Position Statement 59
The mental health needs of children in out of home care
March 2015

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**Definition**

Out-of-home care (OOHC) is one of a range of services provided to children who are in need of protection and who are unable to live with their birth family. OOHC includes residential care, home-based foster care and placement with relatives or kin.

**Background**

The number of children aged 0-17 years in OOHC continues to increase. In Australia in 2012 there were around 39,600 children in OOHC, 44% in foster care, 47% living with relatives/kin and 5% in residential care. Aboriginal and Torres Strait Islander children are 10 times more likely to be in OOHC than non-Indigenous children. There are complex social and historical reasons for this, including the ongoing impact of the Stolen Generations (Fernandez & Atwool 2013, pp. 177). In Australia in 2011-12, children under the age of one were the most likely to be the subject of a substantiated maltreatment in OOHC and almost half (45%) of children admitted into care in 2011–12 were aged less than five (AIHW 2013).

In New Zealand in 2010, there were 4,238 children in OOHC. Māori children account for 52% and Pacific children 6% of that population (Hendricks & Stevens 2012).

Children and young people in OOHC are a highly vulnerable group with increased physical, mental and social health needs and often limited access to services and support. As a consequence of their exposure and experiences prior to entering care, and within the care system, they are more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and are less likely to consistently access health services. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to advocating for adequate care and protection, including comprehensive health and developmental assessment, early intervention, psychosocial treatment and relational support for children in OOHC in order to assist them to achieve their full potential as healthy adults.

Children in OOHC often present with complex psychopathology related to prior experiences with carers, exposure to perinatal risk (e.g. maternal drug use during pregnancy) insecure, disorganised and disrupted attachment relationships, and the cumulative effects of childhood maltreatment including traumatic exposure. Australian and international studies show a high prevalence of emotional and behavioural disorders in the fostered population. Developmental delays are also common, including speech and language cognitive development and gross and fine motor skills problems (Chambers et al 2010; Nathanson & Tzioumi 2007; Stock & Fisher 2006; Tarren-Sweeney & Hazell 2006; Tarren-Sweeney 2008). These can confound both the child’s capacity for communication and the carer’s expectations about and responses to the child. These factors add to the complexity of assessment and intervention. Children in OOHC warrant special attention and priority access to comprehensive health and developmental assessments and multi-disciplinary mental health care that can address their complex health, psychosocial and developmental needs within the context of their placement and the care system.

The home environment provided by foster or kinship carers or in residential placements should be a healing and therapeutic influence, but can itself be a source of relational risk (Dozier & Linhiem 2006). Interventions need to be comprehensive and include a systemic approach that takes into account the
length of time the child has been in the current placement, the capacity of current carers to support and care for the child and the adequacy of the system of services and support around the placement. The task for carers can be difficult, as the infant or child’s behaviour may appear contradictory, apprehensive and/or frankly rejecting or avoidant (Smyke & Breidenstine 2009). Depending on the child’s age and prior experience, considerable time and effort may be required for the child to have the experience of comfort and protection with an available caregiver. Supporting and working with carers is an essential element of assessment and intervention.

In Australia, the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (Australian Government 2011a) was developed to improve health outcomes as part of the National Framework for Protecting Australia’s Children 2009 (Australian Government 2011b). Mental health professionals need to be familiar with initiatives and services in their own jurisdiction developed under this Framework, and to align clinical assessment and decision making with this.

**Assessment and treatment principles:**

- Children in OOHC with mental health problems are given special attention and priority access to mental health services.
- A systemic and developmentally informed understanding needs to be applied to assessment and intervention with children in order to address their complex psychosocial and mental health needs.
- The high rates of psychosocial and developmental difficulties seen in children in OOHC indicate that all children entering or within these placements require a comprehensive multidisciplinary mental health and developmental assessment.
- Child psychiatrists can provide clinical expertise to teams and services who provide health and mental health services to children entering or already in OOHC.
- Assessment and intervention planning needs to include interventions in major domains of the child’s life (e.g. carers, birth family, peers, school) with the emphasis on enhancing strengths through therapy or activities to promote the child’s development. These plans may include medication to reduce symptoms and facilitate functioning.
- There should be a focus on early identification and meeting mandatory reporting obligations in relation to children in the general community at risk of neglect due to parental mental, physical or social incapacity as well as the initiation of support strategies for those children.
- A profile based on a developmental framework of psychopathology that identifies the risks and protective factors that contribute to the dynamic of resilience should be documented for each child as part of the comprehensive assessment.
- There should be provision of integrated, multidisciplinary services competent in meeting the complex mental health needs of children in OOHC.
- Support and training should be provided for carers.

**Recommendations**

- Access to competent, comprehensive, multi-disciplinary health and mental health services is a priority for children in OOHC.
- Increased recognition of and response to the high and complex needs of many children in OOHC within mainstream health and mental health services is necessary to enable timely access to effective health and mental health care for this vulnerable population.
- There needs to be support for the development of targeted interventions for infants, young children and their carers. There is clear evidence for both the high exposure of infants and young children to violence and adversity; as well as the benefits of early intervention and prevention in this age group.
- The influence of culture on the aetiology and manifestation of mental health problems in Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) children in OOHC needs to be well understood and translated into the policies and practices associated with assessing and caring for these populations.
• There should be timely decision making in relation to the best interests of children in OOH and their need for stability and security in their environment. The needs of children in OOH should be advocated for within the legal and child protection system.

• There needs to be increased awareness of the vulnerability of young people in OOH aged 16 years and over who face having services cut back as they move into young adulthood. This cohort are often emotionally disadvantaged and ill-prepared for adult life. The New Zealand Ministry of Health’s *Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drug Services* provides a good framework for planning this transition (2014).

• There needs to be support for research into the health and mental health needs of children in OOH in order to:
  o inform policies and practices; and
  o provide evidence for psychological and pharmacological treatments of their complex psychopathology.

**The RANZCP’s commitment**
To assist in achieving progress in relation to these principles, the RANZCP will, through its national and regional structures:

• Include the mental health needs of children in OOH in Australia and New Zealand as part of the core curriculum for specialist training of child and adolescent psychiatrists.

• Initiate and support research opportunities in collaboration with other disciplines and agencies which expand current knowledge about and skills in intervention with this high risk population.

• Engage collaboratively with state, territory and regional health departments and child welfare agencies in their efforts to establish or enhance systems to ensure all children in OOH are assessed for mental health problems and receive effective mental health treatment if problems are identified (RANZCP 2008).

**References**

- Dozier M, Lindhiem O: 2006. ‘This is my child: Differences among foster parents in commitment to their young children’, *Child Maltreatment* 4(11), pp. 338-345.


Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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