–13 year olds and 1,067 (20%) were aged 14 or older.<sup>36</sup> The approach to ethnicity classification within CYF is that children and young people (or their family) are asked to self-identify their ethnicity. For the purposes of reporting, only the clients' self-identified primary ethnic group is extracted. If a client does not nominate a primary ethnic group, their ethnicity is reported as "Other / Multiple Ethnicities".<sup>36</sup> As at 30 June 2016 3,208 (60%) of children and young people in CYF care had Māori recorded as their primary ethnic group; New Zealand Pākeha was recorded as the primary ethnic group for 1,478 (28%), Pacific Peoples for 407 (8%), Asian for 79 (1%), Other European for 55 (1%) and other or multiple ethnicities for 85 (2%).<sup>1</sup> Most (83%) of the children and young people in CYF care were in out-of-home placements, with the remainder remaining in their own homes, returned to their homes after a period of out-of-home care or in independent living situations.<sup>36</sup>

**Table 1** presents the numbers of New Zealand children and young people in out-of-home State care by placement type, as well as the total numbers in CYF care, in each of the past five years. Numbers of children in care have been fairly stable at around 5000 as of 30 June each year and their distribution between placement types has also been similar from year to year.

Table 1. Individual children and young people in out-of-home State care, by placement type, and total number of children and young people in CYF care New Zealand 2012–2016

Placement Type	June 2012	June 2013	June 2014	June 2015	June 2016
Non Family / Whānau Placement	1,427	1,298	1,269	1,182	1,281
Family / Whānau Placement	1,639	1,698	1,999	2,193	2,303
Child and Family Support Services*	518	521	536	502	507
CYF Family Home Placement	114	103	114	133	154
Residential Placement	47	47	34	29	35
Other Supported Accommodation	139	177	177	124	114
Total children and young people in out-of-home placements	<b>3,884</b>	<b>3,844</b>	<b>4,129</b>	<b>4,163</b>	<b>4,394</b>
Total children and young people in CYF care	<b>4,979</b>	<b>4,960</b>	<b>5,188</b>	<b>5,026</b>	<b>5,312</b>

Source: Child, Youth and Family.<sup>36</sup> The number of children and young people in out of home placements is as at 30 June each year. Out of home placements exclude placement types: 'Independent Living', 'Remain Home' and 'Return Home'; The placement type 'Child and Family Support Services' is approved under s396 CYPF Act, and provided by non-government organisations (NGOs); In CYF care = children and young people in the custody of the Chief Executive of Child, Youth and Family as at 30 June each year; Each child or young person in CYF care at the point in time shown is counted once in this table

Children and young people in CYF care represent only around 10% of all children and young people who come to the attention of CYF.<sup>7</sup> A review of data for every child and young person who was a CYF client showed that for every ten 0–17 year olds who came to CYF attention in 2013:<sup>7</sup>

- Two were assessed at intake as not requiring a statutory intervention; the case was closed or, in a minority of cases, children were referred to a non-government organisation for a partnered response
- Five were subject to a formal assessment or investigation but no further statutory action was taken; the case was closed or, in a minority of cases, children were referred to a non-government organisation for a partnered response
- An additional two were subject to a formal assessment or investigation and as a result received support from CYF in the form of family group conferences (FGC) or family whānau agreements (FWA)
- One was brought into CYF care as a result of care and protection concerns, after a formal assessment or investigation, most often when those concerns were not resolved through a FGC process.

The *Interim Report* notes that about half of the notified children and young people who were assessed as not requiring a statutory intervention were re-referred to CYF within a year because of community or professional concern for their safety and care. A change in patterns of repeat referrals has been noticed over time. In 2004 most notifications to CYF concerned children who were not previously known to the agency. In contrast, 6 out of every 10 children referred to CYF in 2014 were already known to the agency and, on average, CYF had engaged with these children three times previously.<sup>7</sup>

Atwool (2013) notes that children in all children and young people in foster or kin care are members of two or more families. They must manage divided loyalties: to the people with whom they live who are their current

source of care and protection, and also to their birth families toward whom they may have strong but ambivalent feelings. Research has generally shown that children want to continue contact with birth families, and some never give up hope that they can return to live with them. Contact with birth families puts the child or young person into a situation where the two worlds of birth and foster family overlap. The impact of such contact will vary depending on the pattern of belonging to each family as experienced by the child or young person.<sup>2</sup>

## Monitoring State care in New Zealand

The statutory functions of the New Zealand Children's Commissioner include monitoring and assessing the policies and practices of CYF.<sup>5,8,37</sup> In 2015 the Children's Commissioner found that CYF had strong intake and assessment practices with well-developed processes for investigating and making decisions about cases of potential abuse and neglect. Once such decisions had been made, however, oversight and case management of children in all types of CYF placement was poor. There was little available data about the outcomes for children and young people in CYF care, and not enough information to draw any conclusion about whether or not children and young people are better off as a result of state intervention.<sup>5</sup> The aggregated and summarised recommendations from the 2015 *State of Care* report were:<sup>5</sup>

- Set clear expectations about CYF's core purpose and the outcomes it needs to achieve
- Ensure CYF is fully child-centred in all its activities
- Invest more in on-going support for children in all types of care placements
- Address capacity and capability issues across the CYF workforce
- Improve cultural capability across the organisation
- Collect and analyse relevant data to drive improved outcomes for children
- Set clear expectations for other state agencies responsible for improving the outcomes of children in care

The 2016 *State of Care* report focussed on the quality of CYF case management and found some examples of positive practice.<sup>8</sup> Children and young people were considered to be safe in all of the six CYF residences visited by the Office of the Children's Commissioner, most were receiving care and services that met daily needs. However, the review also found that CYF was not sufficiently child centred and was of variable quality. Barriers to achieving high quality case management included inadequate resources, high caseloads, and a lack of cultural capacity and other skills to work in child-centred ways. While welcoming the planned changes resulting from the Modernising Child Youth & Family Expert Panel reports, the Children's Commissioner also expressed concern at potential risks associated with transition between operating models. There is increased risk of a dip in performance at times of operational change. The overarching recommendations from the 2016 *State of Care* report were:<sup>8</sup>

- Plan to reduce the risk to children and young people of a dip in performance during the transition period
- Clarify what child-centred practice means in the New Zealand care and protection and youth justice systems
- Empower and support staff now to strengthen their child-centred practice

## Planned changes to CYF

The Children, Young Persons and Their Families (Oranga Tamariki) Legislation Bill completed a first reading and was referred to the Social Services Committee in December 2016.<sup>22</sup> This omnibus bill covers a wide range of legislative reforms to support the new operating model for the Ministry for Vulnerable Children, Oranga Tamariki. It establishes a statutory framework required to create a more child-centred operating model to meet the needs of vulnerable children and young persons. The proposed changes include:

- Updating the definition of young person in the CYPF Act to include young persons who are (or have been) married or in civil unions
- *Updating the general principles of the CYTF Act to take a more child-centred approach placing all children and young persons (including children with disabilities) at the centre of decision-making, considering them within the context of their families, whānau, hapū, iwi, and broader networks and communities, with specific recognition and respect for a child's or young person's mana tamaiti (tamariki) and the whakapapa and whanaungatanga responsibilities of whānau, hapū, and iwi*

- Introducing a new and separate principle of child and young person participation that clearly recognises the importance of the voice of the child, elevates its status, and more firmly embeds this aspect of child-centred practice
- Development of National Care Standards and provision of financial support for caregivers that is more responsive to the changing needs of children in care. These will set out the rights of children and young persons in care, the standard of care that they can expect, and standards for caregiver training, monitoring, and support
- Amendments to extend the youth justice jurisdiction to include 17-year-olds
- A new entitlement for young persons transitioning out of care to remain or return to living with a caregiver up to age 21 and for CYF, where required, to provide transition advice and assistance to young persons leaving care or a youth justice facility up to age 25
- A bespoke information sharing framework within the CYPF Act
- Accountability arrangements to ensure the co-ordination of prevention activity across government and to address the needs of children and young persons in need of care or protection.

The *Investing in New Zealand's children and their families* report notes that the scale of change required will take many years to rollout and embed. The essential issue is that the change occurs in a way that ensures better outcomes for vulnerable children.<sup>3</sup> The Expert Panel observed a growing appetite for meaningful and lasting change to achieve better outcomes for the children and young people at the heart of the care and protection system. The aim of the proposed changes is to achieve better outcomes for vulnerable children. The aspirational goals for vulnerable children are that they will enjoy positive childhoods and have the opportunity to fully realise their potential.<sup>3</sup>

When children are unable to live with their birth parents at home, they require intensive support to develop a sense of stability and to build new relationships with a family who will be there for them now and in the future. The State has a role in supporting families to build loving and stable relationships with children in their care and to help them ensure that those children enjoy the same opportunities and outcomes as other New Zealand children.<sup>3</sup>

The future operating model envisages a wider range of professional domains (such as health, education, and psychology) working with children and families, both within the department and across agencies. This change will require transformational leadership at all levels that engages people, communities and all of New Zealand to build the momentum to deliver the scale of change required. Services, including health services, would work with young people who have been in care to proactively identify and meet their needs up to the age of 25.<sup>3</sup>

A key component of the operating model proposed in the *Investing in New Zealand's children and their families* report is that the future department (Oranga Tamariki) will commission and directly purchase services for vulnerable children, including therapeutic interventions and health related services that support healing and recovery for children, young people and families. All practitioners will need a robust understanding of child development and trauma-informed approaches.<sup>3</sup> The Expert Panel recommended legislative mechanisms to support more effective interagency and multidisciplinary working at an individual client level, including provisions around information exchange, and support governance and collaboration at a system level. This might include introducing a duty on agencies such as District Health Boards to collaborate and coordinate services to children and families, extending the current obligation under the Vulnerable Children Act. Strong leadership will be required to establish, manage and govern a change programme of this size.<sup>3</sup>

## Conclusion

Children and young people in State care are a New Zealand population group with high needs across all health domains, including secure whānau and family attachment as well as timely assessment and effective management of physical, spiritual, and mental health needs. Health services have a major role in identifying children and young people in need of care and protection, and in working collaboratively with other agencies to address the health needs of children and young people in State care. The proposed direct purchasing of services for vulnerable children will mean that DHBs and other health services need to be well prepared to deliver services that support healing and recovery for children, young people and families. Key infrastructure elements to achieve positive outcomes will include gathering and use of good data, development of staff knowledge, skills and understanding, and effective community programmes to improve child safety.

Within health services it is important to identify children and young people in State care, so that particular attention can be paid to ensuring that vulnerable children, young people and their caregivers have a sound

understanding of existing health concerns and the management of them. This may include specific support for caregivers particularly where the children and young people in care have challenging behaviour. Keeping accurate health records are important not only at this individual level but also at a service and aggregate national level, to add to the sparse evidence base about effective interventions that enable children and young people in State care to enjoy the same health outcomes as their peers.

Health professionals involved with children and young people in State care, and with their whānau, wider families and caregivers, need appropriate skills and competencies to assure high quality services. Guidelines for staff skill development are available from other jurisdictions and could be adapted for New Zealand context.<sup>19,23</sup> There is a high level of co-occurrence of physical and mental health conditions as well as emotional and sleep disorders for many children and young people in State care. Such complex health histories mean that there needs to be excellent co-ordination between paediatric and youth health services and mental health services within and between DHBs.

Making our communities and households safe environments for children and young people to develop and grow will require strong collaborative efforts from many sectors of society. Health promotion and community development initiatives to strengthen parenting skills, provide early additional support when required, reduce social inequalities overall and promote good child development have a valid place within health services' mandate. Health professionals are also in a privileged position meeting with children and young people in State care and can include assessment of placement safety in clinical encounters.

Proposed changes in New Zealand signal a commitment to an effective child-centred approach that will enable all children, including the most vulnerable, to enjoy positive childhoods and have the opportunity to fully realise their potential.

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