

7 Best health possible

“I want my teeth fixed.”⁵⁹

Chapter 7 key messages:

- Children and young people in out-of-home care have greater health needs than the general population.
- The development of the Child Health Passport during 2006 is a positive step towards achieving better health outcomes for children and young people in out-of-home care.
- In 2007 the Child Guardian will be interested in how the outcomes of implementing the Child Health Passport are evaluated.
- In 2006 the Child Guardian recommended improvements to the way the Department of Child Safety manages children and young people’s capacity to exercise choice in relation to medical procedures (‘Gillick competency’).

The National Children’s Bureau in the United Kingdom reported in 2005 that the physical and mental health of children and young people in out-of-home care is often poor when compared with their peers.⁶⁰ The research findings can be summarised as follows:

- Two-thirds of all children in out-of-home care were reported to have at least one physical complaint. The most commonly reported problems were eye and/or sight problems (16%), speech and language problems (14%), bed wetting (13%), difficulty in coordination (10%), and asthma (10%).
- Children and young people in out-of-home care have a high rate of mental health problems. Of these young people aged 15–17, 45% were assessed as having at least one psychiatric disorder and two-thirds of those living in residential care were assessed as having a mental disorder.

Although the exact reason for these significant health problems is unknown, according to the United Kingdom Department of Health:⁶¹

“Looked after children [children or young people in out-of-home care] are the epitome of the inverse care law – their health may not only be jeopardised by abusive and neglectful parenting but care itself may fail to repair and protect health. Indeed it may even exacerbate damage and abuse.”

The Department of Child Safety assessed the health of 70 children (40 girls and 30 boys aged 3 months to 17 years) who had recently entered the out-of-home care system. According to preliminary results,⁶² only 4 children were identified as having no health problems. The remaining 66 children had multiple health problems:

- 29% did not have up-to-date immunisations

59 Young person’s view as quoted at page 88 of the *Child Guardian Views of Children and Young People in Care Queensland 2006*.

60 National Children’s Bureau, *Health Care Programme Handbook*, London 2005 available at <http://www.ncb.org.uk/healthycare/>, as cited at page 4 of the *Report Card on Health: Australia’s Children and Young People in Care*, Create Foundation, Sydney 2006.

61 Department of Health, *Promoting the Health of Looked After Children*, Department of Health Publications, London, 2002 available at <http://www.dh.gov.uk/PublicationsAndStatistics/fs/en>, as cited at page 4 in *Create Foundation Report Card on Health: Australia’s Children and Young People in Care*, Sydney, 2006.

62 As reported in a media statement by the Minister for Child Safety dated 29 November 2006 and entitled ‘Child Health Passports to help foster children’.

- 24% had dental decay
- 24% failed vision screening, and
- 17% needed further testing in relation to their hearing.

The above information indicates the need for the Child Guardian to act to influence both mental and physical health and wellbeing outcomes for children and young people in out-of-home care.

7.1 Health issues according to children and young people

7.1.1 The Child Guardian Survey

The Child Guardian Survey of children and young people in out-of-home care asked young people whether they had an unresolved health issue. Of those who responded, 6.9% of young people and 13.8% of children reported having an unresolved health issue.

7.1.2 Information from Community Visitors

Dental needs

Each time a Community Visitor visits a child or young person they must decide whether the child or young person's dental needs are met or whether they require some action or follow-up. If there is no need for follow-up, a Community Visitor will place a Rating 3 (satisfactory service delivery) or Rating 4 (excellent service delivery) against Standard of Care 'Dental needs met'. An example of service delivery in relation to dental health that did not require follow-up is:

"The child's dental care needs are up to date and regular check-ups have been scheduled. The carer supports him daily to care for his teeth, including regular brushing and flossing."

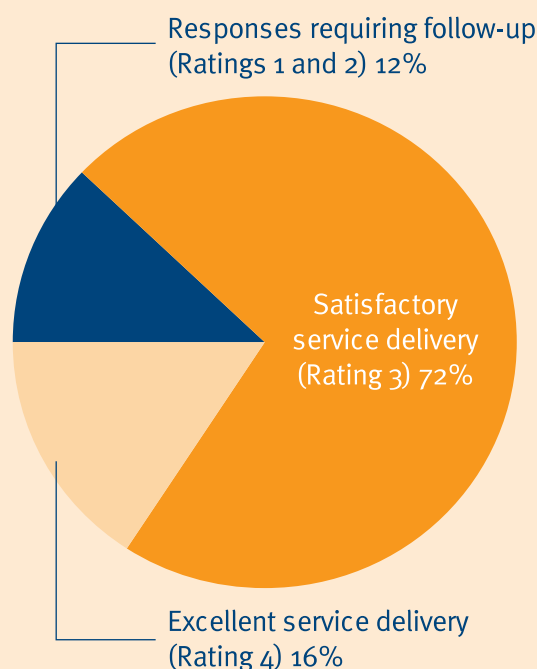
A Community Visitor will place a Rating 1 (serious issue) or Rating 2 (issue) against this Standard of Care when a child or young person's dental needs are not being met. The Community Visitor will then advocate on behalf of the child or young person to encourage appropriate service delivery in relation to this child or young person's dental health needs. An example of service delivery that required some action from a Community Visitor in 2006 is:

"The carer advised the Community Visitor that the child and her sibling had very poor dental health when they were placed in her care. The children had several cavities and teeth had to be removed due to decay. The child still requires further assessment and treatment."

"There has been no action by the Department of Child Safety to facilitate necessary dental care despite regular communication from the Community Visitor and promises by the Department of Child Safety that this issue would be prioritised."

Figure 7.1 shows that approximately 12% of children and young people's responses about dental health required follow-up from Community Visitors (11.95% were Rating 2s and 0.05% were Rating 1s). Approximately 88% of responses in relation to dental health needs were examples of satisfactory (Rating 3, 72%) or excellent (Rating 4, 16%) service delivery and did not require any action by a Community Visitor.

Figure 7.1: Community Visitor reports in 2006 about Standard of Care 12, 'Dental needs met'



Medical needs

When service delivery in relation to a medical issue for a child or young person was satisfactory or excellent, a rating of 3 or 4 is placed against Standard of Care 'Medical needs met', meaning that no further action in relation to this issue is necessary. An example of service delivery in relation to a medical issue that did not require any follow-up by a Community Visitor in 2006 is:

"This month, the child visited his Community Health Centre for developmental assessments, including his growth and fine and gross motor skills. His speech was assessed as being delayed and in need of speech pathology. A

referral has been made. Through regular visits, the Community Visitor has observed that the young person's carers provide all appropriate assistance and support in all aspects of physical health. For example, the carers were concerned about the young person's co-ordination and attended a specialist appointment to ensure that all physical health aspects were addressed."

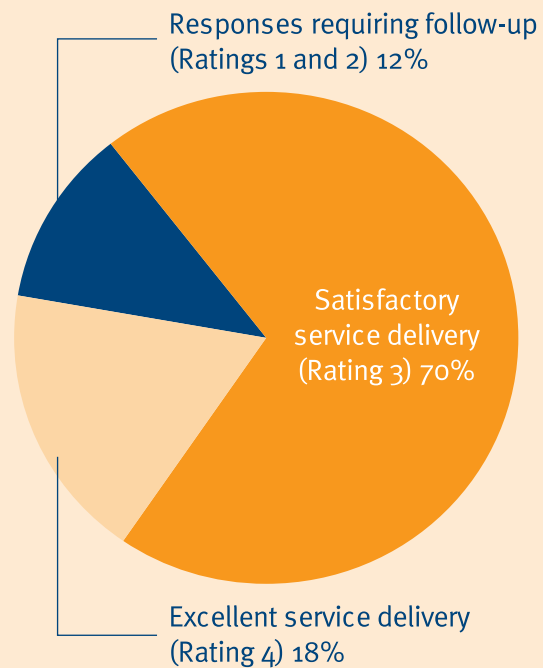
When a child has a medical issue that requires action by their Community Visitor, a Rating 1 (serious issue) or Rating 2 (issue) is placed against this Standard of Care. An example of service delivery in relation to a medical issue that required follow-up in 2006 is:

"The child has a medical condition related to his ears and hearing. This condition has persisted during his previous placements in care and when reunified to his parents. This condition has been known by the Department of Child Safety for several months. The child requires medical treatment before permanent hearing damage occurs. The Department of Child Safety has (allegedly) not provided the carer with any information or support about how to progress this concern. The carer has initiated a specialist appointment but is on a wait list. Further financial support may provide services to the child in a timelier manner."

Figure 7.2 shows the percentage of responses from children and young people about medical issues that required follow-up (Ratings 1 and 2 combined) from Community Visitors in 2006.

As with dental needs, approximately 12% of children and young people's responses about medical issues required follow-up from Community Visitors (11.95% were Rating 2s and 0.05% were Rating 1s). Approximately 88% of responses in relation to medical issues were examples of satisfactory (Rating 3, 70%) or excellent (Rating 4, 18%) service delivery and did not require any action from a Community Visitor.

Figure 7.2: Community Visitor reports in 2006 about Standard of Care 13, 'Medical needs met'



Therapeutic needs

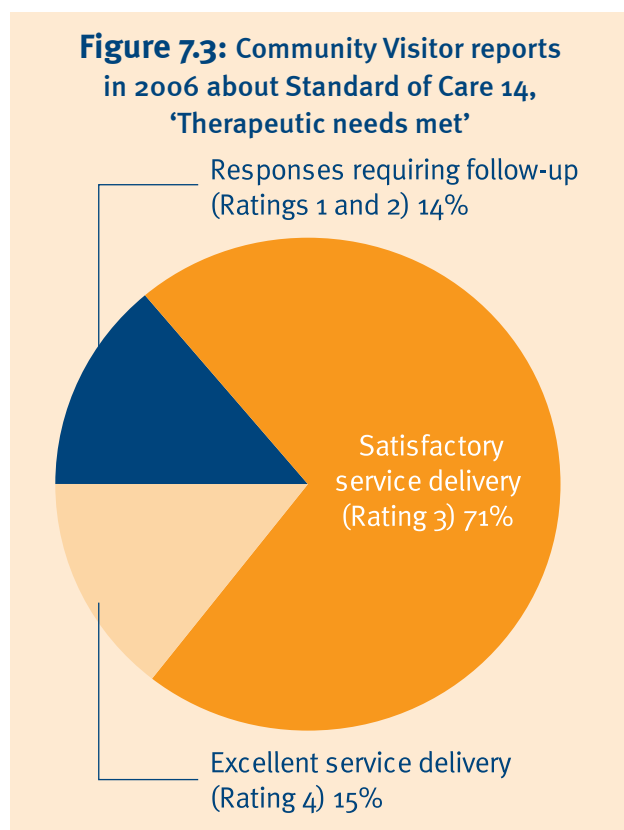
In addition to dental and medical issues, Community Visitors also assess whether the children and young people whom they visit are receiving appropriate therapeutic services. If no further action in relation to a child or young person's therapeutic needs is necessary, a Community Visitor will place a Rating 3 (satisfactory service delivery) or Rating 4 (excellent service delivery) against Standard of Care 'Therapeutic needs met'. An example of service delivery in relation to a young person that did not require any action from a Community Visitor in 2006 is:

"The young person has been engaged in sexual abuse counselling whilst in care. The young person responded well and is ready to participate in other related support, including grief and loss counselling and anger management interventions. The Community Visitor will follow up with the Child Safety Officer to ensure the young person's needs are met."

If the Community Visitor believes that they must act on behalf of a child or young person in order to meet their therapeutic needs, then they will place a Rating 1 (serious issue) or Rating 2 (issue) against this Standard of Care. An example of service delivery that required follow-up about a young person's therapeutic needs in 2006 is:

“During a meeting with the young person, her Child Safety support staff and the Community Visitor, the young person disclosed symptoms of depression and thoughts of suicide. The Child Safety Officer addressed the matter seriously and has encouraged the young person to engage in counselling. The Child Safety Officer has been encouraging engagement in counselling over an extended period; however, the young person has refused.”

As shown in Figure 7.3, approximately 14% of responses about therapeutic issues required follow-up by a Community Visitor in 2006 (Rating 1, 0.1%; Rating 2, 13.90%). This Standard of Care required the most action by Community Visitors compared with all of the other health-related Standards of Care. Approximately 86% of responses in relation to therapeutic needs did not require follow-up by a Community Visitor (Rating 3, 71%; Rating 4, 15%).



The Child Guardian envisages the above data will be useful as a baseline for the Department of Child Safety to assess the impact of initiatives such as the Evolve Interagency Therapeutic and Behaviour Support Services, which are provided in 9 Queensland locations.

7.2 Action at the system level

7.2.1 Advocacy about health

Child Health Passport

The Child Guardian was consulted in the development of the Child Health Passport. The purpose of the Child Health Passport is to meet the health needs of children and young people in out-of-home care. Under the Child Health Passport, children and young people entering out-of-home care will have a comprehensive health assessment and health plan, follow-up of identified health needs and ongoing annual health checks. (Queensland Health has advised that the Child Health Passport is a planned response to the health needs of children and young people and this process is not intended to replace an immediate health assessment that may be necessary when allegations of child abuse and neglect occur.⁶³)

Queensland Health has also advised:⁶⁴

- That the Child Health Passport has been developed in consultation with all key agencies involved in the protection of children and young people, and
- All key agencies acknowledged that the Child Health Passport will commence with the children and young people that enter into out-of-home care after 1 January 2007.

The Child Guardian advocated that the Child Health Passport should not just be available to children and young people coming into out-of-home care from 2007, but should also be available to children currently in out-of-home care. Queensland Health has advised that children and young people in out-of-home care prior to 1 January 2007 will be progressively transitioned onto a Child Health Passport. The decision about the appropriate timeframe for implementing the process for each individual child will be made in the child's case plan, which is reviewed at least every six months.

63 By way of letter dated 14 March 2007.

64 By way of letter dated 14 March 2007.

While the initiative is overall very positive, the Child Guardian has expressed concerns about how the outcomes for children and young people, and the effectiveness of the passport, will be monitored and evaluated over time.

HIV/Hepatitis C and children in out-of-home care

The Child Guardian has implemented its commitment under the *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005–2011* developed by Queensland Health. Queensland Health is the lead agency for a whole-of-government approach to addressing issues related to sexually transmitted diseases. In 2006, the Child Guardian approved a detailed action plan to meet these commitments. This plan includes provision of appropriate professional development for staff, including Community Visitors, who may be alerted to sexual health issues in the course of visiting a child or young person in out-of-home care.

7.3 Action on behalf of individual children and young people

7.3.1 A case study in relation to service delivery to ‘Anne Marie’

The Child Guardian received information in 2005 that a young person under the age of 16 (‘Anne Marie’) in out-of-home care underwent a medical procedure.

Anne Marie was under the long-term guardianship of the Department of Child Safety as a consequence of maternal neglect and physical, sexual and emotional harm.

The Child Guardian commenced a review⁶⁵ to establish whether the Department of Child Safety:

- obtained informed consent from the appropriate person for the medical procedure
- complied with its statutory obligations, and
- reviewed the effectiveness of counselling previously provided to Anne Marie.

The Child Guardian formed the opinion that the Department of Child Safety Practice Manual did not clearly explain the consent that had to be obtained for the young person’s medical procedure and was unclear about the concept of Gillick competency.⁶⁶

In addition, the Child Guardian found that the Department of Child Safety:

- failed to comply with its obligation to report Anne Marie’s suspected sexual abuse to the Queensland Police Service, as required under section 14(2) of the *Child Protection Act 1999*
- did not have clear direction in its Child Safety Practice Manual about its obligation under section 14(2) of the *Child Protection Act 1999* to refer information to the Queensland Police Service where it is suspected the child may have been the victim of a criminal offence, and
- did not take sufficient steps to ensure that Anne Marie had received adequate counselling in response to her past sexual abuse.

As a result of the above findings, the Child Guardian recommended that amendments be made to the Department of Child Safety Practice Manual to clarify the following issues:

- the classifications of medical/health officers who can assess that a child is Gillick competent
- in what circumstances the concept of Gillick competency applies in practice, and
- exactly how Gillick competency is to be used when considering the issue of obtaining consent for a child in out-of-home care to undergo a medical procedure.

In addition, the Child Guardian recommended that the Department of Child Safety review the Child Safety Practice Manual to ensure that all references to section 14(2) of the *Child Protection Act 1999*, and/or alleged harm that may have involved the commission of a criminal offence relating to the child, reflect that:

- the onus is on the Department of Child Safety to identify, from the various sources of information available, that harm may have involved the commission of a criminal offence relating to the child, and
- the existence of alleged harm which may have involved the commission of a criminal offence must be reported to the Police Commissioner immediately.

65 Under Part 3 of the *Commission for Children and Young People and Child Guardian Act 2000*.

66 Gillick competency is a Common Law term based on the decision in *Gillick v. West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL). This case found that a person under the age of 16 may have the capacity to consent to medical treatment on their own behalf and without their guardian’s knowledge or consent, if the young person understands the proposed medical treatment.

Further, the Child Guardian provisionally recommended that the Department of Child Safety review the need to establish an accreditation scheme for counsellors who provided counselling services to children and young people who are victims of sexual abuse.

7.3.2 Community Visitor advocacy for a young person, 'Sue'

In January 2005 Sue was 15 and living in a Brisbane youth shelter. She asked her Community Visitor to talk to her Child Safety Officer about getting braces. Funding for the braces had been approved many months earlier but, because of Sue's frequent moves, self-harm and other issues, no appointment had been arranged to begin the process. The Child Safety Officer had told Sue she must live in one place for one month before she could see an orthodontist, but for the next two months the advice provided to Sue by the Department of Child Safety seemed to change about her eligibility for braces. At this time Sue's placement broke down.

After this it was another two months before Sue had stable accommodation and she complained of toothache and a chip to her front tooth. Ongoing advocacy by the Community Visitor did not yield positive results and Sue tried unsuccessfully to access dental care at the public clinic in South Brisbane in July 2005. The Department of Child Safety advised that the approval for braces was now out of date and no longer valid.

In August 2005, approval was given by the Department of Child Safety for Sue to see a private dentist for a quotation on necessary dental work and a referral to an orthodontist if appropriate. The dentist provided an itemised quotation for urgent work required, including repairs to a chipped tooth and three cavities at a total cost of just over \$500. Sue's need for braces was reconfirmed but a referral was not appropriate until the urgent problems were treated.

Several weeks of negotiation between the Community Visitor and the Department of Child Safety occurred before the Department of Child Safety gave a definite no to funding any of Sue's dental work. She was advised to use the public system, even though she would need to miss many days of school and pay for the work herself (on the dependent rate of Youth Allowance) or seek her family's support. Sue tried on two more occasions to access treatment through the public

system and, having spent three days queuing for treatment, only succeeded in getting one temporary filling.

More moves and difficulties came and were overcome, and in December 2005 she moved again to long-term supported accommodation. Between Christmas and New Year, Sue's chronic toothache became unbearable and she had one emergency filling which the Department of Child Safety reimbursed several months later.

By the New Year, Sue had a new Child Safety Officer, Team Leader and Manager and the Community Visitor began advocating strongly for Sue to receive urgent dental treatment. In May 2006 approval was given for Sue to again get a quotation for required dental treatment. She now had eight cavities and a chipped tooth and the repair bill was just over \$1000. One month and several phone calls from the Community Visitor later, funding was finally approved for Sue's dental work. In less than four weeks she had all her teeth fixed and a current referral to an orthodontist.

7.4 Future Child Guardian work on health

The Department of Child Safety was invited to make a submission to the Child Guardian about its key initiatives for 2006. The Child Health Passport has already been discussed (above). The Department of Child Safety has also advised that Evolve Interagency Therapeutic Services has been developed between the Department of Child Safety, Department of Education, Training and the Arts, Queensland Health and Disability Services Queensland to deliver interagency therapeutic and behaviour support services across the state. Services are now operating in Cairns, Townsville, Mackay, Rockhampton, Maroochydore, the Gold Coast, Logan and Brisbane North. The target group for these services is children on Child Protection Orders with complex and high support needs.

In 2007 the Child Guardian will monitor the implementation of the Child Health Passport and its outcomes for children and young people in out-of-home care, as well as continue to conduct monitoring, review, complaints resolution and Community Visitor work in relation to the health of children and young people in out-of-home care.

Data will also be collected in relation to the following Child Guardian Key Outcome Indicators:

- the number and proportion of children and young people who receive a Child Health Passport within four weeks of entering out-of-home care (including identification of mental health problems)
- the number and proportion of children and young people in out-of-home care who receive a yearly medical examination
- the number and proportion of children and young people in out-of-home care who receive a yearly dental examination, and
- the number and proportion of issues/complaints related to health service provision that are substantiated by the Child Guardian, which includes investigations, reviews, monitoring and visits to children and young people in out-of-home care.