Socio-economic disadvantage and the vulnerable child

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Continuum of adversity
Continuum of vulnerability

Adverse circumstances
What?
Why?
For how long?
Modifiable and remediabale?

Vulnerability to harm/misfortune
Resilience – what promotes it?

Early childhood development
is a determinant of
- Health
- Development
- Growth
- Psychological wellbeing
- Capacity for relating
to others

across the life course

Portrait of "Cosette" by Emile Bayard, from the original edition of *Les Misérables* (1862)
Vulnerability

Children in our world
- War
- Famine
- Disease
- Poverty
- Less opportunity
- Exploitation - $ / labour / sex

Australian and NZ children
Risks within / associated with
  Our local communities
  Families and family structures
  Parental factors
  Child factors
  Interactional factors
  Triggers / stressors
Australian children at high risk

- Indigenous
- Unemployed parent(s)
- People dependent of Gov’t cash benefits
- Sole parent families
- Families of 3 or more children
- Low wages
- Disability / long term illness
- Single people on low incomes
- Homeless
- Migrants and refugees

- 28% children experience at least one episode of poverty
- 14% live in poverty 2 of 3 years
- 5% in poverty x 3 years of Bro of St Lawrence survey
- 14% families incomes = $200 below poverty line
- 11% poverty rate (Vic = 11.5%)
- Rural = more disadvantaged
- 36% of 2001 homeless Victorians = 18 or younger
Socioeconomic disadvantage

Population health – what do we measure?
- Poverty, Henderson poverty line, half median income
- SEIFA,
- Cultural factors (eg indigenous teen pregnancy rates, smoking in pregnancy)
- Adverse health outcomes (Preventable? FAS, immunisation, SIDS)
- Environmental hazards
- Social cohesion
- Service utilisation
  - Maternal and child health
  - Parenting programs
  - Early intervention and family support
  - Child care and preschool attendances and outcomes
  - Hospitalisation / ED visits
- Health surveillance (illness and injury)
- Access (with equity) to broad range of health, welfare & education services
- Mortality and causes of death

Health inequalities + inequities
Children living in poverty -> more:
- Prenatal harms
  - toxins, (alcohol, TCH, nicotine, drugs, environmental toxins)
  - Poor maternal nutrition,
  - Higher risk of harm (violence) and injury, stress?
- Obstetric complications
  - anaemia, UTI, higher infant mortality rates,
- Early infancy and early childhood
  - infections (gastro, resp) SIDS, injury, abuse, neglect, poor attachment
- Childhood
  - infection, injury, family disruption, neglect, emotional and behavioural problems
- Adolescence….. More of the same……..
- Adult life……… cardiac disease, resp disease, cancer, obesity, mental health, life expectancy …..

NB : early adversity has a significant negative impact on the life course
Figure 1. A conceptual framework for identifying the relationships between social factors and health. Adapted from Turrell and Mathers, 2004.
Disadvantaged Australian men

During 1998-2000, men (aged 25-64) living in areas of greatest disadvantage were:

- 2.1 times more likely to die of coronary heart disease;
- 1.9 times more likely to die of stroke;
- 2 times more likely to die from lung cancer;
- 2.5 times more likely to die from a liver disease;
- 2.8 times more likely to die from a respiratory disease (excl. lung cancer);
- 1.6 times more likely to die from suicide;
- 2.2 times more likely to die from a traffic accident; and
- subject to a 43% greater burden of mental disorder.

RACP policy Inequality and Health
Disadvantaged Australian women

Women (aged 25-64) living in areas of greatest socioeconomic disadvantage were:

- 2.7 times more likely to die of coronary heart disease;
- 1.8 times more likely to die of stroke;
- 1.7 times more likely to die from lung cancer;
- 2 times more likely to die from a liver disease;
- 2.4 times more likely to die from a respiratory disease (excl. lung cancer);
- 1.3 times more likely to die from suicide;
- 2 times more likely to die from a traffic accident; and
- subject to a 53% greater burden of mental disorder

RACP policy Inequality and Health
What do we know about Victoria’s children

- 29,000 reports to police of Domestic Violence 2005
- 13,111 indigenous children = half the Vic indigenous popln
  - 48% in rural Vic
- 7 deaths ‘inflicted by other’ 2003
- 37,523 notifications to Child Protection 2004-5
  - 7,398 substantiations
- McMaster Family Assessment Device
  - 15.5% reflected unhealthy family functioning (Vic Child Health and Wellbeing survey)
- 69.2% Vic children ‘performing well’ on Australian Early Development Index. 21.3% ‘developmentally vulnerable’ on 1 or more domains.
Children’s health

General health = poor in low SES
Nutrition - Overweight and obesity is increasing overall, gradient becoming steeper across SES with time
Poor access to medical care
Burden = psychosocial, mental illness, tobacco, alcohol, drugs, accidents, injury, STI, unwanted pregnancy
Unsafe environment
Lower quality and stability care
Risk factors and risk behaviours cluster together

Figure 2.1.5: General health status by SEIFA score

Source: Victorian Child Health and Wellbeing Survey 2006
3 theories – how early circumstances influence the life course

Latency – foetal origins of disease
  – VLBW & cardiac risk – regardless of intervening events

Cumulative – positive and negative exposures influence health and development depending on intensity and duration
  – Family poverty and language skills

Pathway effects / the ‘trajectory’
  – SES & school readiness, social competence, educational success, health, longevity
The impact of adversity early in life

Stress and trauma – CRF, cortisol and regulation of stress responses - Perry
Sculpting of neuron-to-neuron connections - brain wiring (neural networks)
Biological embedding – CNS effects on endocrine, immune systems etc
‘Experience dependent’ development – critical periods in early life

Negative impact of neglect on the developing brain - Bruce Perry 1997
Dendritic remodelling

Developmental programs and neuronal activity influence genes and proteins, leading to the pruning of axonal and dendritic branches. Pruning, in addition to the development of new dendrites, contributes to normal nervous-system development.

Mouse – absent
CREST gene – low calcium -> fewer new dendritic connections

The Scientist 2003, 17(21):22
What do we know about the science of child development?

• The nature vs. nurture debate is obsolete. Both genes and the environment deeply influence brain development and human behavior;

• Whether early relationships promote competence or lead to dysfunction depends on how nurturing and stable they are;

• Society is failing to meet too many children's fundamental needs to ensure safe, emotionally supportive, healthy social and physical environments;

• The science of early childhood development is often disconnected from policy and practice. For example: research underscores the importance of consistent, nurturing caregivers in the first years of life, yet the 1993 Family and Medical Leave Act allows only 12 weeks of unpaid time away from work to care for a child and only covers half of the workforce.

Socioeconomic disadvantage and child development

LBW babies had lower IQ, more deprived - fared worse

Neighbourhood (SES) effects greater for cognitive and academic indicators than behavioural and mental health measures

Less encouraging and interactive language (stimulating / reading)

Less effective and adaptive parenting

Fig. 1 Association between birthweight and children’s cognitive function (mental development index (MDI) at age 2, general cognitive index (GCI) at age 4 and full scale IQ at ages 7 and 11–13).
Can we “vaccinate” our children against later school problems, drug addiction and suicide? – Fiona Stanley 2003

There are 3 main points –

1. The mechanisms (for the development of these problems) appear to be explained by new research in brain development and the interactions between genes and social environments;

2. Adverse social environments interact with genetic potential to influence competencies which act over the whole life course and result in the intergenerational transmission of childhood vulnerability and further worsens social disparities; and

3. We have lots of evidence that early intervention to enhance child development is extra-ordinarily effective.
Fostering Resilience


Increased when
- Attachment to significant adult carer < 1 year old
- Good quality early relationships / mentor
- Optimism
- Self regulation
- Intelligent / self efficacious

Social / emotional development must be given equal priority to physical and language / cognitive development.
Gatekeeper = limits the development of empathy necessary for global citizenship (WHO report 2005)
Poverty – the great confounder!

Feldman (1998) poverty identified as major factor affecting parenting capacity.

Other factors, which have a great impact upon the capacity to parent include:
  – Substandard housing;
  – Insufficient social supports;
  – Social isolation;
  – High stress levels;
  – Own experience of being parented;
  – A history of maltreatment;
  – Depression and poor self-esteem;
  – Little exposure to day-to-day family life in their childhood;
  – Homelessness;
  – Inability to access the formal service system;
  – Access to competency –enhancing supports (both formal and informal);
  – The temperament, personality and specific needs of each child.
Causes of death in childhood

Table 3.1: Major causes of death of children aged 1–14 years, 2003

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number</th>
<th>Rate per 100,000 children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>121</td>
<td>110</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>60</td>
<td>39</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Other symptoms, signs and abnormal findings</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: AIHW Mortality Database.

SEIFA gradients, 1 = 12.8 per 100,000 to V = 20.8 per 100,000

INDIGENOUS 36.9 per 100,000 cf other Australian children 16.2 per 100,000
Accidental trauma

Self harm - ABS – Vic 2003
- 508 15-18 yo admitted to hosp, 21 deaths
0-4 years = largest % of attendances at ED
10-18 years = largest % admitted / deaths
- Poisonings and falls, drowning, hitting, striking
- Pedestrian and motor vehicle trauma
- Burns and scalds,
- Fires (UK SES V = 15 times more likely to die in house fire than SES 1)

In general the rates of death and serious injury in childhood are decreasing
but NOT as significantly for the MOST disadvantaged children
UK data – child pedestrians killed

Most =10-18 year olds
M>F
Populations of especially vulnerable children

ATSI
CALD
Parent with Mental illness
Parent with Addiction
Parent with ID
Children in OOHC
Incarcerated parents
Rural / isolated communities
The medically fragile child
  – Children with disabilities / complex medical needs
Parent with a history of abuse
  – Intergenerational patterns of abuse
Children notified to Child Protection
Aboriginal and Torres Strait Islander Children

2.4% popln ATSI

Low birth weight
- higher rates hospitalisation, NND, physical and neural problems, psychosocial probs

High Infant mortality
28.9% had concerns about kids’ teeth
Less vaccinations
More asthma, ‘generally healthy’

<table>
<thead>
<tr>
<th>Birthweight (grams)</th>
<th>Indigenous (%)</th>
<th>Non-Indigenous (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1,500</td>
<td>3.3</td>
<td>1.5</td>
</tr>
<tr>
<td>1,500-2,499</td>
<td>12.0</td>
<td>5.3</td>
</tr>
<tr>
<td>2,500-4,499</td>
<td>82.7</td>
<td>91.3</td>
</tr>
<tr>
<td>4500+</td>
<td>1.9</td>
<td>1.9</td>
</tr>
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</table>

Source: Department of Human Services 2005

<table>
<thead>
<tr>
<th>Category</th>
<th>Indigenous/1,000</th>
<th>Non-Indigenous/1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirths</td>
<td>12.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Neonatal deaths</td>
<td>7.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Perinatal deaths</td>
<td>20.2</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Source: Department of Human Services 2003
ATSI children

Higher rates
- substance use,
- sexual abuse,
- earlier age sexual intercourse,
- antisocial behaviours,
- Suicide and awareness of suicide in community
- more youth justice settings (Koori Court)
  20 x more likely to be in detention

Higher rates teenage motherhood
- X8 15-17 year olds
- X6 18-19 year olds

Behaviour problems at school entry
13% cf 9%

Lower reading, writing numeracy
WA – extreme isolation and high occupancy households protective for emotional and behavioural problems

Cycle of disadvantage (poor health, multiple risks, limited choices, more life stress)

Table 2.1.10: Teen births, rate per 1,000, Victoria 2003-04

<table>
<thead>
<tr>
<th></th>
<th>All teens</th>
<th>Non-Indigenous teens</th>
<th>Indigenous teens</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–17 years</td>
<td>8.4</td>
<td>7.8</td>
<td>66.9</td>
</tr>
<tr>
<td>18–19 years</td>
<td>35.5</td>
<td>34.0</td>
<td>192.7</td>
</tr>
</tbody>
</table>

Source: Victorian Perinatal Data Collection Unit and Australian Bureau of Statistics 2001
CALD

- 23.3% of Vic population = born OS (UK, Italy Greece, Vietnam, NZ)
- 6.7% Vic children born OS (NZ, UK, China, Vietnam, Phillipines)
- 15.5% children LOTE (Chinese, Vietnamese, Greek, Arabic, Italian)
- Sequelae of social disruption, war on health, development, mental health, family functioning
- Perform less well literacy measures at school
- Disability and CALD = double jeopardy
Children of parents with a mental illness

"When Mum got sick and we were alone with her, we didn't know where to get help. I was nine years old. We didn't understand what was happening, and did not know who to call, except Dad, but we didn't know where he was or how to ring him. We were scared of Mum and what she might do." "You are unsure of who to trust. You don't know who is telling the truth. You love your Mum and want to believe her, even though what she is saying sounds a bit weird. But if you don't believe your mother you feel guilty and you feel like you are deceiving her."

– A young woman who from the age of nine, cared for her mother, who has schizophrenia.

In Australia it is estimated that there are 27,000 children affected by having a parent who has a mental illness. (Cowling, McGorry & Hay, *Medical Journal of Australia*, 163(7), 1995:119-120)

15% mothers have PND 3-9 mo after birth
Parental mental illness effects on the child

When a parent has a mental illness, they may witness their parents often disturbing symptoms and behaviours, self-harm, poor emotional regulation and the impact of their parent’s hospitalisation (Handley et al., 2001)

Children might
Become confused and frightened – especially if parent hears voices, self harms, is sad, crying, withdrawn unavailable
Fear not being believed
Fear others will think poorly of parent (defend parent)
Feel guilt / something I did?
Maintain the secret?
Experience more social isolation
Fend for themselves,
Care for parent
Household chores +++
Have unmet emotional and developmental needs
Children of parents with mental illness

Children often cope well when a parent is ill for a short time.

It is easier for them if they can understand why their parent has become unwell. It is important that things are explained to them, rather than being secretive about the problem.

Children do find it difficult to cope when the problem is more long term.

For many children in this situation, problems can arise if they:
- are separated again and again from a parent who goes into hospital for treatment
- feel unsure of their relationship with the parent with a mental illness
- are not being looked after properly
- are being hit or mistreated (this is more likely if the parent suffers from alcohol or drug dependence or has a disturbed personality)
- are having to look after a sick parent, or are taking care of brothers and sisters
- are upset, frightened, worried by or ashamed of their parent's illness or behaviour
- are being teased or bullied by others
- hear unkind things being said about their sick parent

Royal College of Psychiatrists
Children of parents with mental illness

Some children withdraw into themselves, become anxious, find it difficult to concentrate, find it very difficult to talk about their parent's illness or their problems at home (which may stop them from getting help). Children are often ashamed of their parent's illness and worry about becoming ill themselves.

Children are at more risk of developing a mental illness if they have

- been abused or neglected
- seen a lot of arguments/violence between their parents
- had parents who have separated or divorced
- had a parent who misuses alcohol or drugs
- suffered from poverty, poor housing and instability during childhood.

25 – 50% of children with a mentally ill parent will also experience some psychological disorder during childhood, adolescence or adulthood, and 10 – 14% will be diagnosed with a psychotic illness at some point in their lives (Farell, et al., 1999).
Children of parents with addictions

Women - less likely to access pre- and postnatal care (Finnegan and Kandall, 1992; Glover Reed, 1987, in Byrne et al., 2000).

Women with psychotic disorders are more likely to receive less than optimal antenatal care (Miller, 1990, in Barkla, et al., 2000).

Often avoid seeking help for parent-child problems for many reasons, including: the perception that nothing is wrong, lack of interest or lack of insight, isolation or marginalisation from traditional health services, and general disempowerment (Dawe, Harnett, Staiger & Dadds, 2000).

Parents with dual problems of addiction and mental illness also have poor access of health and support services, due to factors including limited insight into the impact of the illness, poor social resources, fear and poor self-esteem and self-confidence in relation to parenting (Byrne et al., 2000).

Avoid or delay hospitalisation to prevent separation from children or placement of children in care, thereby increasing the risk of exposing children to traumatic experiences and inadequate care (Gaining Ground Project, 1998).
Children of parents with addictions

Competing demands of substance use and child rearing” (Campbell, 1997).

Sedating effect on the users results in inability to respond to child’s needs (Hindman, 1977 in Besinger et al., 1999).

Alcohol and other drugs disinhibiting effects lead to poor impulse control, low frustration tolerance or tendencies towards violence (Flanzer, 1993; Gelles, 1993; Curtis, 1986; Cicchetti & Olsen, 1990, in Tomison, 1996a), including physical or sexual violence (Araji & Finkelhor, 1986, in Tomison, 1996a), and domestic violence.

Parental cognitive functions (memory and consciousness) affected

Different adults may be caring for the children (Schuler, Nair & Black, 2002), thus impacting on the capacity of parents to provide safety, consistency and familiar routines

Greater risk of exposure to traumatic experiences, including witnessing drug use and intoxication, overdose or withdrawal, exposure to the drug culture and possibly illegal activities.
Children of parents with addictions

Children of substance abusing parents show higher rates of behavioural and emotional problems, in particular oppositional, defiant and non-compliant behaviour (Smith, 1993; Willens et al. 1995, in Dawe et al. 2000), they are at greater risk of substance abuse themselves (Johnson & Leff, 1999).


Foetal alcohol syndrome

Eg

- Microcephaly - leads to small head circumference
- Palpebral fissure - short opening of eye
- Epicanthal folds - fold of skin at inside of corner of eye
- Midface - flat
- Nasal Bridge - low
- Philtrum - Indistinct, vertical grooves between nose and mouth
- Upper Lip - thin
- Micrognathia - small jaw
- Ears - curve at top part of outer ear is underdeveloped and folded over parallel to curve beneath. Gives the appearance of a "railroad track"
Disabled parents

In a study by the Social Policy and Research Centre (2000) it was found that:

26.7% of people with a disability in Australia live below the poverty line;

People with a disability are more likely to have lower levels of educational achievement than other groups;

People with a disability more likely to be unemployed. In 1998, 11.5% of people with disabilities were unemployed, compared to 7.8% of people without a disability;

People with a disability are more likely to have health problems that significantly affect their quality of life.

– (Social Policy Research Centre, 2000)
Children of parents with an intellectual disability

Approximately 1-2% of Australian families with children between the ages of 0-17 years include at least 1 parent with learning difficulties (ABS, 2000 in Mildon et al, 2003:3).


Australian research conducted into the parenting capacity of parents with a disability has generally discounted any suggestion that intellectual disability per se is a good predictor of parenting competence and there is evidence that when parenting deficiencies do exist these are to a large extent remediable (Feigan, 1993; Booth and Booth, 1993; Budd and Greenspan, 1985; Dowdney and Skuse, 1993; Feldman, 1994; Llewellyn, 1990; Tymchuk and Feldman, 1991).
Child Protection and parental ID

Child Protection - High-risk infant teams in 2000 - 14% of the mothers they had contact with had an intellectual disability.

Parental characteristics in substantiated cases (Child Protection Victoria in 2000-01)

228 cases (3%), the parent(s) had ID.

For comparison:
- 3% had an intellectual disability
- 4% had a physical disability
- 19% had a psychiatric disability
- 31% had an alcohol dependence
- 33% had a substance dependence
- 52% involved domestic violence
Over-represented

Between 1996-97 and 2000-01 the percentage of parents with an intellectual disability involved in substantiated cases of child abuse has increased from 2% to 3% (with a peak of 4% in 1997-98) (Dept. of Human Services, 2002:27). (Victorian population with an intellectual disability is less than 1%).

30% of cases that proceed to the Children’s Court are where one or both parents have an intellectual, physical or sensory disability.

One third of the total DoCS Care applications to the Children’s Court involved parents with a disability (McConnell, 2000).

25% of parents involved in protection cases in the Children’s Court of NSW had a disability.
Children more likely to be subject to wardship orders and a disproportionate number of children being placed out-of-home.

77 South Australian parents with intellectual disability one third of their children had been taken into care (Bowden, 1994).
Children of parents with an intellectual disability

Around half of parents with intellectual disability provide satisfactory care around one-quarter giving unsatisfactory care - the others somewhere in between.

The factors influencing each end of the spectrum – satisfactory and unsatisfactory care - remain much the same. IQ is not one of these; rather it is the inter-relatedness of several factors that determine whether families headed by parents with intellectual disability does well or otherwise.

These factors are:

– health status particularly of the mother;
– marital (or other) relationships;
– number of children in the family home
– financial resources.
– the influence of the parent’s own upbringing on the way they carry out their parenting,
– parental self-esteem
– the temperament and behavioural characteristics of their child/ children (McGaw, Ball & Clark, 2002; Tymchuk & Keltner, 1991)

• Parents with special learning needs: Professor Gwynnyth Llewellyn
A New Zealand study found 41% of children had been removed in a study of 46 parents with an intellectual disability (Mirfin-Veitch et al, 1999).

In the United States, 45.5% (103 of 226) of children born to 79 families headed by a parent with an intellectual disability had been removed. In St Louis 45.5% of children (103 of 226) “born to parents with learning disabilities had been removed” (Accardo and Whitman, 1990:8).

In Sweden a figure of 45% removal of children was found in a study of 40 children with mothers who have an intellectual disability (Gillberg and GeijerKarlsson, 1983).

Germany (Pixa-Keltner, 1998) and Denmark (Faureholm, 1996) found that 30% of children born to parents with disabilities were involved in child protection systems and placed permanently out of home.
Children in out of home care

387 children in care in Victoria in 2001. These families:
- Were larger than average;
- Higher reliance on income benefits and pensions, higher unemployment;
- Higher rates of substance abuse;
- Higher number of single parents;
- Over 40% of fathers and 14.5% of mothers play no part in the lives of their children, deceased or whereabouts unknown

Poorer physical health and dental health
Mental health needs
Lower educational attainment
more absenteeism
Unemployed
Teenage parenthood
Mental health problems
Homeless
Criminal justice system

After Year 12 - MORE go to uni!

Factors associated with positive outcomes
- Stable positive at least one long term placement
- Fewer schools
- More years schooling
- Encouragement higher education
- Extended financial and emotional support, foster carers and workers
- Contact with family while in care
- Mentor or advocate
- Life skills / independent living skills

Figure 2.3.6: Rate of children aged zero to 14 years admitted to care and protection orders in Victoria 104

Sources: Department of Human Services calculations based on data from Client and Service Information System and Australian Bureau of Statistics, 2003, 2004a, 2004b, 2005
Children in Out of Home Care

June 2004
Aust – 21,795 children (4.5 per 1000)
NZ 4654 children (4.4 per 1000)
56% increase in 8 years
  – Foster care 53%
  – Kinship 40%
  – Institutions 4%

Problems NOT apparent to SW / carers
• Poor general health
• Emotional and behavioural problems
• Developmental delays
• Learning difficulties
• Poor dental care
• Poor immunisation uptake

Mental Health Problems – NSW 2006
• Attachment difficulties
• Relationship insecurity
• Low social competence
• Sexual behaviour
• Trauma related anxiety
• Conduct problems/defiance
• Inattention hyperactivity
• Self injury
• Food maintenance behaviour

Tarren-Sweeney and Hazell 2006
More children in Kinship Care

Fewer new foster carers

Kinship care in Victoria increased 50% between 1997-8 and 2001-2
Greater stability
More re-unifications
60% of new placements
52% carers > 50 years (grandmothers)
38% single
47% dependent on govt income
Intervention for Children in OOHC

RACP policy advice
- Screening on entry to care
- Permanent health record
- Streamline access to services
- Coordination of services
- Research – what works best?
- Gov’t policy and funding LAC
- MD clinics?
- Therapeutic Foster care?

Government initiatives +++

Eg
UK model – screening, monitoring, evaluation
Qld $$$$ for entry to OOHC screening and fast-track to services
NSW – foster care clinics
Vic IGPAC,
SA Charter of Rights, Action plan
Policies for placement of indigenous children
Services for indigenous children
Children of incarcerated parents

38,500 Aust children pa have a parent in prison
<5% of all children have experienced mother’s incarceration
20% indigenous children experience parental incarceration before age 16
60% of children experiencing parental incarceration did so before age 5

What to tell the children?
Children 0-4 in jail with mother – poorer health / less access to healthcare
Parental health risks (hep C, HIV, drug alcohol, mental health)
  – Prison's revolving door (63% m and 61% f previously imprisoned)
Social isolation / stigmatisation
Reduced income
Fractured attachments
More antisocial behaviour, aggression, substance abuse, self harm, future criminal activity
# Early precursors of adult offending

### Early precursors of convictions (aged 19-40 years)

<table>
<thead>
<tr>
<th>Variable at 8-10 years</th>
<th>Odds ratio</th>
<th>(95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Troublesome</td>
<td>2.58</td>
<td>(1.58-4.22)</td>
</tr>
<tr>
<td>Lacks concentration</td>
<td>2.79</td>
<td>(1.68-4.62)</td>
</tr>
<tr>
<td>Daring</td>
<td>2.12</td>
<td>(1.35-3.33)</td>
</tr>
<tr>
<td>Low IQ</td>
<td>2.15</td>
<td>(1.35-3.44)</td>
</tr>
<tr>
<td>Low attainment</td>
<td>3.83</td>
<td>(2.32-6.32)</td>
</tr>
<tr>
<td>Convicted parent</td>
<td>3.30</td>
<td>(2.08-5.26)</td>
</tr>
<tr>
<td>Disrupted family</td>
<td>2.24</td>
<td>(1.38-3.65)</td>
</tr>
<tr>
<td>Poor supervision</td>
<td>2.25</td>
<td>(1.32-3.82)</td>
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<tr>
<td>Large family</td>
<td>2.81</td>
<td>(1.75-4.51)</td>
</tr>
<tr>
<td>Low income</td>
<td>2.22</td>
<td>(1.37-3.59)</td>
</tr>
<tr>
<td>Low social class</td>
<td>1.89</td>
<td>(1.14-3.15)</td>
</tr>
</tbody>
</table>


**Relations between offending, injury and illness** Jonathan Shepherd, **FFPHM FMedSci**, David Farrington, **PhD FMedSci**, and John Potts, **MRCPath**  Violence Research Group, University of Wales College of Medicine, Heath Park, Cardiff CF14 4XY, UK, 1 Institute of Criminology, University of Cambridge, 7 West Road, Cambridge CB3 9DT, UK
Children in rural /isolated communities

The urban - rural divide

- Inequalities in access and nature of services
  - GP consultations
  - Treatment for cancer
  - Specialists – esp surgeons

More alcohol and tobacco in non-metro
- More illicit drugs in metro
- Rural - Leave school early (esp boys)
- 9/10 reports to police of DV = rural

Marginalised children – temporary protection visas, living in detention

<table>
<thead>
<tr>
<th>Area of residence</th>
<th>Boys (yrs)</th>
<th>Girls (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least disadvantaged</td>
<td>80</td>
<td>83</td>
</tr>
<tr>
<td>Most disadvantaged</td>
<td>66</td>
<td>73</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least disadvantaged</td>
<td>80</td>
<td>86</td>
</tr>
<tr>
<td>Most disadvantaged</td>
<td>70</td>
<td>79</td>
</tr>
</tbody>
</table>
Infant deaths 2000-2 AIHW
Higher rates in isolated communities

- 2303 died in major cities
  IMR = 4.6 per 1000
- 1297 died in regional areas
- 246 died in remote and very remote areas
  IMR = 13.6 per 1000

Figure 3.1: Infant mortality rate, 1983–2003

Source: AIHW Mortality Database.
The medically fragile child

7% Victorian children have a disability
- Strong association with low SES
- Higher % live outside capital cities
- 15.7% special health care needs
- 9.3% dependent on medications
- 9.5% require services
- 4.1% functional limitations

Table 5.1: Profound or severe core activity limitation rates among children aged 0–14 years, by income quintiles, 2003 (per cent)

<table>
<thead>
<tr>
<th>Total weekly equivalised(a)</th>
<th>Profound core activity limitation</th>
<th>Severe core activity restriction cash income quintiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest 20%</td>
<td>32.4</td>
<td>26.8</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>23.8</td>
<td>30.0</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>18.8</td>
<td>15.7</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>7.2</td>
<td>7.6</td>
</tr>
<tr>
<td>Highest 20%</td>
<td>7.0</td>
<td>6.6</td>
</tr>
<tr>
<td>Not living in a household</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Not known</td>
<td>10.5</td>
<td>13.0</td>
</tr>
<tr>
<td>Total children</td>
<td>77,979</td>
<td>87,335</td>
</tr>
</tbody>
</table>

\(a\) Equivalised means that income is weighted to take account of the size and composition of the household.

Chronic illness
Australian Children 2001

44% of 0-14 year olds have chronic condition
25% had 2 conditions
18% had 3 or more

Costs of chronic illness
(medications, transport, Drs, services)
Financial burden +++
Limited opportunities to increase income
Poverty trap

Figure 4.1: Most frequently reported chronic conditions in children aged 0–14 years, 2001

Note: Chronic conditions are defined here as conditions lasting, or expected to last, 6 months or more.
Mental Health problems in children

Michael Sawyer 2000
14% aged 4-14 years
M= 14.7%, F= 13.8%
more mental health problems in children
– One parent and step parent families
– Low income
– Internalising and externalising problems

Figure 6.2: Mental health problems among children aged 4–14 years, by household income, 1998 (per cent)

Source: AIHW analysis of the 1998 Child and Adolescent component of the National Survey of Mental Health and Wellbeing, unit record file.
Family structure in Australia

75% intact families
17.9% 1 parent families
  88% of these = mothers
  36% increase 1992 to 2003

How are children affected by separation and divorce?
Significantly lower living standard
Less control of time / opportunities
Less autonomy
In the midst of the battle?
Parent busy / emotionally unavailable
A child may feel:
  • a sense of loss - not only loss of home, but whole way of life
  • different, with an unfamiliar family
  • worried about being left alone - if one parent can go, perhaps the other will
  • angry at one or both parents for the split-up.
  • responsible for having caused the split-up, guilty
  • rejected and insecure
  • torn between two parents.
Intergenerational patterns of abuse

20-30% ‘transmission’ (70 - 80% do NOT become abusive parents)
Prospective studies = lower estimates
Why?
  Genetic – inherent predisposition?
  Social learning? Observational learning, modelling, reinforcement
    (macaque monkeys - Harlow)
  Cognitive model - parent–child attachment affects behaviour
  Long term effects on neuro-endocrine development, function and emotional processing
  Biological vulnerability – gene-environment interactions
    • MAOI VTR-n gene & more aggression in males maltreated in early childhood, Poulton
    • Caspi – depression if maltreatment + ‘s’ 5HT gene polymorphism

Patterns of abuse that ‘recur’,
  Scape-goating,
  CSA (incest)
  Neglect / abandonment
  Matrilineal transmission of infant physical abuse?
  Physical abuse ‘discipline’
Child Protection – an integrated welfare / early intervention / forensic approach

2/3 of all notifications to Child Protection = re-notifications
80% of families (Vic) investigated for alleged child abuse are poor
63% of cases investigated have a parent(s) dependent on a benefit or pension.
45% = sole parents
Innovations projects – reduced rate of re-notification
Children’s Health and Wellbeing

A Political Imperative
Consumer demand / children matter
Humane and decent
Good economic sense
Whole of government approach
Office for children / Children’s commissioner – ‘designated responsibility’
Universal and targeted services
Policies and programs that translate research evidence into practice

VULNERABLE CHILDREN
We know what groups to target
We are learning about what interventions work best
We have money, good will, opportunity and ability to make a difference
Children can’t wait
Their time is NOW
Take Home Messages

Some children, by virtue of their genes, social, psychological and environmental circumstances, are more vulnerable than others.

Socioeconomic deprivation is strongly associated with vulnerability to adverse outcomes.

Socioeconomic factors, linked to adverse circumstances and adverse outcomes for children, cluster together.

Child Protection is everyone’s business

Early intervention is vital. Act, don’t hesitate.

The most powerful intervention is one that strengthens and improves the quality of the parent-child relationship.

The most effective parenting interventions are embedded in a broader eco-behavioural perspective. It is necessary to also pay attention to the individual’s broader physical, social and psychological environment. Warren Cann VPC