Meeting the needs of New Zealand **children** and **young people** who have been **abused** and **neglected**

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NEARLY ONE QUARTER OF NEW ZEALAND CHILDREN and young people come to the attention of Child, Youth and Family (CYF) before they reach age 16 years. Over half of the children who end up in CYF care are Māori.

The majority of these children are identified when they come to the attention of police through family violence incidents. Only 7% of the 124,921 notifications received in 2010 by CYF were from health professionals, and of these only 400 were made by General Practitioners. This suggests that these children are not presenting for or receiving the medical attention that they require and more needs to be done. Every contact with a caring professional must be seen as an opportunity to identify needs, advocate for solutions and monitor the child's progress towards effective social, educational and vocational engagement.

This group of very traumatised young New Zealanders generally have poor outcomes, yet the health system struggles to engage with them.

What is needed now is a radically different approach. Whānau Ora provides an opportunity to deliver a comprehensively different service – one that enables all agencies to work together to identify and address the complex needs of these children.

Child, Youth and Family have been invited to present a series of articles highlighting the issues this group of children pose for the health system and presenting some of the ways that their needs can be addressed.

This is the first article in the series and endeavours to outline the problems faced by this group of children and young people and the challenges for the health sector.

Abuse and neglect has a devastating impact on New Zealand children and young people. It also generates an extraordinary burden on the New Zealand economy. Children who have been abused and neglected have poor long-term outcomes, with increased rates of suicide, criminal conviction, unmet health needs and education support needs. Unfortunately, their circumstances often interfere with their ability to access health care.

The health system is primarily designed to respond to a patient's presenting problems, so is poorly structured to recognise or address the complex range of needs of these children and young people.

These children require an integrated comprehensive development plan that addresses their needs, including those of their parents or caregivers. The plan needs

to provide treatment options in the context of their environment and should encompass the contribution of primary care, social workers, teachers, specialists and community services. Responsibility for monitoring the outcomes must be agreed between the various agencies who are engaged with these children and their families.

Children known to Child, Youth and Family

Nearly one quarter of New Zealand children and young people come to the attention of Child, Youth and Family (CYF) during the first 16 years of their life.*

Last year CYF received 124,921 notifications. The majority of these notifications were raised by police as a consequence of family violence. Health practitioners generated 8,326 (7%) of these reports of concern, and of these only 400 were made by General Practitioners.†

Of those children who were the subject of notifications, 21,000 were found to have been maltreated, including 12,535 findings of emotional abuse, 4,403 cases of neglect, 2,886 findings of physical abuse and 1,201 cases of sexual abuse.

CYF determined that 3,178 children should be brought into the care of the Chief Executive, including children who required non-temporary care, respite care and emergency care.

Fifty-three percent of the children and young people in care are Māori.

Children in care have generally been exposed to repeated significant trauma. A recent survey of young people in the CYF residences‡ aged between 12 to 18 years, found that: 56% of boys and 26% of the girls had been hit three or more times in the previous year, 67% had parents with alcohol and other drug issues and 54% of the girls had a parent with a mental health condition.[1] Only half of the young people in the survey had breakfast – this compares with a survey of secondary school students in New Zealand which found that 90% of the young

Government devotes $30 million for services to children in care

The 2011 Budget included close to $30 million over four years for services to children in care. This investment in meeting the needs of these children comes at a time of extreme fiscal constraint and highlights the Government's commitment to addressing the needs of this group.

The funding will be used to provide Gateway Assessments of the health and education needs, of:

- All children who enter care (approximately 2,200 per year)
- Those children and young people in care who have significant health and behavioural problems (approximately 500 per year)
- Those considered to be at high risk when they present to a Family Group Conference (approximately 1,500 per year)

Additional mental health services for children that do not meet the criteria for access to specialist Child and Adolescent Mental Health Services (CAMHS) will also be funded. While the details of these mental health services have not been determined, they will include an expansion of the Intensive Clinical Support service and the development of a primary care based mental health service for children with emotional and behaviour problems.

* Child, Youth and Family has records of notifications for over 13,000 of the 56,000 individual children born in 1989.

† For a discussion on barriers to reporting child abuse by GPs see: Coles J. GPs and child abuse: recognition, responses and experiences in reporting child abuse. Monash University, Department of General Practice: 2010.

‡ CYF operates eight residences. Four are for young people involved in the Youth Justice system (146 beds) and four are for those with Care and Protection needs (60 beds).

people regularly had breakfast (Youth'07 Survey).[2] Only 54% of girls reported regularly having an evening meal (compared with 99.6% in the Youth'07 Survey).[1]

Seventy-six percent had a regular general practice, but only 56% of the young people had a consistent General Practitioner and only 44% had seen a dentist in the previous year (compared with 79% of young people in the Youth'07 Survey).[1]

A review of 100 files of children and young people who were approved for funding through the High and Complex Needs Unit found they had suffered a combination of: abuse and neglect (76%), parental separation (63%), multiple caregivers (53%), domestic violence (52%), parental mental illness (51%), multiple school placements (45%), parental alcohol and other drug issues (43%) and parental offending (24%).

A review of the health status of the mothers of the 400 children who came into care before their second birthday in the 2005 fiscal year showed 71% (of the mothers) had alcohol and other drug issues, 43% had mental health problems, 10% had intellectual disabilities and 25% had criminal convictions.[3]

The social and economic costs of children in care

The social costs of children and young people who have been in care are high and their outcomes are poor. While many demonstrate extraordinary resilience and achieve outcomes that are celebrated (at CYF's annual William Wallace Awards), many end up at considerable cost to the state. A 2006 study in Victoria, Australia calculated that children in care generate an additional lifetime cost of $738,741 when compared to other children.[4]

The incidence of extremely high risk behaviours is higher in this population. Thirty percent of completed suicides in youth have been in people in the care of CYF and 50%[§] have been in young people known to the agency.[5] A survey of young people in CYF residences found that 39% of girls had tried to commit suicide in the previous year (compared with 7% in the Youth'07 Survey).[1]

The survey also revealed that 92% of young people in care claimed they were sexually experienced (compared with 36% in the Youth'07 Survey) and 35% of boys and 18% of girls had ten or more sexual partners.[1] Twenty-one percent of girls reported that their first sexual experience was unwanted.[1] Similarly, a study from New South Wales, Australia looking at the outcomes of young women who transitioned out of care found that 37% were pregnant within 12 months of leaving care.[6]

Eighty percent of boys and 68% of the girls in the survey used cannabis (compared with 16% in the Youth'07 Survey).[1] Sixty-five percent of the young people had driven after drinking (compared to 8% in the Youth'07 Survey) and 38% never, or rarely, wore seat belts.[1]

Thirty percent of children in care require education support.[7] Australian statistics show that only 35% complete high school, compared with 80% in the general population.[8]

Twenty-nine percent of children who come to the attention of CYF end up with a corrections sentence – constituting 67% of the adult justice population.[**]

Health needs of children and young people in care

Exposure to repeated trauma and adverse life events creates significant health issues for children and young people in care.

Since 2009 CYF has run a pilot programme in four DHBs, with the Ministry of Health and the Ministry of Education, to assess the health and education needs of children

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§ Also confirmed through TWB research by Wellington School of Medicine 2010

** Data match undertaken by CYF between CYF and Justice in 2010

coming into care. This programme demonstrated 88% of these children have unmet health conditions, with 65% having an emotional or behavioural problem and 41% having a mental health disorder. Other conditions identified requiring treatment include: dental conditions (41%), hearing (37%), general development (13%) and vision (11%).

Mental disorders frequently identified within this group include: depression (≤ 36%), anxiety disorder (≤ 26%), conduct disorder (17-45%) and ADHD (10–30%).[9]

In a 2006 report from the Royal Australasian College of Physicians it was noted that there "is clear evidence from studies conducted in the United States and the United Kingdom that children entering care have a high prevalence of acute and chronic health problems and developmental disabilities, and subsequently have a broad range of health care needs."[10]

Barriers to meeting the health needs

Unfortunately, while these children and young people have high health needs, systemic barriers exist for them accessing health services.

These children often lack an effective adult advocate to ensure their health problems are recognised and addressed. Their parents are likely to have a mental illness, drug or alcohol problems, an intellectual disability, transience or financial difficulties limiting their ability to ensure their children access the services they need. Furthermore, they may avoid medical treatment for fear that a regular medical practitioner would identify or suspect child abuse.

When offered an appointment, these children have a high "Did-Not-Attend" rate.†† This further complicates their engagement with health services. The Health and Education Assessment pilots have identified children who have been lost to follow-up after major health interventions including cardiac surgery, urological procedures, orthopaedic surgery or treatment for chromosomal anomalies.

Social workers are trained to focus on care and protection issues, but are increasingly looking at addressing issues that impact on wellbeing and longer term outcomes. Although they become the primary advocate for children brought into care, they do not have expertise to detect mental health disorders or developmental concerns and they often lack the shared language with their medical colleagues to facilitate access to the right health services.

Some effort has gone into strengthening interagency collaboration. For instance CYF and disability support have developed a range of protocols to establish shared responsibility for children in care who have significant disabilities.

Current primary care service delivery models are geared towards diagnosis and treatment of single presenting conditions. Funding, facilities and workforce constraints work against being able to comprehensively assess the needs of the child in the context of his or her family. Specialist child health services are poorly equipped to address the needs of children whose parents require parallel interventions. Little coordination exists between adult mental health and alcohol and other drug misuse services and child mental health, or between paediatric services and Child and Adolescent Mental Health Services (CAMHS).

Undertaking a holistic assessment of a child or young person with complex needs is time consuming. The Health and Education Assessment pilots have shown that collating existing health information and contacting parents and caregivers takes between six and eight hours. The health assessment takes an additional two to three hours, particularly when exploring developmental, emotional and behavioural issues. Such holistic assessment is made more complicated by the fact that medical records are scattered around multiple hospitals, outpatient centres,

†† Experience from the Health and Education Assessment pilots shows a DNA rate of up to 30% despite pre-contact and travel arrangements.

emergency departments, Accident and Medical Clinics and primary care providers.

Primary care has lacked the resources to recognise or treat mental illness in children. The limited capacity in CAMHS restricts treatment to those with the most severe conditions.

These children and their families often require complex evaluations from cross disciplinary teams including developmental paediatrics, child psychiatry, psychometrics, disability support, dental, vision and hearing services, adult mental health and drug and alcohol. Coordinating all these services in the context of poor attendance rates and transience can be extremely challenging.

Professional relationships in health are built around trust. This professional relationship becomes fraught if health practitioners consistently need to question whether the information given to them by families is correct or misrepresented.

Pockets of funding are dispersed among various agencies, for instance: CYF funds assessment and some treatment services, the Ministry of Health funds some mental health and contributes to primary care costs, the Ministry of Education provides special education services, ACC funds sexual abuse counselling and little funding exists for community based counselling services.

Even where funding exists the most appropriate service may not. Although health funds services such as CAMHS, it excludes services solely oriented to conduct disorder, sexual abuse or relationship issues – the very issues that affect so many of the children in care.

Designing a new approach

Children who come to the attention of CYF have the same right of access to health services as all children.

Effective intervention strategies recognise the needs of the child from as early an age as possible. The longer the needs are left unaddressed, particularly the mental health needs, the more complex the emotional and behavioural problems become and the more expensive, and potentially less effective, the intervention.

These children deserve an integrated child development plan that addresses all their needs and those of their parents or caregivers. It must address the care, education, health and support needs for the child and their caregiver. Such a plan should identify intervention options in the context of their community and articulate the role of the social worker, the teacher, primary care provider and specialist services. Responsibility for monitoring and reviewing plans needs to be agreed between agencies.

The needs of the child are interlinked with the needs of their parents and caregivers. Ignoring this may be counterproductive. Parent management training or specific skills in working with children and adolescents with emotional, developmental, intellectual or relationship disorders may be required.

Services need to focus on solutions, rather than problems. Making a diagnosis is only the first step.

The complex needs of these children and young people mean health practitioners cannot afford to take a narrowed approach to their care. Each contact should provide an

opportunity to look beyond the presenting complaint to explore underlying emotional and behavioural issues, development, parental health and mental health and care and protection issues.

Final thoughts

Children who grow up in an environment of repeated trauma or emotional chaos often struggle in their relationships with others, their education and their interaction with society. The estimated additional cost to the state of meeting the lifetime needs of children who have been maltreated to the extent that they are brought into the care of CYF is estimated at over $750,000 per child.

The health system, including primary care, is not designed to address the complex needs of these children. However, every contact with a caring professional must be seen as an opportunity to identify needs, advocate for solutions and monitor their progress towards effective social, educational and vocational engagement. If we fail to provide such a service, then we continue to create an extraordinarily (socially and economically) expensive population of young adults.

What is needed now is a radically different approach. Whānau Ora, Better Sooner More Convenient, and the Government's emphasis on agencies working together provides an opportunity to deliver a comprehensively different service – one that enables all agencies to work together to identify and address the complex needs of these children. To achieve this more sensible approach will require a massive cultural and service delivery change.

There is another way. We as New Zealanders need to invest in new ways to recognise and meet the needs of children who come to the attention of CYF.

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