Children in Care Collective

Understanding Out-of-Home Care

A Guide for Health Professionals

Introduction

This booklet aims to explain the key elements of the out-of-home care system in Australia, which is slightly different in each State and Territory. It provides a guide to who can authorise the medical treatment of children and young people living in out-of-home care (OOHC) and sets out legal requirements and responsibilities.

It also sets out the challenges faced by these children and young people. There are immediate and long-term consequences of children's exposure to traumatic experiences and maltreatment that need to be considered in any services or treatment provided.

This booklet includes a guide to their needs.

Children in out-of-home care

Children living in OOHC are just like other children except they have experienced significant disruption in their lives and cannot live with their families for a period of time. This may be because they have been abused and/or neglected, exposed to family violence, or have not had their needs met due to parental incapacity resulting from mental illness, disability or drug and alcohol abuse. They can be of any age up to 18 years old and may be supported through extended care arrangements up to age 21.

Aboriginal and Torres Strait Islander children and young people are grossly over-represented at every stage of the child protection system. Systemic challenges continue to impact the rate at which Aboriginal and Torres Strait Islander children are removed from their families and their restoration.

Parental authority

When children are placed in out-of-home care, there is usually a formal court order transferring parental responsibility, either temporarily or permanently, from their biological parent(s) to someone else.

Parental responsibility means all the duties, powers, responsibilities and authority that parents have in relation to their children. It includes all the actions necessary for the child's daily care and decisions about the child's long-term care, welfare and development. This includes healthcare decisions. A guide to who can give consent for medical and dental treatment can be found below.

If a court decides it is necessary, these duties, powers and responsibilities can be allocated to the relevant minister or head of the child protection department. Parental responsibility is sometimes shared between parents and the minister/head of department.

Whoever holds parental responsibility can make all necessary decisions about a child's care, welfare and development. It is important to be clear about who holds responsibility for what aspect of a child or young person's life.

Out-of-home care structures and requirements

A team of people manage the care of children in OOHC. Foster, kinship/relative or residential carers provide daily care and supervision. Caseworkers and managers coordinate care, and individual clinicians may provide treatment or address specific care needs. Most children and young people in care have a dedicated caseworker who works with the child and the carers to meet the child's individual needs and long-term goals that are set out in the child's case/care plan.

Depending on the structure of the OOHC service provider, and the preference of the child or young person, they may be accompanied to health appointments by either their caseworker/case manager, carer, residential worker, or therapeutic specialist.

Case Management

Case management is the structural framework that ensures the coordination and delivery of services provided to a child or young person in OOHC.

Case management is usually the responsibility of the child protection department in each state and territory. In New South Wales case management may be contracted to a non-government agency.

Case management responsibilities include:

- implementing the child or young person's case/care plan with the support of the care team, of which the carer is a significant member
- working directly with the child or young person and their family, and undertaking case management tasks specified in the case/care plan
- engaging with other specialist agencies and services, when required and consistent with the case/care plan, and authorised by the child protection department
- providing court reports, and participating in court processes and proceedings when required
- providing a copy of plans and other relevant documents to the carer
- maintaining regular contact with the child protection department, including quarterly reports and providing progress updates when requested
- participating in the case/care plan process
- coordinating contact between the child or young person and their family and assisting with transport and supervision of the contact.

Children in out-of-home care should have the following plans in place where needed.

Case/Care Plan

A case or care plan outlines what is required to meet the needs of the child or young person. Children and young people placed in OOHC must have a case/care plan and it should be reviewed regularly.
The plan sets out goals and covers the significant decisions about:

- care arrangements and placement
- family time
- cultural support
- health care
- developmental needs
- education or employment
- financial decisions
- legal matters
- crisis management.

Health Management Plan

A primary health assessment should be commenced within 30 days of a child or young person entering care. A further comprehensive multidisciplinary health assessment is sometimes warranted. Based on these assessments, in most jurisdictions a health management plan is developed for the child or young person, identifying their state of health, recommended interventions and a review process.

A health management plan is also generally required as part of the leaving care planning for a young person.

Cultural Support Plan

A cultural support plan is an individualised, dynamic written plan or agreement that aims to develop or maintain children or young people's cultural identity through connection to family, community and culture. Cultural support plans help to ensure that planning and decision-making are culturally appropriate and in the best interests of the child – preserving their cultural identity and their connection to culture and family. They are mandatory for children and young people from First Nations and multicultural backgrounds.

Behaviour Support/Positive Behaviour Support Plan

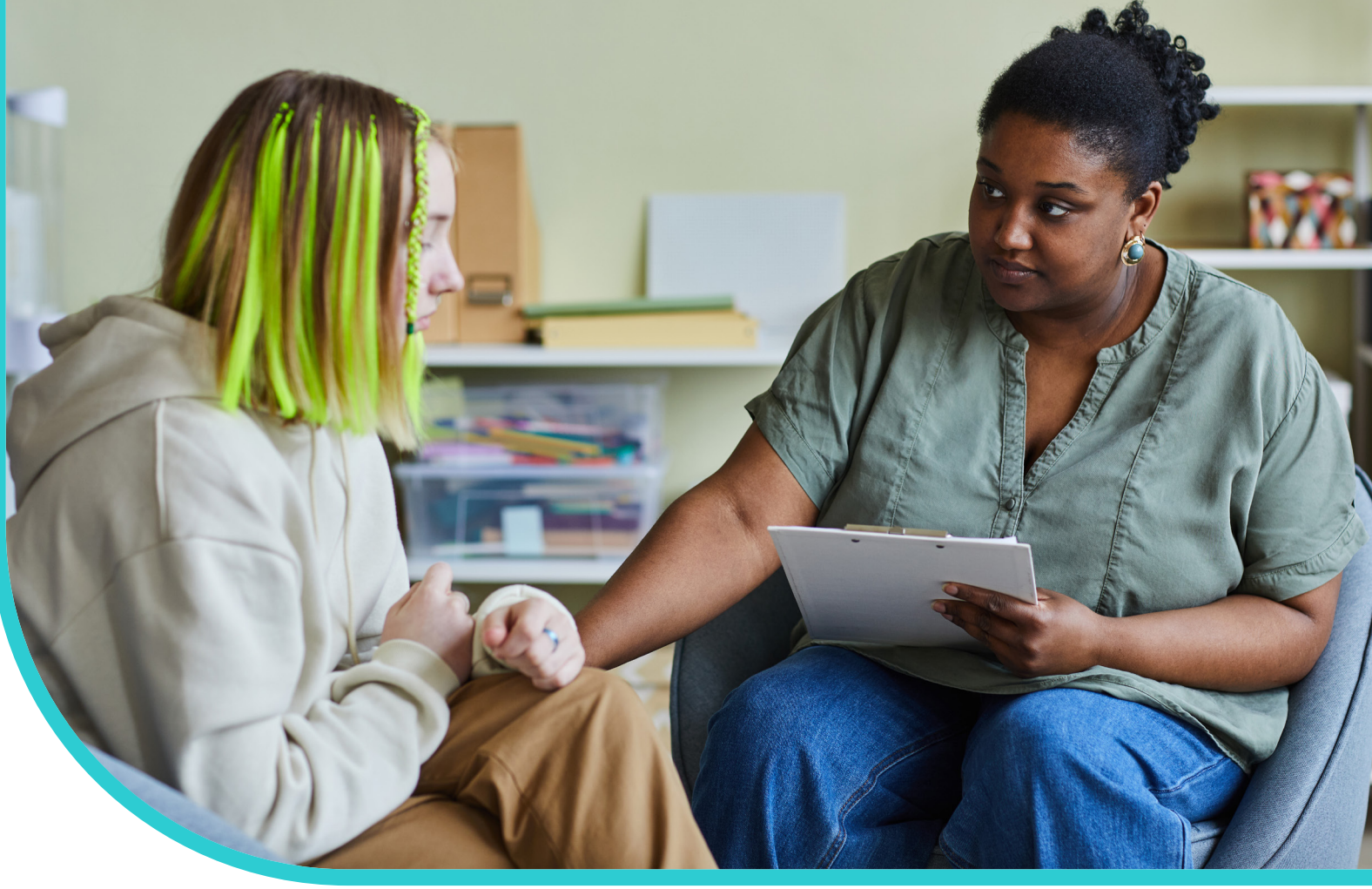
A behaviour support plan (BSP) or positive behaviour support plan (PBSP) documents behaviours of concern and provides carers with advice on appropriately supporting behaviour, including prevention and response strategies. It also identifies any restrictive practices that may have been authorised. A BSP/PBSP should be informed by the plans described above, as well as observations of the child's behaviour by caregivers and other stakeholders. BSPs/PBSPs are typically developed by behavioural specialists and coordinated by the OOHC care team.

Not all children and young people who display challenging behaviours need a BSP/PBSP.

A BSP/PBSP is required when:

- the child's behaviour is dangerous to themselves or others and/or is having a major impact on their daily functioning
- the child or young person is at risk of being excluded from daily activities
- a medical practitioner or specialist prescribes psychotropic medication
- a behaviour support expert determines that physical restraint is required to keep the child safe
- approved restrictive practices are recommended.

A BSP/PBSP that includes the administration of a psychotropic drug must be approved by a senior authorising officer from the child protection department or relevant out-of-home care agency. Health professionals prescribing medication may be required to provide input into the BSP/PBSP.



Use of Restrictive Practices

Interventions that limit a child's rights or freedom of movement - including the use of psychotropic medication, physical restraint, exclusionary time-out, restricted access to items, activities, experiences and physical barriers such as locks - are known as 'restrictive practices'.

When restrictive practices are used for children and young people in OOHC, they must be part of an approved BSP or PBSP. They may be used only in exceptional circumstances to prevent harm to the child or others.

Psychotropic Medication

Any prescribed medication that affects cognition, mood, level of arousal and behaviour is considered a restrictive practice in OOHC. Psychotropic medication may be prescribed by a medical practitioner as part of a treatment plan for a child or young person experiencing mental illness, psychiatric disorders, or related symptoms. In many service settings, a senior officer is responsible for authorising the administration of such medication, based on the recommendations of qualified health professionals and in accordance with relevant legislation and organisational policies.

Chemical restraint – the intentional use of a medication to restrain a child's behaviour where no medically diagnosed condition is being treated, treatment is not necessary or amounts to over-treatment - is a prohibited practice.

Who is responsible for decisions about medical treatment of children and young people in OOHC?

Emergency Situations

In emergency scenarios where delaying treatment risks a child's safety and wellbeing, healthcare providers may proceed without formal consent in line with general medical-legal emergency principles.

General or Routine Medical Treatment

It is important to clarify who has responsibility for making decisions about the medical services and supports for a child or young person in OOHC.

The powers and authority of the chief executive/secretary of the child protection department are usually exercised by department officers under delegation (and staff of non-government agencies in New South Wales). There is considerable staff turnover in child protection/OOHC systems so the individual may change but the roles and responsibilities remain relatively consistent.

Caseworker/Case Manager/Social Worker/Practitioner

A caseworker employed by the department or non-government provider is the child or young person's primary support. They are responsible for ensuring the safety and wellbeing of children through regular contact with the child or young person, identifying and meeting their needs and ensuring all case plans are implemented. A caseworker may be the person who attends appointments with the child or young person. They will usually have delegated authority to give consent for routine or minor medical procedures.

Sometimes the child's caseworker is also responsible for supporting foster and kinship/relative carers, including providing information and responding to requests for financial and other support. Some non-government agencies have dedicated carer support teams.

Casework Manager/Case Management Coordinator/ Team Leader/Team Manager

All front-line workers will have a supervisor who is responsible for allocation of cases and resources. This more senior officer may be required to give consent for high risk or major medical treatment.

In New South Wales (where case management is generally held by a non-government agency) the Principal Officer of that agency must ensure a child has a BSP

or PBSP in place when a medical practitioner prescribes a psychotropic drug or recommends restrictive practices. In all jurisdictions, a BSP or PBSP must be authorised by a senior practitioner/ departmental officer.

Foster or Kinship/Relative Carer

Foster and kinship/relative carers are volunteers responsible for providing a child or young person with a caring environment that meets their physical and emotional needs. Kinship/relative carers are extended family or 'kin' (someone with close community connection to the child). Foster carers are carers who are not related to the child.

Carers are responsible for daily care, making day-to-day decisions for the child or young person and implementing the child's case/care plan. This includes arranging and attending all health appointments including medical and dental. Major health decisions should be made in consultation with the child or young person, their foster/kinship/relative carers and the OOHC care team/department employee. In some instances, biological parents or family members may also be involved in decision making although this happens on an individual basis and should be communicated by the OOHC care team.

Residential Care Worker

Residential care workers provide direct care, supervision and support to children and young people living in residential care facilities. Residential care workers are paid rostered staff, not full-time carers. Residential care workers should check with the casework manager/case management coordinator or team leader about medical decisions.

Therapeutic Specialist

A therapeutic specialist is a clinical expert employed by an OOHC agency who works across residential care programs and Therapeutic Supported Independent Living. The primary role of therapeutic specialists is to understand the needs of the child or young person and support the wider care team to ensure those needs are being met within a therapeutic, trauma-informed approach. Typically, this is through the development and monitoring of individualised behaviour support and other plans. They would consult with the casework manager/case management coordinator or team leader about medical decisions.

Therapeutic specialists working in OOHC settings do not provide individual therapy to a child or young person. Their role is to support the care team to provide for the needs of children in care. They are not a substitute for professional therapeutic intervention.

Parents

When a child or young person is under a care/protection order, parental consent for medical treatment is not generally required. If there is an order for shared responsibility, for example a Child Protection Care Agreement in Queensland, parents must be contacted for consent. The child's caseworker will know whether this is required.

Mature Minors

A child or young person under 18 may consent to their own medical treatment if they are deemed a 'mature minor' by a doctor. This is known as Gillick Consent, and it allows a child or young person to make their own decisions about medical treatment without parental consent if they have sufficient understanding and intelligence.

This principle is recognised in all Australian jurisdictions, both in statute and common law. It does not apply to non-therapeutic procedures or refusal of life-saving treatment.

The needs of children and young people in care

Children and young people in OOHC have significantly higher rates of chronic and complex physical, mental health and behavioural conditions compared to the general population. These may include developmental conditions such as Autism Spectrum Disorders (ASD), Foetal Alcohol Spectrum Disorders (FASD), Attention-Deficit/Hyperactivity Disorder (ADHD), and intellectual disability, as well as various anxiety and depression-related diagnoses. Their physical health is also often impacted when families have not engaged in routine protective health checks and services.

Complex/Developmental Trauma

Children and young people who come to the attention of the child protection authorities may have been exposed to multiple, chronic and prolonged periods of adverse treatment, including abuse and/or neglect. These circumstances are associated with what is known as complex or developmental trauma.

The extensive research into complex/developmental trauma and its impacts suggests that it can seriously impact neurodevelopment, immune system functioning and stress response systems. There are well-documented key presenting symptoms.

Key Presenting Symptoms and Needs

1

Mental Health and Emotional Regulation

- High prevalence of trauma-related disorders: PTSD, anxiety, depression
- Emotional dysregulation: sudden mood swings, intense emotional reactions, or emotional numbness
- Attachment difficulties: distrust of adults, fear of closeness, or overly familiar behaviour with strangers.

2

Poor self-concept

- Low self esteem
- Feelings of shame and guilt
- Diminished sense of hope.

3

Behavioural and Social Challenges

- Aggression or oppositional behaviour: often a protective response to perceived threats
- Impulsivity and hyperactivity: may mimic ADHD but rooted in trauma
- Social withdrawal or inappropriate social interactions: difficulty forming age-appropriate peer relationships.

4

Developmental and Cognitive Concerns

- Delayed milestones: especially in speech, motor skills, and emotional maturity
- Learning difficulties: trouble concentrating, processing information, or retaining new knowledge
- Executive functioning deficits: poor planning, organisation and impulse control.

5

Physical Health and Somatic Complaints

- Chronic conditions: asthma, obesity, untreated infections and poor dental health
- Somatic symptoms: headaches, stomach aches and fatigue without clear medical cause
- Neglect-related issues: malnutrition, poor hygiene and missed vaccinations.

6

Risk and Safety Considerations

- Self-harm and suicidal ideation: especially in adolescents with prolonged trauma exposure
- Substance use and risky behaviours: often as coping mechanisms
- Running away or placement disruptions: may reflect fear, instability, or unmet emotional needs.

The central or most-frequently encountered outcome of complex/developmental trauma is an impaired ability to manage or regulate the emotional states. For example, minor frustration triggers a rage, anxiety morphs into panic, and sadness to desolation. They may also become hypervigilant and impulsively reactive to perceived threat. On the other hand, some retreat into dissociation when stressed or threatened and appear to under-respond to threats or cues of danger.

Many of the problematic and challenging behaviours associated with complex/developmental trauma can be understood as strategies to cope with pervasive emotional, psychological and body impacts. This may include the impact of separation from parents and siblings that occurs following placement in OOHC.

Responding effectively to the multiple needs of these children requires an in-depth psycho-social assessment and clear intervention and support planning that identifies priorities, goals and strategies and assigns tasks and responsibilities to the various involved parties such as direct carers, caseworkers, statutory workers, teachers and mental health professionals.

For those providing the direct, day-to-day care for affected children, the priorities would include a focus on:

- creating a safe, stable, welcoming and comfortable living environment
- building trust and nurturing connections
- supporting the young person to develop healthy and adaptive coping skills.

Intergenerational Trauma

Intergenerational trauma refers to the psychological and emotional and behavioural impacts of trauma that are passed down from one generation to another. The negative outcomes for descendants of trauma survivors include difficulties with attachment, disconnection from families and culture, high levels of stress, emotional and impulse management, and developmental issues. This can create a cycle of trauma where the impact continues to be passed to the next generation. Unfortunately, many children in OOHC have siblings who are also in care. Many also have one or more parents who themselves spent time in care.

Types of out-of-home care

A child or young person can be placed in OOHC for just a few nights, a period of weeks or months, or for many years and until they turn 21. There are different types of care and children and young people may move between them.

The following is a summary of all types of care in Australia although not all types of care are provided in every state or territory.

Emergency Care

When a child or young person's immediate safety is at risk, they may urgently need a safe place to stay. Emergency carers can be asked to care for children of all ages, including infants, often at short notice and after hours and for up to six weeks.

Kinship/Relative Care

If possible, children and young people are placed with a family member, extended family, community or close family friend. A child may need kinship/relative care for a short or a long time.

Short-Term and Medium-Term Care

Short-term carers look after children while their families work to bring them home. There is a strong focus on reuniting children with their birth parents or extended family within two years of the placement.

Sometimes the carer is looking after children while permanent carers are found.

Long-Term or Permanent Care

When children cannot be reunited with their families, long-term foster care provides a permanent home for them until they are 18 – 21 years old.

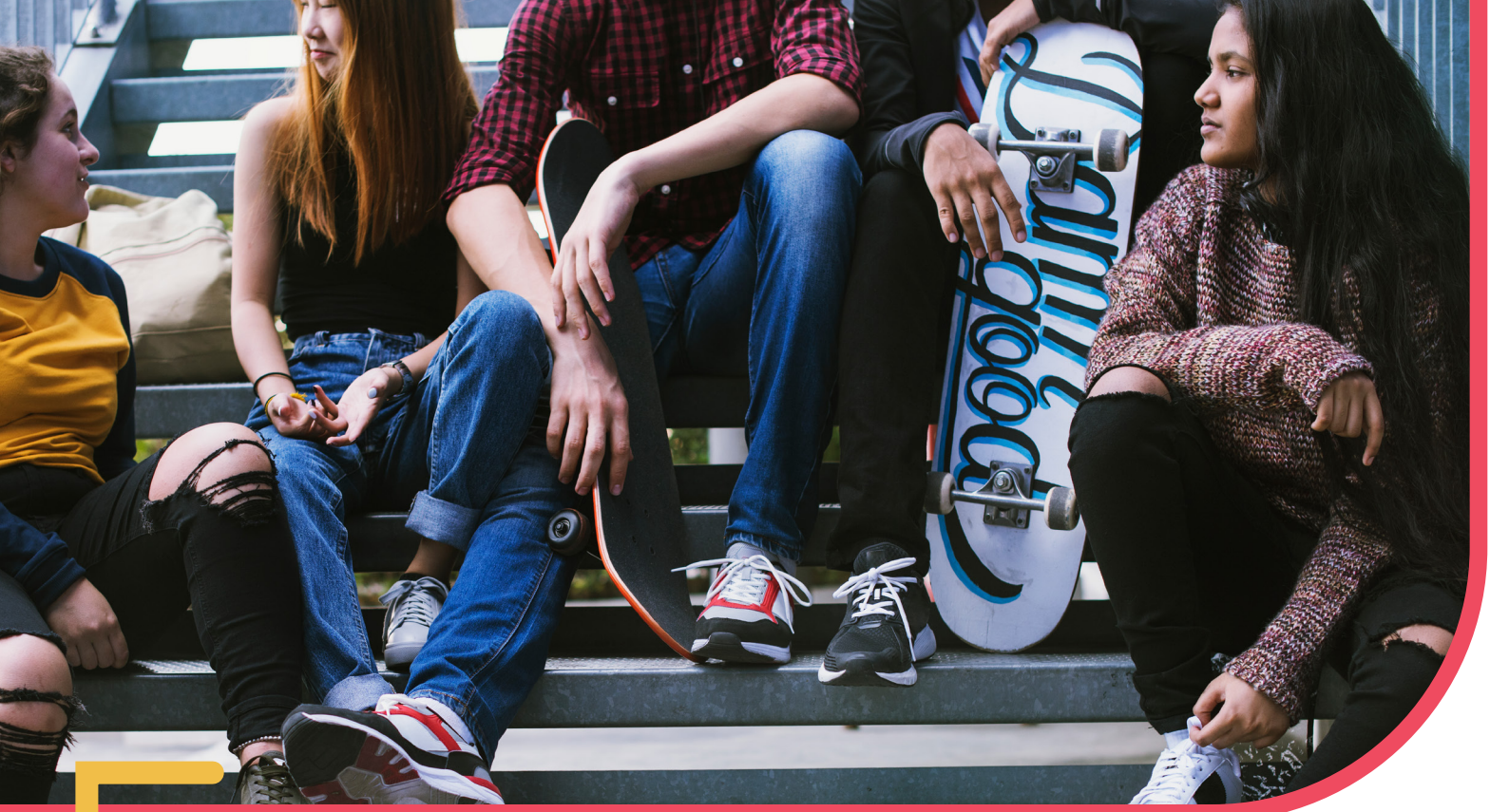
In some cases, carers can apply to become the legal guardian (or in New South Wales, the adoptive parent) of a child who has been in their long-term care, providing them with the legal rights and responsibilities for the child's long-term wellbeing.

Therapeutic Foster Care

Specialised foster carers provide one-on-one care and support in stable home environments for children and young people with complex needs. The tailored support goes beyond traditional foster care by proactively addressing a child's emotional and behavioural needs to provide opportunities for healing.

Respite Care

Respite carers look after children on an occasional basis to give their families or regular carers an opportunity to recharge. It also provides children with a whole other opportunity to develop safe and supportive relationships with trusted adults. Respite carers provide a secure home for children and young people for short periods of time, for example, for one weekend a month or during school holidays.



Residential Care

Residential care is when a small number of children and young people (usually no more than six) live in a home provided by a government department or a non-government agency with rostered staff employed to provide care. Sometimes sibling groups are housed together.

Therapeutic Residential Care

Therapeutic residential care is an approach to providing OOHC that is sometimes available for children and young people with identified high and complex needs who cannot live in foster care and require specialised and intensive supports to maintain stable care arrangements. There is no single model of therapeutic residential care. In New South Wales, all funded residential care is termed ‘intensive therapeutic care’.

The National Therapeutic Residential Care Alliance recognises that: ‘therapeutic residential care is an intensive intervention for children and young people, which, in Australia, is part of the out-of-home care system. It is a purposefully constructed living environment which creates a therapeutic milieu that is the basis of positive, safe, healing relationships and experiences designed to address complex needs arising from the impacts of abuse, neglect, adversity, and separation from family, community and culture.’

Alternative Care Arrangements/High-Cost Emergency Arrangements

A child or young person is accommodated in a hotel, motel or caravan park with rotating shift workers when they are removed from their family or carer but there is no suitable placement for them. These arrangements are usually provided by fee-for-service agencies.

These arrangements are being phased out.

Supported Independent Living (SIL)

A young person is living in a private board or lead tenant household and is responsible for their own care with a department or agency overseeing their welfare. The young person is preparing to transition to fully independent living.

Therapeutic Supported Independent Living (TSIL)

Therapeutic Supported Independent Living is an integrated accommodation and support program that aims to prepare and support young people to make a smooth transition from OOHC to independent living, self-reliance and adulthood. Therapeutic Specialists work closely with young people to assist them to build the skills, knowledge and connections in the community that they need to achieve their life, education and employment potential.

Extended Care To Age 21

This refers to recent policy changes in each state/territory that allow young people in out-of-home care to continue receiving support beyond the age of 18, which is traditionally when statutory care ends.

All young people leaving care should have a leaving care plan and/or an after care plan. Work on a leaving care plan often begins when the young person is 15. It should include a health management plan.

The extension of care until age 21 acknowledges that many young people growing up in care face significant challenges transitioning to adulthood, often without the family safety net that their peers rely on. Through extended care arrangements these young people can access stable housing, financial assistance, education and employment support, and emotional guidance during a critical developmental period. After care support is also provided in most states and territories until the age of 25.

Research shows that extended care improves outcomes in areas like mental health, education, and homelessness prevention, helping young people build more secure and independent futures.

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