CHAPTER FOUR

LAW AND JUSTICE

4.1 INTRODUCTION

The overwhelming majority of submissions and testimony that examined the issue of children and the law indicated that advocacy for children in the area of law and justice is inadequate. The Committee was informed that this inadequacy, in the context of children as defendants, as victims or witnesses for prosecution matters, and as participants in family law matters, has meant that children can be effectively denied a right to be heard and their access to justice can be seriously compromised.

It was submitted to the Committee throughout the Inquiry that a lack of specialist children's lawyers, a general insensitivity or ignorance by members of the legal profession and the judiciary to children's issues and needs, and the whole adult-oriented structure and process of justice in this state, has contributed to the failure of effective legal advocacy for children and young people in New South Wales. In his evidence, Hogan told the Committee:

> *the legal profession has neglected its responsibility to children and families. Probably there are only a handful of specialist children's lawyers of the 12,000 lawyers we have in New South Wales, and that is a matter of concern. Clearly, as matters involving children often do not involve substantial commercial interests, the incentive is not there for lawyers to provide those services ... the Law Society, the Legal Aid Commission or bodies such as the Law Foundation have not done enough in this regard* (Evidence - 9 November, 1995).

The Committee has dealt extensively with issues relating to the adequacy of legal advocacy to children in the juvenile justice system in its 1992 report, *Juvenile Justice in New South Wales*. Where appropriate it will refer to the findings in that report throughout this Chapter. The Chapter will also discuss the issue of children as witnesses and children in family law proceedings.

The Committee notes that the Human Rights and Equal Opportunity Commission and the Australian Law Reform Commission are currently conducting a national inquiry into children and the legal process. Among the areas being considered by that Inquiry are children and the criminal law, children as witnesses and victims of crime, children in the care and protection system and children and the Family Court. To date, the Law Reform Commission and the Human Rights Commission (1996) have released an Issues Paper and called for submissions to the Inquiry.

4.2 JUVENILE JUSTICE

Since completing its report into Juvenile Justice, the Committee is aware of some changes that have been made in the area of legal advocacy for children. Changes to the Legal Aid Commission include the establishment of the position of detention centre solicitor, the requirement that solicitors in metropolitan areas must apply to be placed on a special children's duty solicitor roster, agree to certain performance standards and attend specialist accreditation or specialist legal education (Humphrey Evidence - 22 April, 1996). Mechanisms now exist for solicitors who do not "perform" on the roster, to be removed (Humphrey Evidence - 22 April, 1996).

At a community level a number of legal advocacy services have been established since 1992. These include: the National Children's and Youth Law Centre (NCYLC), where one solicitor provides case-work; the expansion of Burnside Adolescent Legal Service to three solicitors and one welfare worker; and the establishment of Shopfront Legal Centre, which has one and a half solicitors engaged in case-work. Although the NCYLC aims to service children and young people throughout New South Wales, all other community based legal centres are Sydney-based. The Committee notes that funding has recently been approved for the establishment of five new Community Legal Centres located in Mt Druitt, Wyong, Lismore, Armidale and Dubbo. The Committee has been told that these centres, when fully operating, will be generalist centres - there will not be any specialist children's services.

Since 1987 the Legal Aid Commission has had a Children's Legal Service based at Cobham Children's Court in Sydney's west. That service consists of one Children's Court solicitor who undertakes criminal and care matters at Cobham, a social worker and a detention centre solicitor. Other Children's Courts are serviced by duty solicitors, who are private solicitors on a roster whose fees are paid by the Legal Aid Commission. Commenting on this situation Hogan stated in evidence:

> *The Legal Aid Commission has a scheme in one children's court in which it provides a salaried solicitor, together with private solicitors on a rostered basis. That scheme was evaluated close to 10 years ago and the recommendation was made to extend that model to all specialist children's courts in this State. A number of subsequent reviews were conducted, but that recommendation still has not been acted upon notwithstanding the fact that the report found the process to be cost efficient and improved the quality of the representation* (Evidence - 9 November, 1995).

Despite the changes over the last three years, most of the information received by the Committee revealed that legal advocacy services for children and young people in the Juvenile Justice process remain unsatisfactory. For Aboriginal young people and those living in rural or remote communities, the problems are further compounded. There are no specialist Children's Legal Services in rural areas and very few solicitors in rural communities specialise in children's law. This presents an immediate disadvantage to rural

young people by potentially compromising the quality of representation and advocacy they might receive.

Commenting on the situation for young people who are represented at the Children's Court by solicitors on the Legal Aid Commission Duty Roster, then Public Defender and currently District Court Judge, His Honour, Robert Bellear argued before the Committee:

> *Their time is short and sometimes, it might be a Monday, they might have six or seven kids who front up and it does not give them time to go and talk with the parents and talk with the kids and gather the necessary evidence and information. That is really not done. It is not like an adult case* (Evidence - 22 April, 1996).

Moreover, Theresa O'Sullivan of Marrickville Legal Centre and convener of the Youth Justice Coalition explained to the Committee:

> *(Law and justice) is one of the areas where there are major concerns for the lack of advocacy for young people, as ... their very liberty comes into question, which is an important right. The major problems for children involved with the criminal system is the inadequacy of the representation, which is really only the Duty Solicitor Scheme, which provides for a solicitor for the young person when they attend court .... On average young people would only see their duty solicitor for five, ten if they were lucky, minutes before they go into court. It would seem that this would be one of the reasons why there are so few defended hearings* (Evidence - 22 April, 1996).

The Committee notes that inadequate legal advocacy can impact upon bail and sentencing outcomes. Indeed, as O'Sullivan (Evidence - 22 April, 1996) further explained to the Committee:

> *The statistics I have heard, I think up to ninety percent of children plead guilty in the Children's Court. In other jurisdictions the rate is much higher for pleas of not guilty or defended hearings, such as in Victoria where there seems to be a much more comprehensive system of advocacy for children in the criminal system.*

The Committee understands that advocacy, in the context of law and justice, is generally considered to refer only to advocacy at the court level. However, as a number of witnesses told the Committee, legal advocacy for young people involved in the juvenile justice system should be available when a young person is at the police station. The duty solicitor scheme does not fulfil this role and since most young people are arrested at night or on weekends, it is difficult for Community Legal Centre solicitors to assist a young person at a police station.

Section 13 of the *Children (Criminal Proceedings) Act 1987* provides that no statement made by a young person to the police is admissible in evidence unless it was made in the presence of a responsible adult. If an adult is not present a magistrate or judge must be

satisfied that there was a proper and sufficient reason for the absence of such an adult from the place where, or throughout the period of time during which, the statement was made before allowing it into evidence.

However, the Committee has been told:

> *Where children are detained in custody in New South Wales there is no statutory obligation for the police to notify the parents or guardians of a child who has been arrested .... In New South Wales police often deny access to lawyers and other third parties before an interview. It is clear that access to a third party depends very much on police discretion and children and young people have no right to an advocate in these situations* (Submission 34).

Where a young person is interviewed in the presence of a parent, guardian or other independent adult, it is often the case that these adults have little knowledge of the young person's rights. According to the Youth Justice Coalition:

> *Where third parties were used (in a national review of the policing of children and young people) police were selective about whom they considered to be appropriate. In New South Wales, for example, a particular officer from the Salvation Army would be chosen who would tell the child to cooperate, to "tell the truth" and "own up"* (Submission 34).

The Committee is extremely concerned about the lack of effective specialised legal advocacy for children and young people in rural New South Wales. Whilst undertaking the Juvenile Justice Inquiry, the Committee was told that significant numbers of young offenders are from rural areas yet there is a dearth of expertise in children's matters both from solicitors and magistrates. It would appear from the evidence received for this Inquiry that this situation remains substantially unchanged. According to Judith Ryan of the NSW Legal Aid Commission:

> *our statistics show us that, of the 24,000-26,000 children that are likely to be represented directly or funded by the Legal Aid Commission, 65 percent of them will be non-Sydney metropolitan based, so it is in fact a very, very significant number of children whose needs and issues arise in the non-metropolitan context* (Evidence - 22 April, 1996).

Nevertheless, as Doug Humphreys of the Legal Aid Commission (Evidence - 22 April, 1996) also told the Committee:

> *there are some non-metropolitan practitioners who do an excellent service and provide very, very, very good representation to all of the people they see, including children. However, in some cases it may be a person who has had very little experience in the criminal area and particularly in any children's work at all. Within the country, in*

addition, there is a lack of appropriate referral services and support services to back the solicitors up in being able to refer them off for reports easily and to get other specialist intervention that might be required to assist the child.

The Committee understands that successful legal advocacy requires a sensitivity to the level of understanding of the young client. As the Committee heard throughout this and the Juvenile Justice Inquiry, many young people who appear in the Children's, or other higher criminal, Court have difficulty in understanding the technical legal jargon and exchanges between the lawyers and the bench. The Committee has also heard that contrary to section 12 of the *Children (Criminal Proceedings) Act*, Children's Court proceedings do not always involve young people. That section provides, *inter alia,* that:

12(1) If criminal proceedings are brought against a child, the following matters shall be explained to the child:

(a) the nature of any allegations made against the child; and

(b) the facts that must be established before the child can be found guilty of the offence with which the child is charged.

(2) Until those matters have been explained to the child, the court before which the proceedings are brought shall not proceed further.

In addition, because of time constraints or even a disregard, many solicitors often failed to explain fully to their young client the process or outcome of a matter (Standing Committee on Social Issues, 1992:194).

The Committee's Juvenile Justice Report (1992) made a number of recommendations that dealt with the issue of legal advocacy for children and young people charged with a criminal offence. These were:

Recommendation No. 126:

That the Attorney General's Department, the Department of Courts Administration, the Legal Aid Commission and the Law Society review the option of the expansion of the children's duty solicitor scheme and provision of a social worker, to other Children's Courts, using the scheme at Cobham Children's Court as a model. As part of the review, consideration be given as to whether more than one salaried solicitor would be required to service Children's Courts.

Recommendation No. 127:

That the duty solicitor scheme be expanded to include a legal service for young people in Juvenile Justice Centres that could assist detainees with bail applications, appeals, complaints and any other relevant legal matter.

Recommendation No. 128:

That a special Children's Section be established in Head Office of the Legal Aid Commission that would be responsible for the coordination and monitoring of the duty solicitor scheme, including an expanded duty solicitor scheme.

Recommendation No. 129:

That a scheme be established by the Legal Aid Commission whereby a children's solicitor travels on circuit to country areas where there is no specialist Children's Court or specialist children's solicitor to assist in children's criminal proceedings.

Recommendation No. 130:

That all solicitors participating in the Children's Court duty solicitor scheme be provided with training and education on issues relevant to the needs of the clients that they are to represent and that such training and education be ongoing throughout their time on the roster.

Recommendation No. 131:

That the Attorney General's Department, the Department of Courts Administration, the Legal Aid Commission and the Law Society examine the option of setting up a 24 hour telephone advice line for young people at police stations, who are charged with a criminal offence.

Recommendation No. 132:

That Children's Court proceedings be conducted in language that is simple and able to be understood by young people appearing at court and that young people and their families or other support people, be encouraged to participate in the proceedings.

To date only one of those recommendations has been acted upon namely, number 127. That recommendation called for the expansion of the duty solicitor scheme to include a legal service for young people in Juvenile Justice Centres (detention centres). The Committee notes that the Legal Aid Commission has appointed one solicitor to fulfil this role, and she is part of the Commission's Children's Legal Service. Whilst the Committee

commends this initiative it is concerned that one solicitor for all New South Wales' detention centres is inadequate.

The Committee considers that legal advocacy for children and the juvenile justice system would be substantially improved if all the recommendations made on this issue in its Juvenile Justice Report were implemented. Building on those recommendations the Committee makes the following further recommendations and calls on the government to implement them as soon as possible.

Further, the Committee considers that the Children's Court jurisdiction should be changed to that of the District Court. By enhancing the status of the Children's Court the Committee believes that a significant body of case law would be established and more practitioners would be attracted to practice in the area of children's law.

RECOMMENDATION 6

That the Attorney General establish within the Legal Aid Commission a Children's Section, which is adequately resourced and staffed, to undertake matters in relation to juvenile criminal matters and care and protection matters throughout New South Wales. That Section shall be staffed with both solicitors and social workers.

RECOMMENDATION 7

That the Children's Section proposed in Recommendation 6 establish, coordinate and monitor a children's duty solicitor and social work scheme, as currently operates at Cobham Children's Court, for all specialist Children's Courts throughout New South Wales.

RECOMMENDATION 8

That the Children's Section proposed in Recommendation 6 establish, coordinate and monitor a scheme whereby children's solicitors and social workers travel on circuit to country areas where there are no specialist Children's Courts or specialist children's solicitors.

RECOMMENDATION 9

That the Children's Section proposed in Recommendation 6 establish, coordinate and monitor an expanded legal service for children in all detention centres throughout New South Wales.

RECOMMENDATION 10

That the Children's Section proposed in Recommendation 6 establish, coordinate and monitor a training and education program for all solicitors participating in the Children's Court duty solicitor scheme on issues relevant to the needs of the clients that they are to represent and that such training and education be ongoing throughout their time on the roster.

RECOMMENDATION 11

That the Attorney General extend funding to Community Legal Centres so that broad-based legal advocacy on a range of issues can be provided to children and young people throughout New South Wales.

RECOMMENDATION 12

That the Attorney General elevate the jurisdiction of the Children's Court to that of the District Court to increase the status of that jurisdiction.

The Committee recognises that there are groups of young people who are particularly vulnerable to entry in the juvenile justice system. Among them are Aborigines, young people from non-English speaking backgrounds, young people with an intellectual disability, state wards, and young people from rural and remote areas. These groups were referred to extensively in the Committee's reports, *Juvenile Justice in New South Wales* and *Youth Violence in New South Wales.*

Regrettably many of the findings from those reports remain pertinent to the situation for a number of young people in the juvenile justice system today. Aboriginal young people are still over-represented at all stages of the juvenile justice system and represent at any one time 25-30% of all young people in detention. They remain under-represented in cautioning rates and court diversion schemes. Moreover, as Cain found (1995:41-42)

> *the Indo-Chinese, Lebanese, Pacific Islanders and Maoris, have disproportionately large numbers of their youth in custody on remand and in control. Such over-representation also raises the possibility of discrimination operating in relation to these groups.*

Whilst girls represent only a small minority of offenders in the juvenile justice system they have very specific needs. As this Inquiry has confirmed, most young female offenders have a background of sexual and/or physical and emotional abuse leading to serious substance abuse and a lack of stable accommodation. For these reasons these young women have

specific and often complex needs that should be appropriately responded to in order to prevent both further abuse and further offending.

For this Inquiry, the Committee received a number of submissions in relation to young people with an intellectual disability who are involved in the juvenile justice system. The Council for Intellectual Disability stated in its submission that:

> *if an adolescent with intellectual disability becomes involved in the juvenile justice system, he or she is likely to progress to the adult criminal justice system. Statistics illustrate that a high percentage of adult offenders have spent time in detention as children. There are numerous factors which contribute to children entering the juvenile/criminal justice system. These include vulnerability, impulsiveness and the need for immediate gratification. People with intellectual disability are also easily exploitable and less able to conceal their crime* (Submission 14).

That same submission notes that as a result of:

> *disempowerment and limited access to advocacy, people with an intellectual disability are not regarded as reliable witnesses in the criminal justice system. People with intellectual disabilities, particularly children, are not perceived as credible witnesses and the authority of their evidence is frequently questione* (Submission 14).

The Committee is very concerned that such a situation may impact upon a young intellectually disabled defendant having to plead guilty when he or she may be innocent.

4.3 CHILDREN AS WITNESSES FOR THE PROSECUTION

The issue of children as witnesses in prosecution cases is a matter of serious concern for the Committee. The Committee considers that this is an issue that goes to the very heart of a child's right to be heard and to their access to justice.

As the Committee has been told, many children who are victims of abuse and violence do not proceed to the prosecution stage because of their age, the perceived impact a trial would have on them, and their perceived competence as witnesses for the prosecution. This can be especially the case for children with an intellectual disability who, according to the Council for Intellectual Disability, are not adequately represented in the criminal justice system:

> *advocacy is crucial to people who possess only a limited knowledge of their rights, lack knowledge about the procedures which they need to go through and how to articulate their needs* (Submission 14).

Consequently, these children are effectively denied an opportunity for justice.

Those who do choose to proceed with the prosecution can face considerable difficulties. Lengthy and prolonged court delays and the fact that trial dates are not given until shortly before they commence, often can cause enormous problems for the child witness. As Megan Latham, Crown Advocate and former Director of the Criminal Law Review Division, told the Committee:

> *You are still looking at something like two to three years between the time when the child discloses and makes a statement and the time that the matter comes to trial, and that is unacceptable for children, unacceptable for most adults, but for children it represents a most appalling disruption to their lives. It means that they cannot reconcile a whole host of problems that they have, socially, educationally, within family relationships, in terms of their own maturation, particularly when these offences are occurring by and large on prepubescent children, who when they appear before the court, might be two years, three years older and look a lot different and behave a lot more differently than they did at the time of the alleged abuse* (Evidence - 22 April, 1996).

Latham (Evidence - 22 April, 1996) further commented that although cases involving children take some priority they do not take the "best priority in the system". The Committee is very concerned about the potential injustices for child victims and witnesses who are compelled to wait for extremely long periods before their case proceeds to trial. It therefore urges the Attorney General to expedite **all** cases where a child is the main prosecution witness in matters involving sexual or physical abuse.

RECOMMENDATION 13

> **That the Attorney General devise a system to expedite all cases where a child is the main prosecution witness in matters involving sexual or physical abuse.**

The Report of the Children's Evidence Taskforce, *Taking Evidence in Court* (1994:42) found that:

> *Problems faced by child witnesses when giving evidence in the courtroom include the fear of having to testify often about events usually of an explicit and embarrassing nature, in front of the accused, who is often well-known or closely related to them, together with a number of people they do not know, in intimidating formal courtrooms in which unfamiliar language and procedures are used.*

These comments were reiterated by a number of witnesses and in a range of submissions.

For many people and especially children, the language used in court rooms can be inaccessible and overwhelming. Megan Latham stated before the Committee:

> *We (lawyers) speak in terms which most adults do not understand and it is a very difficult thing to do to change a language but I think we could be doing a lot more than we are presently doing to change our language with children* (Evidence - 22 April, 1996).

The Report of the Children's Evidence Taskforce, *Taking Evidence in Court* (1994) made a number of recommendations relating to children's evidence. These included the following.

That:

- *closed circuit television ("CCTV") be adopted as the preferred technical solution to assist child witnesses give testimony (recommendation 3);*
- *screens and other alternative arrangements continue to be an available option where CCTV is not used or not available and that a protocol be developed providing guidance to courts in the application of screens in the courtroom (recommendation 6);*
- *the presumption against children giving evidence by CCTV be replaced with a general rule that children should give evidence by CCTV (recommendation 15);*
- *the child witness should be able to elect not to give evidence by CCTV or by alternative arrangements if he or she does not wish to (recommendation 16);*
- *while screens and other alternative arrangements should be retained as an alternative to the use of CCTV, there be no general rule in favour of using these alternative arrangements for children giving evidence (recommendation 17);*
- *an application for use of an alternative arrangement should be made pre-trial by the party calling the child witness (recommendation 18);*
- *the use of CCTV and alternative arrangements be extended to child witnesses as well as child victims of crime (recommendation 19);*
- *the use of CCTV and alternative arrangements be extended to accused children appearing in the higher courts (recommendation 20);*
- *"child" in relation to provisions for the use of CCTV and alternative arrangements be defined to mean a child under the age of 16 years at the time*

at which he or she commences to give evidence in the proceedings (recommendation 21);

- *the use of CCTV be extended to include any criminal proceedings in which it is alleged that the accused person has committed "personal assault offence" (recommendation 22);*

- *"personal assault offence" be defined as:*

  (a) an offence under Part 3 or sections 562AB and 562I of the Crimes Act 1900 or an offence under section 25 or the Children (Care and Protection) Act, 1987; or

  (b) an offence (such as an offence under sections 37 or 112 of the Crimes Act 1900) which includes the commission, or an intention to commit an offence referred to in paragraph (a); or

  (c) an offence of attempting, or of conspiracy or incitement, to commit such an offence referred to in paragraph (a) or (b) (recommendation 23);

- *the provisions for CCTV and alternative arrangements apply to any court in which a "personal assault offence" is being heard (recommendation 24);*

- *CCTV and alternative arrangements be available in hearings of applications for apprehended violence orders (recommendation 25);*

- *where CCTV is to be used the trial judge issue a warning to the jury that this is a usual procedure and that no adverse inference is to be drawn against the accused as a result of the use of the procedure and that the child's evidence should not be given any greater or lesser weight simply because it is being given by CCTV (recommendation 26);*

- *where a child witness is called to give evidence, the party not calling that witness has a right to make an application prior to the trial that in the circumstances of the case it is not in the interests of justice that CCTV or an alternative arrangement be used (recommendation 27);*

- *where the accused is unrepresented:*

  (a) and CCTV is available, the accused be allowed to cross examine the child witness directly;

(b) *and CCTV is not available or not used, questions to the child witness be directed through a third party, preferably the trial judge, and*

(c) *where the interests of justice require, the judge may intervene in either of the above situations to either allow or disallow direct cross-examination of the child witness, as appropriate (recommendation 28);*

- *where the evidence of a child is given under the CCTV provisions and the identification of the accused is an issue; the child is not to be required to be in the presence of the accused:*

  (a) *for any longer than is necessary for that purpose; and*

  (b) *before the child's evidence (including cross-examination and re-examination) is completed (recommendation 29);*

- *any application that CCTV or alternative arrangements not be used be made in advance of the trial (recommendation 30);*

Additional recommendations included that:

- *the Attorney General establish a Taskforce to consider issues relating to the use in evidence of videotapes of out-of-court statements made by children (recommendation 1);*

- *the Attorney establish a Taskforce to consider issues relating to the giving of evidence by persons who may be disadvantaged or vulnerable within the court system, and to consider the relevant recommendations of the Law Reform Commission emanating from its reference on People with an Intellectual Disability and the Criminal Justice System (recommendation 2);*

- *the level of existing CCTV installations be reviewed with a view to increasing the availability of those facilities State-wide (recommendation 4);*

- *where CCTV facilities are not available a power be retained to permit the adjournment of proceedings to another court where CCTV facilities are available (recommendation 5);*

- *the use of screens be evaluated to assess their efficacy as a solution to the problems experienced by child witnesses in court (recommendation 7).*

The Committee strongly endorses all of these recommendations.

Commenting on the outcomes of some of these recommendations and, whilst welcoming the recent announcement to increase the availability of CCTV, Latham told the Committee:

> *We still do not have a standard form of screen which is approved and used and available in New South Wales courts. So when I have a child who wants to go into a court room but does not want to be confronted with a line of sight to the accused, then I turn to the sheriff's officer and say, 'Can you get me a screen?' ... they do not have one, [or] they do not have one which is appropriate for that use [or] that can be brought into the court room straight away. It is not part of their equipment in the same way that they have microphones, tape recorders, or whatever. The same goes for things like gas lift chairs, so the height of the witness box. Lapel microphones, because what happens is the microphone sticks out from the box, and what children do is they drop their head and talk down there, so you cannot hear what they are saying* (Evidence - 22 April 1996).

The Committee notes that in the recent State budget the Government announced that it will install closed circuit television systems over the next 3 years, at a cost of $2.5 million, in courts in all major locations across New South Wales and in the Children's Courts. The Government has stated that:

> *this will ensure that country children have the same support while giving evidence as city children* (NSW Government, 1996:6).

The Committee commends this initiative.

The Committee notes also that a Bill entitled the *Crimes Amendment (Children's Evidence) Bill 1996* is currently before the New South Wales Parliament. The Committee understands that the Bill will recognise many of the recommendations of the Children's Evidence Taskforce.

The object of the Bill is to reform the law relating to children's evidence in criminal and other proceedings by:

- making it possible for all children who give evidence as witnesses in certain proceedings to be accompanied by a parent, relative, friend or other supportive person;

- allowing children giving evidence in criminal or civil proceedings arising from a personal assault offence (including sexual and physical assault), or in proceedings involving the making of an apprehended violence order, to give that evidence by means of closed-circuit television facilities or similar technology;

- allowing a child who gives his or her own defence in proceedings in the Children's Court the limited right to give evidence by means of closed-circuit television facilities.[1]

The Bill creates a presumption that the evidence of any child witness will be given by means of closed-circuit television facilities or similar technology, regardless of whether or not the child is the victim. Further, it creates an absolute right for all children who give evidence in specified proceedings to have a person of their choice with them. That person may be there to give support, assistance with language problems, or assistance with any difficulty associated with a disability.

The Committee notes that the *Crimes Amendment (Children's Evidence) Bill 1996* provides that a judge must warn the jury about the weight to be given to the evidence of a child who uses closed circuit television or other similar technology. Section 405H provides:

> *(1) In any criminal proceedings in which the evidence of a child is given by means of closed-circuit television facilities or any other similar technology (by virtue of section 405D), the Judge must:*
>
> *(a) inform the jury that it is standard procedure for children's evidence in such cases to be given by those means and*
>
> *(b) warn the jury not to draw any inference adverse to the accused person or give the evidence any greater or lesser weight because of the use of those facilities or that technology.*

The Committee supports the *Crimes Amendment (Children's Evidence) Bill 1996.* It anticipates that once the Bill is passed, many of the problems faced by child witnesses will be overcome. However, the Committee considers that the effect of the warnings as set out in Section 405H on a jury's perception of a child's evidence should be strictly monitored.

The Committee is concerned about the trauma that might be incurred by a child victim who is required to give his or her statement and repeat the story of the offence(s) to a range of people and on numerous occasions during the prosecution process. The police, counsellors, officers of the Department of Community Services, solicitors and barristers, may all require a statement from the child.

This issue was given extensive consideration by the Child Sexual Assault Taskforce. According to the Report of the Taskforce (1986:106):

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[1]As this Report went to press, the Bill was passed, with amendments, in the Legislative Council. The amendments, if accepted by the Legislative Assembly, would exclude children who are accused of personal assault from provisions that give a presumption that evidence will be given by CCTV.

> *each worker who seeks to interview the child, comes to the interview with different aims in mind. This in itself should not however prevent joint interviewing .... It is important that no more than two workers attempt this exercise. The Task Force received many submissions drawing attention to the danger of overwhelming the child with too many "interrogators".*

Linked to this matter is the issue of a child giving his or her statement by way of audio-visual recordings. Submissions to the Child Sexual Assault Task Force were mixed on this issue. Marrickville Women's Refuge, Delvena and Rape Crisis Centres argued in a submission to the Task Force (1986:110):

> *We in the collectives could not come to a consensus. Some of us agreed that the use of audio and video tapes was to be considered if they could be used in lieu of the child in court. This would dramatically lessen the trauma of court proceedings for the child. Others thought that the audio tape should be sufficient for the entire reporting and court proceedings and used in lieu of the child in court. The video taping process could be more traumatic to an already stressed child and we don't see the necessity of video as well as audio.*

The Task Force also received submissions stating that a tape of the child's statement must be destroyed once the statement is typed. The Task Force itself found (1986:111) that:

> *there may be some value in recording the child's statement audio-visually provided the child is made aware of the procedure and is happy to comply, and provided the recording is made by personnel with some expertise ... the Task Force favours audio-recording of the child's statement as less intrusive and having substantially the same advantages over present methods of recording. This is not to say that this method does not require a certain level of expertise and that personnel do not need to be sensitive to the aims of other workers wanting access to the recording.*

The Report of the Children's Evidence Taskforce, *Taking Evidence in Court*, did not consider at length the issue of the admissibility of video tapes of out of court statements but stated (1994:16) that:

> *the Attorney agreed with the view of the Taskforce that the issues raised by this topic were too complex to be capable of resolution within the given time frame and that the Taskforce's original terms of reference should be amended accordingly. The Taskforce considers that the potential benefits of using videotapes of out-of-court statements should be amended accordingly.*

The Committee notes that a Videotaping of Children's Evidence Taskforce has been established in line with the recommendation of the Children's Evidence Taskforce. It understands that a report will be prepared shortly that will address many of the issues associated with the taping and admissibility of children's evidence.

In recent times there has been considerable discussion about possible changes to the structure of the whole legal and court process in relation to cases of child sexual abuse. Debate concerning such cases was heightened following revelations of Wood Royal Commission that many children do not report cases of sexual abuse because of the intimidatory nature of court proceedings. In her evidence to the Committee, Megan Latham addressed this point:

> *I think you have got to take the position that if you want to expose an accused person to the full rigours of the criminal law for an assault which is, in the criminal calender, in my view one of the most dire assaults with such dire long-term consequences on the health and wellbeing of a person, an offence against a person which warrants the maximum penalty that we give them under the criminal law, then you cannot simply say: Well the process is too intimidating let's do it another way, because if you do it another way you cannot then visit the accused [re-try or re-sentence], if he is convicted, with those penalties.* ***What you do is, in effect decriminalise the whole thing.*** *The protections that are afforded to an accused person are there because the potential consequences are so extreme, and they should be extreme, and if we start saying let's do it in a tribunal, there will not be any terms of imprisonment, there will not be any consequential gravity attaching to the offence and the community over time will see it as they once saw it, it is a matter for the family. I do not accept that position. I think it is inherently unsound ....* ***I really think (that you should) modify your procedures as much as you can within the confines of that discipline to allow for children to be heard*** (emphasis added)(Evidence - 22 April, 1996).

The Committee concurs with these views. It considers that the implementation of the recommendations of the Children's Evidence Taskforce Report, *Taking Evidence in Court* and the enactment of the *Crimes Amendment (Children's Evidence) Bill* will go a long way in assisting children and young people who are victims of abuse to give evidence in court.

4.4 FAMILY LAW MATTERS

The Committee recognises that family law matters fall within the Federal jurisdiction. Nevertheless, a number of issues relating to the involvement of children in such matters fall directly with the concerns of this Inquiry.

The Committee understands that the vast majority of children involved in family law matters are not represented. A recent decision of the Full Court of the Family Court, *Re K* (1994) established parameters for the representation of children in family law proceedings. The Court identified thirteen categories of cases where the trial judge or registrar of the court determines when children should be given separate representation. Judith Ryan, Manager of the Family Law Programme at the NSW Legal Aid Commission told the Committee in evidence that as a result of *Re K*:

> *the court should enquire whether the family comes within one of these thirteen categories, and although they are not proscriptive and they would not excuse other factual circumstances, there will be cases, for example, where there are particular cultural issues which are relevant to the welfare of the child, special medical procedures, for example, where a child is proposed to be sterilised, cases where there are allegations that the child has been sexually abused or physically abused, where there is a history of domestic violence, where neither of the parents are represented. They are the sorts of cases .... The court makes the order (and), the order is remitted to the Legal Aid Commission* (Evidence, 22 April, 1996).

The Committee welcomes the approach of the Court in *Re K.* However, it is aware that in spite of that decision, there have not been any additional resources provided to the Legal Aid Commission to implement fully the Court's order. As Ryan further explained to the Committee, once an order is remitted to the Legal Aid Commission:

> *it is then a matter for the Legal Aid Commission whether they implement those orders or not. The court does not have the power to order us to provide the representation. You will see that there is a difference developing nationally in the approaches taken by the Legal Aid Commissions. For example, the Legal Aid Commission in Western Australia, because of the budgetary pressures, funds only two of the thirteen categories of cases that are mentioned in Re K. We have continued to fund them all but we are in a position now of extreme financial distress.*

The Committee strongly supports the separate representation of children in family law proceedings. It considers that such representation is vital given that children can be the most vulnerable parties to any family law matter. The Committee is extremely concerned that a lack of resources is potentially undermining this process. The Committee is aware that legal aid funding generally, is stressed but considers that children should not suffer from budget constraints and cuts. It therefore calls on the Legal Aid Commission to quarantine an amount of money to ensure that children are provided with adequate legal representation in family law proceedings, as laid down in *Re K.*

RECOMMENDATION 14

> **That the Legal Aid Commission quarantine appropriate funds to ensure that children are provided with adequate legal representation in family law proceedings as laid down in Re K.**

CHAPTER FIVE

HEALTH

5.1 INTRODUCTION

The Terms of Reference of this Inquiry require the Committee to examine the degree to which the needs of children throughout New South Wales are being effectively advocated for and promoted in the area of health. All the submissions and witnesses who addressed the issue of health agreed that, in certain areas and among certain groups, there needs to be more effective advocacy for children and young people.

Due to their special needs and vulnerabilities, a holistic approach to advocacy and the health of children and young people needs to be adopted. As the submission from the Youth Action and Policy Association stated (Submission 40):

> *the health needs of young people are affected among other things by their social context: class, gender, ethnicity, ability, sexuality, education, employment, income, housing, family relations. All have an impact on young people's health, and must be taken into account in the development of strategies and services for improving and maintaining the health of all young people. A purely 'medical model' of health care can only provide a limited understanding of young people's health needs. It is also important to particularly acknowledge both the immediate and long term effects of violence, and domestic violence on the health of young people.*

The Committee is aware that in recent times particular health needs of children have been given increased consideration. For instance, the tragic reality of youth suicide has resulted in a greater acknowledgement of the mental health needs of children and young people and of the need for a "whole of community" response to the problem.

Moreover, over the last 5-10 years there has been a greater awareness of the risk of injury many young children can face in the home and there have been a number of education campaigns designed to minimise the potential for such injury.

Children and young people have recently been targeted in education strategies to highlight the health risks associated with smoking and alcohol abuse.

Further, the tragedy of Sudden Infant Death Syndrome (SIDS) has resulted in a public information campaign designed to inform parents and carers how to minimise the risks associated with SIDS.

Nevertheless, despite these and other health campaigns and strategies, the health needs of many children and young people throughout New South Wales have, to date, remained unmet.

The Committee heard that our current health system has traditionally been geared towards adult patients and consumers - children are subsumed into the general system and not accorded a particular status which their age requires. Children, according to the submission of the Australian College of Paediatricians, "are not promoted in mainstream provision of health care" (Submission 28).

The Committee recognises that this is particularly the case for Aboriginal children whose health status has been described as being akin to Third World standards. Child Advocate Dr Ferry Grunseit, in a document tabled in evidence (29 November, 1995) stated that:

> *Aboriginal children still suffer from poor health and have a sickness pattern reminiscent of the last century. For example, 40% of Aboriginal toddlers are admitted to hospital with chest infections and the incidence of pneumonia is 80 times that in non-Aborigines. Two hundred Aboriginal communities do not have a local health service, over 300 lack a clean water supply and 250 do not have electricity .... Family disruption, domestic violence, lack of care and supervision by young unskilled and poorly adjusted parents contribute to the stressful life faced by many of these children since their birth. The rate of child abuse and neglect notifications is high amongst Aboriginal children in this state compared with the rest of the population.*

The Committee also acknowledges that children of lower socio-economic status generally have lower standards of health in a number of areas, often due to poor nutrition, housing and environment. Children with a disability have special health needs that are often not adequately met by the health system - their disability being frequently identified as the major reason for accessing health services.

The Committee was told that limited services and facilities in rural and remote areas place children from these regions at a marked disadvantage in terms of detecting health disorders and receiving adequate health care. The Committee is also aware that children as carers, that is, those who are responsible for the care of an ill or disabled parent, are a group whose needs have not be fully recognised. The Committee anticipates examining all of these issues throughout this Chapter.

The Committee understands that the Minister for Health has recently launched a Discussion Paper on the development of the NSW Child Health Policy (Department of Health, 1996). The paper is open to community consultation and the responses will form part of the final report on the NSW Child Health policy. Among the issues canvassed in the Discussion Paper are immunisation, injury, asthma, dental health, nutrition, mental health, child protection and gender issues. Some groups are identified as having special needs and requiring priority attention, including Aboriginal children, children from non-

English speaking backgrounds, children from poor families, those with a mental illness, and children who are abused.

The Committee welcomes the development of a Child Health Policy and hopes that the material presented in this Chapter will assist in the development of that policy. When the policy is fully developed the Committee trusts that it will be implemented without delay so as to address the manifold health needs of all children in the state.

5.2 THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

The health needs and rights of children make up a number of articles in the United Nations Convention on the Rights of the Child. Article 24 provides:

1. *State parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation to health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

2. *State parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*
   - *(a) to diminish infant and child mortality;*
   - *(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
   - *(c) to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;*
   - *(d) to ensure appropriate pre-natal and post-natal health care for mothers;*
   - *(e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;*
   - *(f) to develop preventative health care, guidance for parents and family planning education and services;*

3. *State parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.*

> 4. *State parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.*

In spite of its international obligations under the United Nations Convention, the Committee was told during the Inquiry that both the nation as a whole and the state of New South Wales are failing to properly maintain the standards required by the Convention.

Examples provided to the Committee that illustrate this situation included:

- the lack of facilities and medical aids for children;
- limited child mental health specialists and services;
- limited child and adolescent drug and alcohol specialists and services;
- the low immunisation rates in Australia and New South Wales compared to other OECD countries (although the Committee received a submission questioning current vaccination policy); and
- the appalling state of Aboriginal child health and the fact that, today, Australian children from disadvantaged backgrounds have worse health than the rest of the community, as measured by a wide range of indicators including perinatal outcome, infant mortality, illness and accident rates and health service use.

It must be recognised that Article 24 of the United Nations Convention should also be read in conjunction with Article 12, which provides for the views of the child to be taken into account where that child is capable of forming his or her own views. As the Committee has learnt from a document tabled by the Health Care Complaints Commissioner, Ms Merilyn Walton (Tabled Document: 29 November, 1995), this Article in the context of health means:

> *informing children, listening to them, and actively involving children who have views in making decisions about their care. It means listening to mothers who pick up clues from their baby about how the treatment is benefitting or harming them, and how it might be improved .... It also means overcoming age-assumptions, such as that children aged under 3 years cannot understand explanations (they can) ... or do not mind their privacy and dignity being disregarded (they do), or that children aged 5 to 6 years can never take part in making complex, serious decisions about their treatment (some do), or that older adolescents do not need or want close mothering care (many do during the early days after major surgery).*

Evidence to this Inquiry has revealed that in many instances the principles of Article 12 are not being adhered to in relation to children's health. The Committee believes that this can be addressed by professional education and policy guidelines for use throughout the health system.

5.3 GOVERNMENT RESPONSES

The Committee was told that one of the factors contributing to children's health problems, and one which highlights the need for effective advocacy in the area of health, is the traditional lack of a discrete child-specific health policy.

At a federal level, the National Health priorities are largely oriented to adult health. The Australian College of Paediatrics commented in its submission to the Committee:

> *The current National Health priorities are Heart Disease, Cancer, Injury, Aboriginal [health] and Mental health. As children do not necessarily "fit" into these prescribed conditions a separate set of goals [needs] to be developed so that some consideration could be given to the health needs of children* (Submission 28).

At a state level, and as noted above, the Government has recently announced that it is developing a child health policy. The Committee is pleased with this initiative as children's health should finally be accorded a priority in terms of the state's health goals.

In his submission to this Inquiry the Minister for Health outlined child health priorities as including increasing rates of childhood immunisation, developing strategies to minimise blood lead levels in children, developing antenatal and postnatal parenting education programs and introducing a dental assessment and prioritisation scheme for school children (Submission 32).

The Committee notes that in recent times there has been a positive move, at both a state and federal level towards developing mental health strategies for children and young people following alarming revelations about Australia's unacceptably high youth suicide rate. At the state level, a suicide prevention strategy has been established which will be completed in 1996 (New South Wales Government, 1996:6). At the federal level a Youth Suicide Prevention Advisory Group was established in 1995 which is examining strategies to prevent young people committing suicide.

During the Inquiry the Committee heard that within the Child and Family Health Unit in the New South Wales Department:

> *staffing has been so eroded that it is effectively 1 full time policy adviser and 1 part time medical officer* (Submission 57).

It is apparent that the present structure is inadequate since it does not allow for research and policy development in areas of urgent need such as Aboriginal child health and rural family issues (Submission 57).

The Committee agreed that one area of concern that has yet to be adequately addressed in a consistent child and young person's health policy is the problem of ear and hearing

disorders. The Committee recognises this as a major issue, not just from a health perspective, but because of the impact untreated disorders may have on a child's learning ability and behaviour. In a previous Inquiry, *Juvenile Justice in New South Wales* (Standing Committee on Social Issues, 1992), the Committee heard that the source of many young offenders' problems could be traced to hearing disorders caused by *otitis media*. This is a major problem among Aboriginal children. The Committee therefore calls on the Government to address this issue as a matter of urgency.

The terms of reference require the Committee to review the adequacy of the Health Care Complaints Commission. The Commission investigates complaints against medical practitioners and health workers. Evidence was received from Commissioner, Merilyn Walton, and the Committee received a range of submissions that addressed its adequacy in relation to advocating for, and redressing the grievances of, children. Most of those considered that the Health Care Complaints Commission was essentially adult-oriented with the complaints procedures too complicated for children to access effectively. Of course, the lengthy time frame for the resolution of matters deters children and young people from accessing the Commission. The Committee also heard that parents do not utilise the Complaints Commission on behalf of their children. Much of this has to do with the fact that the Complaints Commission is not widely known to health consumers. These issues are addressed further in Chapter Seven.

5.4 PREVENTION

The Committee recognises that a major component in successful children's advocacy generally is prevention and early intervention. This is particularly pertinent in the area of child health. Prevention of injury, disease and mental health problems should be an overriding concern for the community. As noted above, Australian children from disadvantaged backgrounds have worse health than those from more affluent backgrounds. Mathers' (1995) analysis of health differentials among Australian children provides the following information in support of this claim:

- *Children in single parent families had a clear pattern of worse health and higher levels of use of health services than children in two parent families;*
- *Children aged 0-4 years in single parent families were substantially more likely not to have been breastfed;*
- *Girls aged 2-6 years in single parent families were 30% more likely not to be fully immunised;*
- *Children in low income families had significantly more serious chronic illnesses than those in high income families;*

- *Children aged 0-4 years in low income families were substantially more likely not to have been breastfed;*
- *Boys aged 2-6 years in low income families were nearly 3 times more likely not to be immunised for measles than boys in high income families;*
- *children whose parents were unemployed or not in the work force had around 25% more serious chronic illness than children with an employed parent;*
- *Boys and girls aged 0-4 years whose parents were not employed were much more likely not to have been breastfed for at least 3 months;*
- *Boys and girls aged 2-6 years whose parents were not employed were around 30% more likely not to be fully immunised, with substantially higher levels of incomplete immunisation for measles, mumps and whooping cough;*
- *There was a clear gradient of increasing death rates for Australian children with increasing level of socioeconomic disadvantage of area of residence;*
- *Mental disorders (for girls) and bronchitis, influenza and deafness (for boys) were reported more frequently for children living in the most disadvantaged areas;*
- *Children whose parents did not speak English at home were much more likely not to be immunised for all the diseases where vaccination is recommended.*

Mathers (1995:x) concludes that there is clear evidence of:

> *poorer health among Australian children in socio-economically disadvantaged families where neither parent is employed and in single parent families .... Monitoring of health differentials among Australian children can help to identify priority groups for the development of targeted preventative and curative health interventions to assist economically disadvantaged children to achieve better health and, potentially, to reduce health differentials in adulthood.*

In his evidence to the Committee, paediatrician Dr Victor Nossar, emphasised the need for prevention in any effective form of advocacy for children, including in health. Dr Nossar stated to the Committee:

> *You have to try and prevent the disadvantage occurring if you can .... As a paediatrician, it concerns me that when I evaluate resources that impact on health programs, the people who gain most are the people in the middle and upper classes from programs which are intended to help the poor, or the children of the poor ...*

(nevertheless) what I am convinced about is something like disadvantage having an effect on health (Evidence - 29 April, 1996).

Fundamentally linked to the health status of children in New South Wales is nutrition. Good nutrition can also impact significantly on learning ability and concentration, and on mental health, including self-esteem and confidence. In a report prepared by the New South Wales Health Department (1994), *Food and Nutrition in New South Wales: A Catalogue of Data*, a range of findings were made in relation to the nutritional standards of children and young people in New South Wales. Aboriginal children, as the report reveals, have very low nutritional standards. Some of the findings are summarised below:

- *Aboriginal children may be at higher risk of nutrient deficiency that non-Aboriginal children;*
- *children of lower socio-economic status had:*
    - *higher intakes of energy and a higher proportion of energy from fat, saturated fat and monounsaturated fat; and*
    - *a lower density of fibre in the diet, a lower ratio of polyunsaturated to saturated fat and a lower proportion of energy from protein and carbohydrates;*
- *high infection rates in Aboriginal infants and children are associated with growth faltering and frank malnutrition;*
- *several studies of New South Wales Aborigines, particularly studies of children, have reported a high prevalence of iron deficiency anaemia, low blood levels of vitamins, and infections or parasitic infestations;*
- *infections are closely related to malnutrition in Aboriginal children. Improvements in nutritional status therefore require attention to water quality, sanitation, housing, food availability and consumption;*
- *several studies have found New South Wales Aboriginal children to be growth retarded compared to international standards or compared to non-Aboriginal Australian children. In some studies, growth measures indicated both past and present malnutrition;*
- *one of the major causes of death among adolescents and young adults (15-24 years of age) was mental disorders, a category which includes alcohol dependence and eating disorders such as anorexia nervosa and bulimia;*

- *infant, neonatal and perinatal death rates in New South Wales decreased considerably from 1971 to 1987. Aboriginal infant and perinatal mortality in New South Wales and Australia were two to three times higher than for the total population;*

- *while there is no apparent socio-economic gradient for blood cholesterol, the prevalence of high blood pressure, and overweight and obesity is greater among those of lower socio-economic status. It appears that these risk factors are prevalent in New South Wales children, and contribute to the development of heart disease over many years.*

Poverty and a lack of food have been identified to the Committee in its Inquiry into *Juvenile Justice in New South Wales* as being one factor associated with offending behaviour among certain young people. In that Inquiry, the Committee heard (1992:43):

> *evidence ... of young people committing so-called survival crimes, that is, crimes which related generally to accessing food, clothes and ... accommodation.*

The Committee considers that lack of nutrition and health care among children and young people is unacceptable. That Aboriginal health remains at such an appalling level, and that the health of the children of the disadvantaged has become worse, is a serious indictment on our community and an unfortunate indication of the priority we accord children.

Children of minorities and children of the poor are particularly vulnerable when children's needs are not a priority.

All children are entitled to a healthy lifestyle and this is a pre-requisite for them being able to reach their full potential as human beings. Advocacy for children in the area of health should therefore concentrate on preventative and early intervention strategies to ensure that each child does in fact have equal access to a healthy lifestyle.

As the Committee has noted earlier, advocacy for children involves providing appropriate support and assistance to families, especially families in crisis. To this end, the Committee considers it critical that appropriate support is offered to vulnerable families at the time of the mother's confinement. It considers that such support should begin at the hospital stage following the birth of a baby, where it is considered that vulnerable parents may need support. The support should then continue, by way of home visitations, for the next five years. The Committee considers that a program of this nature must be culturally sensitive.

The Committee sees such a program as being crucial to the prevention of neglect or abuse of children. The Committee notes that this was the approach in the National Strategy for the Prevention of Child Abuse.

RECOMMENDATION 15

> **That the Minister for Health establish an outreach program for vulnerable families at the time of the mother's confinement. Workers of the outreach program would conduct regular home visits to such families until the child reaches five years of age. Among the tasks of the workers of the outreach program would be to provide advice about nutrition, child development and parenting skills.**

The Committee considers that Aboriginal child and adolescent health, including mental health, must be a priority of the New South Wales Health Department. Effective and practical strategies, developed in consultation with members of the Aboriginal community, that address the dreadful state of health amongst this group, must be devised and implemented as a matter of urgency.

RECOMMENDATION 16

> **That the Minister for Health and Aboriginal Affairs establish an Aboriginal Child Health Unit within the Department of Health as one means of addressing the unacceptable health status of Aboriginal children. (As a priority that Unit should examine and implement strategies to overcome the problems associated with poor nutrition and otitis media).**

As noted earlier, the special needs and vulnerabilities of children require a holistic approach to health issues and health care. Currently, mainstream health services, such as clinics and hospitals, follow a largely medical-only model, and as such miss many of the broader issues affecting the well-being of the child or young person. As Adrian Ford, Chairperson of the New South Wales Child Protection Council told the Committee in evidence (Evidence - 9 November, 1995):

> *There may be children in the hospital system who are there for a physical health reason but, along with that physical health reason, there may be other issues that are not picked up. There may be behavioural issues or emotional issues but, because the child is being seen under the label of a particular health issue, the particular group of experts involved may not necessarily see the other issues which are apparent to other people's eyes .... There can be appropriate and excellent work done but there may not*

be more fundamental and broad-ranging holistic views of what is happening to children in a system like that unless someone, or a group, is looking at the broader issues.

5.5 CONSENT TO MEDICAL TREATMENT

The issue of consent to medical treatment has been raised throughout the Inquiry as one area which may give children and young people a say in decisions that affect them. The power of parents in relation to their child's medical treatment is not unfettered (Manning, 1996:32). Manning explains (1996:32):

> *First, there are some procedures which do not come within the ordinary scope of parental power to consent to medical treatment, and which require the approval of the Family Court (or Guardianship Board). Secondly, parents are required to act in the child's best interests. If a parent or guardian appears not to be acting in a child's best interests the state may direct that treatment be given. This may be done by application to overrule parents (petition to make child ward of the court) or application by welfare authorities to make child ward of the state .... Finally, there comes an age where children are entitled to consent to their own treatment.*

New South Wales law provides that at 14 years or over, young people can legally give consent to their own general medical or dental treatment.

A child under the age of 14 years may consent to medical treatment if they are considered to be sufficiently mature:

> *the doctor must be satisfied that the child has sufficient understanding and intelligence to understand fully what is proposed* (Manning, 1996:32).

In relation to terminations, parental consent is not required for girls over the age of 14 years. Depending on the doctor, parental consent for girls under that age may be requested. If the child's parents refuse consent, she may seek another doctor or make an application to the court for an abortion.

One of the leading cases in the area of consent to medical treatment and which provides some protection to the wishes of children, is the House of Lords case of *Gillick* (1968 Family Law 11). In that case the House of Lords dismissed the mother's claim that the medical practitioner should not provide contraceptive advice or treatment to children under the age of 18 years without parental knowledge or consent:

> *The decision was based partly on the notion that parental powers over children 'dwindle' as children grow up and their autonomy increases* (Redfern Legal Centre, 1995:224).

The New South Wales Department of Health has specific guidelines regarding the consent to medical treatment by minors. These are as follows:

- *Where a patient is under the age of 14 years, the consent of the patient's parent or legal guardian is necessary, except in an emergency.*

- *A child aged 14 years and above may give consent to medical or dental treatment. For this consent to be valid the child must be able to adequately understand and appreciate the nature and consequences of the procedure/treatment.*

- *However, where a patient is aged 14 or 15 years, unless the patient objects, the consent of a parent or legal guardian should also be obtained.*

- *Where a patient is aged 16 years and above the consent of the patient is sufficient, unless the person is incapable of giving consent, in which case the provisions of the Disability Services and Guardianship Act take effect.*

- *A registered medical (or dental) practitioner may carry out medical (or dental) treatment on a minor aged less than 18 years without consent, if the practitioner is of the opinion that it is necessary to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health.*

- *A person shall not carry out medical treatment on a child aged less than 16 years that is:*

  (a) intended or reasonably likely to have the effect of rendering the child permanently infertile;

  (b) an experimental procedure that does not conform to the NH and MRC Statement on Human Experimentation and Supplementary Notes 1989;

  (c) an aversive therapy;

  (d) a drug of addiction (otherwise than in association with the treatment of cancer), over a period totalling more than 10 days in any period of 30 days;

  (e) a long acting injectable hormone, such as Depo-Provera, for the purpose of contraception or menstrual regulation;

  unless:

(i) *the treatment is required as a matter of urgency to save the child's life or to prevent serious damage to the child's health; or*

(ii) *the Supreme Court consents to the treatment.*

- *Special requirements exist for consent to anal, vaginal or penile-urethral examination of children living in residential care, and the Children (Care and Protection) Act should be consulted as to these requirements* (NSW Department of Health, 1993:9).

In all decision-making, adequate information and appropriate language to assist the child should be ensured in practice guidelines.

5.6 HOSPITALS

The Committee received both oral testimony and written submissions regarding the hospitalisation of children and young people.

Paediatric medicine is a specialist area and many hospitals in the State have in-patient wards and out-patients services for young people. Although hospitals have a brochure for all in-patients regarding patient rights, the Committee heard that it is not "child-friendly". The Committee heard that it should be mandatory for every health facility that cares for paediatric patients to develop, introduce and manage a preparation program for young people entering hospital. This would include multi-lingual brochures, information for parents, and a guide to the hospital and procedure information (Submission 57). The Committee supports this proposal.

The Committee also supports the recommendation of the Australian Red Cross in its submission that there should be 24-hour visiting by parents and siblings and the provision of parent accommodation (Submission 16).

The Committee notes that the issue of parental involvement in procedures is not universally agreed to by experts in the health field. However, it is generally recognised that health care professionals need to consult with both the parents and the child on the involvement of the parents. In its submission, the Association for the Welfare of Child Health stated that:

> *there is an urgent need for hospital policy to be developed in consultation with anaesthetists and other health care professionals, to reflect the need for parental involvement as a matter of routine* (Submission 57).

A broad range of issues were raised in submissions and by witnesses about the important features of hospital care for young people. Among those was the issue of adequate and appropriate facilities in hospitals. The Association for the Welfare of Child Health argued that there is a need to ensure there is provision for child-sized equipment, such as baths, furniture and medical equipment (Submission 57). The Australian Red Cross further emphasised the importance of play to a child's well being and for the successful recovery of a child (Submission 16). This was identified as one area which is the first to suffer under budget cuts.

Many submissions were concerned with the education of children during hospital stays. The Committee firmly believes that children who spend lengthy periods in the hospital environment should continue to receive education, as is their right under the United Nations Convention on the Rights of the Child. However, a number of problems were identified to the Committee during the Inquiry, including:

- *teacher numbers are being decreased and adequate staffing levels are not available to maintain a quality service to children both in the hospital school room and those who require teaching by the bedside;*

- *access to hospital schooling is being offered or declined on the basis of 'anticipated length of stay' in hospital. Length of stay is frequently unpredictable, particularly in dealing with children's health, as children's patterns and rates of illness onset and recovery vary markedly from those of adults.*

- *these issues are complicated by the difficulty of the hospital schools being administered under two separate government departments, New South Wales Health and the Special Education section of the Department of Education.* ***Closer co-ordination between departments and more consultation with parents, hospital teachers and health professionals is required*** (Submission 57).

5.7 COMMUNITY HEALTH CARE

The Committee notes that the change in the delivery of health care services, and in particular the reduced time children (and adults) spend in hospital, has put new pressures on community health care. The increased pressure on the health care system has meant that patients are sent home from hospital still requiring care from health care professionals. The Committee heard evidence that this is often placing undue stress on parents and children.

One of the major concerns of the Committee is the apparent lack of co-ordination in community health care for children. The Committee heard that there is inadequate follow-

up by community support services. According to Irene Hancock of the Association for the Welfare of Child Health, one means of addressing this is to ensure that the general practitioner is included in the discharge plan from hospital. Ms Hancock also suggested in evidence that some form of nursing care should be provided to assist the child in the convalescent process (Evidence - 3 May, 1996). The Committee supports each of these proposals and urges hospitals and the New South Wales Chapter of the Royal Australian College of General Practitioners to develop an appropriate strategy to ensure that general practitioners are included in discharge plans.

The Committee was informed of community-based youth specialist centres including Cellblock and High Street. The Committee understands that such centres offer information and advice to young people on a range of health related issues. According to the submission from the Youth Action and Policy Association there are only a small number of youth health centres, and young people in outer urban Sydney regions and rural areas currently have few youth specific services (Submission 40). That same submission argued that:

> *Community health receives approximately 2% of the New South Wales budget. Youth Health Centres are then allocated accordingly from that 2%. This is clearly inadequate.*

The Committee recognises that community youth health centres are well placed to provide an integrated holistic approach to the health needs of young people. That is, workers are trained to deal with a variety of problems and issues brought to them by young people, such as accommodation, employment, gender, sexuality, ethnicity and family relations to name but a few (Submission 40). The Committee considers that youth health centres are an appropriate health model which can meet the rights and needs of young people. It therefore proposes that funding to community based youth health centres be expanded to ensure that the needs of the clients are being adequately met and that all young people throughout New South Wales have access to them.

5.8 SPECIAL NEEDS GROUPS

A significant proportion of children and young people who come into contact with the health system have special needs. As the following discussion will demonstrate a number of those needs remain unfulfilled by that system, highlighting the very real lack of systemic advocacy for these children and young people in particular.

An examination of the health status and needs of **Aboriginal children** has already been given throughout this chapter. As that discussion has indicated **Aboriginal children have probably the greatest unmet needs in relation to health of any other member of our community.**

The following discussion will examine the situation of children with a disability, refugee and children from a non-English speaking background, children from rural and remote areas, girls, homeless young people, children as carers, children with a mental illness and children of parents with a mental illness.

A number of submissions argued that **children with a disability** are especially disadvantaged in the health system. The Committee heard that in relation to children with a disability there is a:

> *pervasive lack of advocacy in the area of health. Health care provision is random and currently no attempt is being made to improve access to health care* (Submission 14).

The submission from the New South Wales Council for Intellectual Disability stated that children with an intellectual disability are "extremely vulnerable" because they suffer a lack of access to resources, made more difficult by a society which, despite legislative efforts, continues to discriminate against difference.

The Committee was told that children with disabilities can be neglected in hospitals and other health services because they often cannot articulate their views and because they are ignored. Moreover, the New South Wales Council for Intellectual Disability argues that disabled children are especially disadvantaged in receiving sexual health information and advice, making them more susceptible to sexually transmitted diseases (Submission 14).

The submission from the Youth Action and Policy Association stresses that there are clear differences between mental health issues and intellectual disability issues. However, as that submission observes:

> *young people with intellectual disability, who are also represented disproportionately among the young homeless for example, have few support services available to them, and are often inappropriately placed in mental health settings* (Submission 40).

Drug and alcohol services are also often inaccessible to children and young people with a disability. Lack of knowledge of these services, or exclusion from them, are reasons cited for this inaccessibility (Submission 14).

Children and young people of a non-English speaking background and in particular, those with refugee status, can face particular difficulties accessing health services. Language and cultural differences are often reasons for these difficulties. The Youth Action and Policy Association states (Submission 40):

> *access to health and information and services is a major issue for NESB young people, particularly those with limited English language skills. Furthermore, western concepts of health, medicine and counselling are foreign to many NESB communities who may therefore be reluctant to utilise counselling and other support services. This is*

> *particularly true in rural areas. Services that can provide these supports must become more accessible to this group - particularly through education campaigns to local ethnic communities.*

The Committee understands that in recent times there has been a greater awareness of the mental health needs of young refugees and those of a non-English speaking background. The 1995 *State of the Nation* report observed that refugee young people are at particular risk of developing mental health problems. The Committee notes that:

> *frequently these are compounded due to cultural factors, a lack of adult support and assistance, unstable living conditions, past trauma and migration stress* (Submission 40).

Children and young people from rural and remote areas face particular problems in relation to accessing health care. Vast distances and the lack of specialist health services make many of these children vulnerable to particular health risks. Moreover, as the Committee found in its report, *Suicide in Rural New South Wales,* as disadvantage and poverty has increased in these areas, the health status of the populations has declined. Lawrence and Williams' study noted that (1990:42):

> *rural and remote area populations exhibit higher than average levels of premature mortality and death through ischaemic heart disease, cancer, suicide, tuberculosis and malnutrition.*

The Committee's report, *Suicide in Rural New South Wales* (Standing Committee on Social Issues, 1994), identified the problems associated with mental illness for young people in rural and remote areas. Although the Committee found that mental illness among young people is as prevalent in the country as it is in the city, many rural young people's disorders go undetected. Among the reasons for this are a lack of specialist workers and services and the very strong stigma that attaches to mental illness in the country, often preventing disclosure. As the Committee found during the course of its Suicide Inquiry, these issues, together with such factors as access to means (guns), and alcohol abuse, have been found to have contributed to the alarmingly high rate of suicide among young rural men.

During its discussions with students from Taree High School, the Committee was told of the real and perceived problems of confidentiality and privacy when accessing health services in country areas. This was especially the case in relation to matters relating to contraception and/or counselling. Medical practitioners for young people in country regions are normally family doctors which can often make it difficult for a young person to disclose a personal or troubling matter.

As a number of women's health policy reviews have documented, **girls** have special health needs. As well as the health issues common to boys, girls' health needs are often linked to gynaecological issues (including contraception), body health and image, and mental

health. In its report, *Girls at Risk*, the Women's Coordination Unit (1986) found that of the 100 girls interviewed for the study, 83 perceived their health to be an issue at some time. The report noted (1986:177) that:

> *their concerns ranged from general physical well-being, contraception, stress/anxiety, through to pregnancy, asthma and major operations, with the three major concerns being contraception, stress/anxiety and general physical health.*

The *Girls at Risk* report (1986:177) also noted that girls felt intimidated and powerless in relation to medical services. Moreover, those who sought assistance from traditional services such as general practitioners or hospitals "did not believe the assistance they were seeking was gained" (1986:179).

The issue of teenage pregnancy or "children having children" is one of considerable concern to the Committee, both in terms of the welfare and well-being of the mother and the baby. The Committee notes that the problem has become so great in the United States that a federal government taskforce has been established by President Clinton to investigate effective and practical strategies to deal with teenage pregnancies. In a document tabled in evidence, Dr Ferry Grunseit provided the following disturbing information (Tabled Document: 29 November, 1995):

> *teenage pregnancy is an important public health and social problem especially today when family structures and support systems are often weak. Teenage mothers are at greater risk of failing to cope with their babies who may be of low birth weight or premature. Child abuse in the single mother family is more common than in complete families .... In 1991-92 6% of mothers in New South Wales were teenage, while in the N.T. 15% of confinements were in teenagers. In 1990 there were 1680 mothers whose age at confinement was 16 years or less .... (In relation to Aborigines) the higher incidence of teenage pregnancies and births is a disadvantage which may start a pattern from which recovery is unlikely throughout childhood and later on.*

Homeless young people have very special health needs, in terms of both their physical and mental health. As the Report of the Human Rights and Equal Opportunity Commission into Homeless Children found (1989:52), young homeless people are likely to suffer chronic ill-health yet very few access health services. The dangers of life on the street can pose the obvious risks of violence or injury as well as give rise to illnesses that are associated with poor diet and nutrition, and exposure to the cold, including respiratory problems. Moreover, many young homeless people are intravenous drug users and prostitutes which increases the risk of contracting HIV/AIDS, various strains of hepatitis and other sexually transmitted diseases.

The Homeless Children report explained (1989:52) that cost was the primary barrier to homeless children seeking medical attention. According to the Report's findings (1989:52):

most respondents did not have a Medicare Card or a Department of Social Security Health Care Card, nor could they afford to fill prescriptions. Specialist care, including dental treatment and physiotherapy, was beyond the reach of most.

Mental illness, particularly severe depression, is a common phenomenon among homeless children. The report of the House of Representatives Standing Committee on Community Affairs into Aspects of Youth Homelessness (1995) found that there is a clear link between the onset of mental disturbance and homelessness. According to that report (1995:37-38):

the reluctance to diagnose mental illness among children and adolescents, as well as the paucity of services for these children and their families, is a major factor contributing to many of them ending up in shelters and continuing on the road to chronic homelessness.

The very fact of homelessness, bringing with it considerable vulnerability and loneliness, can be a precipitating factor to depression, severe anxiety disorders, suicide ideation, suicide attempts and completed suicide. The Human Rights Commission's report on homeless children found that many of the children interviewed experienced episodes of serious depression and many had engaged in self-harm, including drug and alcohol abuse and attempted suicide. A thirteen year old girl who had made several suicide attempts explained (1989:53):

the way I feel ... you can't survive, so why live if you can't survive. That's what I keep saying to myself.

The Committee understands that **children as carers** are a group whose needs have been overlooked by the health system. Nationally, there are an estimated 33,000 children under the age of 16 years caring before and after school.

These children act as carer for a sick or disabled parent which can be not only time-consuming but extremely stressful and distressing. Children who fulfil these roles are therefore vulnerable to emotional and psychological problems that are often overlooked or not acknowledged by other adults in their lives.

The Committee understands that currently, Interchange Respite Care (N.S.W.) Inc is conducting a pilot project in relation to children and young people who are carers of parents or adults living at home with disabilities in New South Wales. Interchange has received Commonwealth Respite for Carer funding to undertake the project. The project has the following aims:

- *to investigate the incidence and needs of children and young people who are carers of parents or adults living at home with disabilities across New South Wales;*

- *to raise the awareness of community organisations to the existence of these children in their local area so that eventually they may start to consider them as part of their target group;*

- *to educate service providers, teachers and others who may know young carers so that they may better respond to individual needs;*

- *to record and analyse information from a questionnaire based research project and present it in report form with recommendations for state and federal funding bodies;*

- *to facilitate referrals to appropriate local services; and*

- *to assist young carers in establishing and maintaining peer support networks through Interchange and then in their local areas.*

The final report is due for release in December 1996 and the Committee hopes that its findings and recommendations will assist children and young people who are carers.

5.8.1 Mental Illness

The study, recognition, diagnosis and treatment of child and adolescent mental illness has been a relatively recent focus in the field of medical practice. Today, with improved data collection and analysis we now know that children and young people are vulnerable to a range of emotional, behavioural and psychological disturbances.

In 1993, the Human Rights and Equal Opportunity Commission completed the most comprehensive report to date into the human rights of people with mental illness. A major section of that report dealt with child and adolescent mental illness. Among the findings of the Report were that:

- 15% of young people in Australia have an emotional or behavioural problem that required assistance;

- 5% have emotional or behavioural disorders which require intervention; and

- 1% or 2% have a serious or severe disorder which requires specialist assessment and treatment.

The *Human Rights and Mental Illness* Report documented that the average age of the onset of mental illness is 16 years. About 90% of psychiatric disorders have their onset in

adolescence or early adulthood and 50% of emotional and behavioural disorders first appear in people aged between 16 and 18 years. Haliburn (1993:45) also observes that:

> *all indicators of emotional illness rise sharply during mid to late adolescence .... Onset of schizophrenia occurs before the age of 25 years in approximately 60% of those affected .... Onset of manic depressive disorder occurs between the ages of 10 and 19 years in approximately 30% of those affected.*

The Committee considers that this information is vital to understanding the concerns expressed by organisations and members of the community with regard to the limited resources for mental health services for children and young people.

While New South Wales has a number of bodies which potentially advocate on behalf of children with a mental illness including the Mental Health Advocacy Service, the Mental Health Review Tribunal, the Guardianship Board, and Health Care Complaints Commission, no specialist body deals exclusively with children and mental health issues.

The overwhelming majority of evidence heard by the Committee suggested that children are not adequately represented by the current advocacy bodies and there is a desperate need for a specialist service.

As the Youth Justice Coalition points out, one of the problems is that the majority of mental health non-government organisations deal with adults (Submission 34). Moreover, as the Human Rights Commission report found, the generalist advocacy bodies are limited in their ability to represent people with a mental illness.

According to Dr Robert Hayes, President of the Mental Health Review Tribunal, the greatest issue for children with a mental illness is the adequacy of programs and services available to detect and intervene in 'at risk' cases. Failure to detect and intervene can have devastating consequences including school exclusion, involvement in the juvenile justice system and even suicide.

The Committee heard during the Inquiry that there is a lack of appropriate hospital inpatient treatment for childhood sufferers of mental illness. Moreover, in spite of the prevalence of mental illness in children and young people there are only three publicly funded community-based child psychiatry facilities in the whole of New South Wales, all of which are based in Sydney.

There is some concern amongst organisations working in the area that centralised advocacy bodies would not be able to meet the very specific needs of these children. The Mental Health Review Tribunal suggests that State-wide community-based multidisciplinary programs and services would be more appropriate and would allow for early intervention in psychosis as it emerges in children and adolescents (Submission 53).

In the area of private practice, the training of child and adolescent psychiatrists seems to be ranked as a low priority compared with other areas of psychiatry. There is little on-going education in this area or in the allied profession of general practice (Submission 53).

The Committee considers that the *Mental Health Act, 1990* lacks an appropriate child-focus. It believes that a review of the Act should take place to ensure it is appropriate to the needs of children.

RECOMMENDATION 17

> **That the Minister for Health review the *Mental Health Act 1990* to ensure it is appropriate to the needs of children.**

The Committee heard evidence that **children of parents with a mental illness** are greatly at risk of psychological disorder. There is a greater likelihood of these children experiencing social problems while young, and developing a mental illness in adulthood. According to Janet Devlin, coordinator of the IMPACT program (Evidence - 3 May, 1996):

> *their problems result mainly from issues relating to emotional deprivation and emotional and physical neglect (and) inadequate supervision.*

Very often these children are taking on added responsibility at home for a mentally ill parent. The child may find him or herself taking on the substitute parenting role which may be detrimental to the child's development.

The primary issue raised in numerous submissions concerning children with, or at risk of, a mental illness, is the need for programmes and services to ensure early intervention.

A further problem identified by the Committee is the lack of a co-ordinated body at a government level responsible for meeting the needs of these children. It is currently left to the adult mental health workers, or to child protection workers dealing with sexual and physical abuse. According to Agnes McMillian, a psychologist from the IMPACT Program, there are no targeted programmes currently available which offer appropriate support in relation to pre-school age children of parents with a mental illness (Evidence - 29 April, 1996).

RECOMMENDATION 18

That the Minister for Health investigate the most appropriate existing body which would provide mandatory education, training and professional development for:

- **health and allied professionals;**
- **teachers and school counsellors;**
- **psychiatrists and general practitioners; and**
- **early childhood workers.**

The focus of this training shall be detection of, and early intervention in, mental illness as it emerges in children and adolescents.

5.8.2 Summary

The obvious vulnerability of all the children described above, demonstrate the very real lack of advocacy for these groups in the health system. The fact that the health needs of so many children still fail to be properly met reflects the minor status accorded to children generally, and the Committee is strongly of the view that particular policy development and targeted services should be pursued to overcome these deficits in delivering health programs to all Australian children and young people.

5.9 CHILD PROTECTION SERVICES

Children who have been physically, sexually or emotionally assaulted and abused are amongst the most in need children of specialist services and effective advocacy. They are also amongst the most silent - often being unable to disclose the assault or their feelings of distress. Because of their vulnerability, the Committee firmly believes that child protection services must be able to respond effectively to the needs of these children and to appropriately assist them in overcoming the trauma of assault.

The Committee notes that children do not disclose neglect. A large proportion of children who are in care have been removed from their families because of neglect. The principle of disclosure does not apply in cases of neglect; neglect can only be revealed via observation. The Committee considers that early intervention programs can be the greatest benefit to these children. It considers that the implementation of Recommendation 15 concerning the home visitation outreach programs will, through the workers' appropriate observations, go some way to preventing the neglect of children and their removal from their families.

The role of the New South Wales Health Department in relation to child protection is to provide physical, psychological and social assessments as necessary, crisis and ongoing

counselling including individual, group and family counselling and to provide a broad range of health services to the child and family (NSW Child Protection Council, 1991:16). Specially trained doctors also undertake forensic examinations of abused children, the results of which may be used as prosecution evidence at trials.

In defining the guidelines of relevant government departments and agencies, the NSW Child Protection Council (1991:16) considers the Department of Health should:

- *ensure that all medical practitioners are aware of their obligations to notify under the provisions of the Children(Care and Protection) Act 1987, and that all other relevant health workers understand the indicators of child abuse how to report suspected cases and are aware of the Ministerial Direction to notify;*

- *liaise with D.C.S. and other agencies to assist in the co-ordinated care of the child and family;*

- *conduct a medical assessment and provide medical follow up where appropriate;*

- *provide crisis and ongoing counselling and support the child and family;*

- *provide educational and preventative programmes that assist workers and the community in gaining a better understanding of sexual assault, physical abuse, emotional abuse and neglect and of the care of victims of these abuses;*

- *provide support for the child and non-offending family members prior to and during court proceedings;*

- *promote the development of services to children who have been sexually assaulted and, where appropriate, non-offending family members.*

The Health Department operates three highly specialised child protection units. These are located at the New Children's Hospital, Westmead, Sydney Children's Hospital, Randwick and John Hunter Hospital, Newcastle. The Units here deal with the most complex child abuse cases and cases where a serious injury has occurred requiring tertiary paediatric intervention. Multidisciplinary teams staff the Units and consist of child protection health professionals, including paediatricians, social workers, registered nurses and allied health workers. As well as the tertiary paediatric services, these Units provide undergraduate and postgraduate teaching and statewide education as well as conducting research. A 24-hour service is provided.

Each Area Health Service provides a wide range of community and some hospital based services which include early identification/prevention programs, counselling and referral

services. A range of 24-hour service, counselling and referral services are provided through 17 hospital based centres.

In relation to child sexual assault, Department of Health Sexual Assault Services are based in certain hospitals and community health centres throughout the State. Most of these services see both adults and children but in some areas there are separate services for adults and children under 16 years of age. The Committee understands that although it is not mandatory for children who have been sexually abused to be examined by a paediatrician, they must be examined by a medical practitioner trained in sexual assault examinations. The Committee also understands that most of these services offer both crisis and long-term counselling, including support through the court system. It further recognises that caseloads are generally considerable and that staff can be extremely stressed and overworked, creating the potential for inadequate service to traumatised children.

The Committee acknowledges that child sexual assault is a serious crime and that specialist services must be available to assist the victims. However, it also recognises that approximately two thirds of abused children suffer physical and emotional abuse with often extremely damaging consequences. Over the last few years it seems that services and policy direction have tended to place priority on sexual assault matters over physical and emotional abuse cases.

The Committee considers that children and young people who have been physically and emotionally abused or neglected, both individually and as a group, also require their needs to be addressed with urgency. The Committee notes that the Government has recently allocated an additional $300,000 per annum for the expansion of the Health Department's Physical and/or Emotional Abuse and Neglect of Children Service. It also notes that recently, New South Wales Health has sought to address this issue by providing training on early intervention of physical and emotional abuse of children. The Committee encourages and supports this initiative.

5.10 CHILDREN BORN THROUGH DONOR INSEMINATION

The issue of donor insemination (DI) is complex and clearly a matter of human rights. The Committee received a number of submissions, and spoke with interested parties, which raised concerns about genetic inheritance and the rights of DI children to information about their biological inheritance. Currently in New South Wales, donor insemination children have no right of access to identifying donor information. Availability of non-identifying information can vary from clinic to clinic. The Committee notes that the New South Wales Health Department is currently undertaking a review of the *Human Tissue Act* to investigate the implications of sperm donation and donor registers (Submission 6).

The Committee acknowledges the concerns expressed by members of the community as evidenced in their submissions to the Inquiry. It recognises that under the United Nations Convention on the Rights of the Child, Article 7 provides that:

> 1. *The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.*
>
> 2. *State Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.*

Article 8 further provides that:

> 1. *State Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognised by law without unlawful interference.*

The Committee considers that the issue of the right of children born through donor insemination to information about their genetic inheritance requires urgent attention and resolution by the Minister for Health.

It notes that Victoria has responded to the issue with the enactment of the *Infertility Treatment Act, 1995*. Section 79 of that Act provides that a person born as a result of a donor treatment procedure may, on attaining the age of 18 years, apply for information about the donor. The rights of parents to apply for this information is contained in section 74. The Act also provides for the establishment of a donor treatment procedure information register (s. 82). Information contained at that Register includes the names and addresses of persons born as a result of donor treatment procedures, the descendants of persons born as a result of donor treatment procedures, donors, women who have undergone donor treatment procedures and their husbands and the relatives of all such persons. The *Infertility Treatment Act, 1995* also provides for counselling for donors and for applicants applying for relevant information.

The Committee sees considerable merit in the *Infertility Treatment Act, 1995*, as a means of meeting the needs of all those involved in donor insemination procedures, including recognising the rights of children born through such procedures. It therefore recommends that the Minister for Health introduce and implement similar legislation in New South Wales. The Committee considers that this action will help to advance a national approach to issues concerning donor insemination. The Committee also considers that the Minister for Health immediately provide guidelines to public and private clinics regarding the collection of relevant donor program information.

The Committee is concerned about the safe-keeping of the donor insemination records when the Royal Hospital for Women, Paddington is re-located to the Prince of Wales Hospital, Randwick. It therefore calls on the Minister for Health to guarantee the safe-keeping and preservation of all donor insemination records when this re-location occurs. It also recommends that the 10 year rule relating to the destruction of files be stayed in relation to donor insemination records.

RECOMMENDATION 19

That the Minister for Health introduce and implement legislation that is similar to the Victorian *Infertility Treatment Act 1995*, as soon as possible. As an interim measure the Minister for Health should provide guidelines regarding the standardised collection of relevant donor program information for use by public and private clinics.

RECOMMENDATION 20

That the Minister for Health guarantee that all records relating to donor insemination procedures are safeguarded and preserved when the Royal Hospital for Women is transferred to the Prince of Wales Hospital and that the 10 year rule relating to records be stayed in relation to donor insemination.

5.11 CONCLUSION

The Committee recognises that generally speaking, Australia and New South Wales have successful models of health services for adults and children alike. According to Taylor and Salkeld, (1996: 233),

> *Australia has improved its ranking for life expectancy (at birth) since 1960, and in 1990 ranked ninth and seventh of 24 countries for females and males respectively; this is ahead of the United States and United Kingdom, and approximately equal to Canada.*

However, in both oral testimony and submissions received for this Inquiry, the Committee found overwhelming support for improved advocacy for children in relation to health-related concerns. The broad goal of advocacy for children in the area of health requires first and foremost a prevention-based approach.

As Dr Victor Nossar told the Committee in evidence:

> *we have to make sure children grow and develop.*
> (Evidence - 29 November, 1995)

The health of a child is dependent on ensuring that children do not have their development and opportunities blighted by poverty, are educated and do not suffer from discrimination. These are the factors identified as having the greatest influence on the health of a child. According to the many submissions and evidence, part of this goal must be to ensure that the services in the public sector are adequately resourced.

A part of this approach is the improved awareness and understanding of the risk factors for all children. The Committee is encouraged by the statements made by the Minister for Health that a policy on child health priorities is currently being developed. The Committee supports the need for child specific policy development which provides universal access to health care services.