[Stuart Malcher] Can I first and importantly start by acknowledging I'm in the office in Ashfield today, which was its own struggle, but coming to you from the land of the Wangal people of the Eora Nation and pay my respects to their elders, past, present, and emerging, and obviously extend that respect to Aboriginal colleagues joining us today and from around the State who are obviously working in the most critical industry when it concerns with Closing the Gap for our First Nations people. By way of introductions, like I said, these Roundtables are being held in place of last year's annual Advisory Group meeting. So now we've got sixteen completed, national and international leading academics have completed their research papers, and over the course of this week, we're going to have the opportunity to hear from them, and we've got joining us, in addition to the Researchers, we've got the Advisory Group, we've got our Evidence to Action group, and we've got a range of subject matter experts working in this field and other people from across DCJ and many of our peak organisations and critical stakeholders. So it's a real, pretty impressive brains trust to put it mildly, and our great challenge is how do we take some of this emerging evidence and research and turn it into policy, practice, and operational action that's going to make a meaningful difference for the children that we're talking about today? And obviously, that's our critical bit. How do we turn research into evidence and into action is the challenge that I know a great many of us constantly struggle with. So as I mentioned before, we've got four Roundtables happening throughout this week. So today, Child Development, Wellbeing, and Children with a Disability. Tomorrow, we're focusing on Cultural Connections and Family Time. Thursday, we're then looking at Education and Youth Justice, and finally on Friday, the focus will be on Casework and Support, and in addition, there'll be a further Roundtable held in the middle of the year on exits, re-entries, and permanency pathways. So Roundtables are based on policy and practice themes and provide an opportunity for the assembled POCLS Advisory Group and Evidence to Action Working Groups to really discuss the key researchers, to discuss the key insights with the Researchers directly, and to really flesh out the implications for policy and practice, and what we ideally want is at the end of each Roundtable to have at least one to two really concrete and actionable recommendations that we can take from these discussions and move forward on them. So, as I said today, I guess we're onto the focus. We've got a pretty packed Agenda. We are going to hear from the five research papers that have been tabled for today's discussion. Ideally, we're going to move through those with about ten minutes for each to present. Can I please ask that we hold questions until the end? We've got time scheduled for discussion, but we'll just move firstly through what is quite a lot of information to take in and absorb through those first five presentations. So to help frame today's discussion with the papers, we had posed a problem statement, and that problem statement, I guess, is both born out of previous research from POCLS and across this sector, but really focusing on the idea that when we intervene in the lives of vulnerable families, it has the potential to adversely impact on children's developmental outcomes. How do we improve the cultural sensitivity, how do we improve culturally sensitive assessments and monitoring of children's development to ensure they receive appropriate and timely support? And so with that question in mind, I'm going to invite our first speaker, which is FACSIAR's own Joanna Hopkins. So for those who don't know, Joanna is currently the Data Manager for POCLS. She's worked for DCJ for over 15 years in child protection and out of home care reporting and analysis area supporting reforms, policy, and practice. Over to you, Joanna.

[Joanna Hopkins] Thanks, Stuart. So this morning, I'll be talking about findings from a paper about children in out of home care with high needs or cognitive and behavioural problems. So this analysis was originally undertaken to support Their Futures Matter reform, and specifically, the project that looked at high needs kids who were aged 5 to 12 in out of home care. So the brief was to provide an overall picture of these children and their characteristics and experiences. So to get the definition of high needs children for the project, we used the standardised measures that children and the carers participate in their interviews. So children who were in the clinical range for behavioural problems or the below average range for language skills or non-verbal intelligence broadly met the criteria that TFM were interested in and were considered high needs for this project. So for the comparison group, we looked at children in the same age in POCLS who were in the typical or borderline ranges across all of the domains. So the main findings from the analysis were that of all the children in the POCLS who were aged 5 to 12 years at their Wave 3 interview, around 40% were found to be high needs based on our definition. Overall behavioural problems were found to be the most common issue followed by verbal ability and then non verbal ability, and in terms of the combination of issues found, around a quarter of the high needs children had clinical range issues in two domains, and around 5% in all three domains. So in terms of the children's characteristics, we found that the high needs children tended to be older, which given the criteria for the POCLS, means that they tended to have entered care at a later age for the first time, so entered at an older age. Around half were found to be Aboriginal, which is an over-representation of the children in out of home care, and looking at their child protection histories, the high needs children tended to have more child protection reports prior to their first entry into care and were more likely to be reported for issues involving psychological harm and carer issues such as the carer being in prison, having disability, financial or gambling issues, and domestic violence. So in terms of the children's education and learning, most of the carers had a high degree of involvement in the child's schooling. They were more likely to have been in contact with the child's teacher, Year Advisor, Principal, or School Counsellor, and many of the children were found to be vulnerable at risk on the Australian Early Development Census, the AEDC, in the domains of language, cognitive ability, communication skills, and general knowledge. So the AEDC is collected by the teachers in the child's first year of school and measures their ability across five domains. In terms of NAPLAN, much larger proportions of the children were at or below the national minimum standard for numeracy and reading at year five and year three. So with regard to services and support, the children more likely to have seen a Paediatrician, counselling or psychologist services, seen a Speech Pathologist, Occupational Therapist, Ear, Nose, and Throat Specialist, or have attended behavioural management services, they were also might more likely to have been in respite places. So looking at relationships with household members and friends, for the majority of the high needs children, their carers stated that they were very close to the child, but this was much lower than for the comparison group. Around a fifth of the high needs children had no close friends, and a further one in ten had only one close friend. The high needs children were also more likely to be rated poorly by their carers at getting along with siblings, getting along with other children, or playing and working alone. In terms of relationships with their birth families, the high needs children had contact with similar birth family members. So three quarters had contact with their birth mothers, around 60% with their siblings, and just under half were in contact with their birth fathers. However, according to the carers, the high needs children were less likely to have good relationships with those people. So with their birth mother, birth father, and grandparents. From the carer's perspective, the majority were satisfied with their parenting role, although this was lower than for the comparison group, and the carers of the high needs children were less satisfied with their working relationships with other agencies and support received from the caseworkers, although they were generally satisfied with their ability to reach their caseworker, and the carers indicated that they would still like more access to respite, access to transport, and before and after school care. So the feedback that we had from the DCJ policy areas on what they thought their key findings were that they thought that it was really important that the children had less, were less likely to have good relationships with their birth parents and grandparents, and that this had important implications for family restoration and the child's overall wellbeing, and that it was also important to recognise that they had been the subject of more ROSH reports prior to their entry and that this demonstrated the level of trauma that this group had experienced. Also that the children had been vulnerable or at risk on the AEDC. So this shows that they had been struggling from the beginning of school, and there may have been opportunity to better support these children earlier on. Okay, thank you.

[Stuart Malcher] Wonderful. Thank you, Joanna. A lot of questions I've got from that presentation, but I'll stick to my own rules and save them all for the end. So could I next invite Professor Paul Delfabbro. Paul is going to talk to us about Aboriginal children's development. So just by way of introduction, Paul works at the School of Psychology at the University of Adelaide and has Degrees in Commerce, Economics, and a PhD in Psychology, and he has published extensively in several areas, including the Psychology of Gambling, Child Protection, and Child Welfare, and with that, can I please invite Paul to take over?

[Paul Delfabbro] Great, thanks, Stuart. Everyone hear me okay?

[Paul Delfabbro] Yeah, great.

[Paul Delfabbro] All clear, great. I'll keep this fairly high level because I know that it's often hard to retain lots of micro facts, which are otherwise contained in some detail in the reports. So the work I conducted involving, or which relates to Aboriginal children comes from two main reports. One was a principle comparative study of Aboriginal children and non Aboriginal children across the first three waves of the POCLS study. So there might be some additional work we'll hear about during this week, which might have extended some of those findings, so what I say may need to be qualified by potentially more refined analyses that might have been conducted since. The second bit of work I did was looking at kinship care and non kinship care across time across the three waves where we looked at Aboriginal and non Aboriginal children, but also look at the type of placements they were receiving. So whether there were different developmental outcomes depending upon whether Aboriginal children were placed with kinship carers as opposed to foster carers, or whether they were placed with Aboriginal versus non Aboriginal families, so we've got some analysis of those differences, and that they provide some subtle variations in the outcomes observed, which may have some policy implications. This work was really predicated on the, as Stuart mentioned, upon the focus upon closing the gap considerations, how do the Aboriginal and non Aboriginal children compare? but of course, we are very much interested in how Aboriginal children are doing as a population, irrespective any of those sorts of comparisons. What we generally find, picking up some of Joanna's points, is that a certain, Aboriginal children, of course, are massively over-represented in the out of home care system. That's overwhelming, but because many kids come into care irrespective of their background often for similar reasons, one of surprising findings, I guess, from the study is that even though I guess the over-representation of someone looking from the outside is quite startling, it's always shocking to see how high the figures are. The outcomes in care are relatively similar because when you've got lots of different reasons for coming into care which occur in both populations, you find that developmentally, the trajectories you observe in care are relatively similar. So, but nonetheless, many Aboriginal kids in care, about 30% experience significant behavioural problems. I think Joanna mentioned that's a very common over-represented problem in the care system. About 15% experience significant emotional difficulties. This is after three waves of data collection, about 18 months into care, so these are ongoing problems, and about 30% need extra support with language and those types of problems. Some of the analysis we looked at also look at the relationship between some of the risk exposure, the ROSH reports, which came before young people entered care, and you do see that the children who are functioning not quite so well even by wave three often will have a higher proportion of these risk exposures in their family prior to coming into care. So for example, kids who have been physically abused tend to have poorer functioning than those who didn't have those sorts of experiences. So some of those sort of ideas about ongoing trauma as having ongoing developmental consequences was coming through a bit in some of the analyses which I started to do with these reports. The other thing which I looked at was, as I mentioned, was whether the type of placement makes a difference to developmental outcomes. On the whole, the evidence suggests that the effects are very, very small, but there were some subtle differences, which I think we emphasized might need to be looked at in a bit more detail. So for example, caseworkers had a negative attitude towards Aboriginal kinship care, which we thought was one of the concerning findings to come from some of the work I'll talk about I think tomorrow, but some of developmental outcomes seemed to be actually slightly better in Aboriginal kinship care. Kids had lower, I think, externalising behaviour I think at Wave 3, although I think it was only a very small effect. Whereas some of the other outcomes in non Aboriginal care weren't quite so good. So one of the issues was that we have the carers saying, well, this type of care, perhaps cause of resourcing and challenges is not doing so well, yet the psychological outcomes might not necessarily reflect that. So that divergence I thought was an interesting thing to look at and whether, as I said, the findings are relatively small in terms of the effect size, but that seemed to be an interesting policy thing to have a look at because we know that kinship carers are often very under-represented, sorry, under resourced, and that may be particularly so for Aboriginal kinship carers. So these are some of the things which I looked at, and I guess it's hard to talk about the Aboriginal outcomes without some of the cultural connection stuff, which we'll provide more context tomorrow. So I'll be coming back to some of these issues with more of a cultural context focus tomorrow, but that'll give you a general overview of what we found. So in general, not a huge difference between Aboriginal and non Aboriginal children across time in the trajectories of development, but maybe some subtle differences there in the types of placements as an effect on the outcomes.

[Stuart Malcher] Wonderful. Thank you, Paul, for sharing those insights with us, and yeah, I agree I think there's some really important insights there that we need to unpack certainly moving into tomorrow's Roundtable. Can I keep us moving on our Agenda? Next invite in a moment Associate Professor Melissa O'Donnell, and she will be talking to us about infants health, development needs, service provision, and developmental trajectories. Again, just by way of introduction. Melissa is the Deputy Director of the Australian Centre for Child Protection at the University of South Australia, and is an internationally recognised researcher in the area of child maltreatment, vulnerable children and families, and has utilised population based linked administrative data for almost fifteen years to contribute to new knowledge, including the development and implementation of public health model to prevent child abuse and neglect. So very grateful for Melissa joining us today. Over to you.

[Melissa O’Donnell] - Great, thank you very much. I just wanted to start by saying that my study is predominantly looking at the infants that are entering out of home care, and we know that infants are now over-represented in child protection data, so they're the age group most likely to be receiving child protection services, and that's been what I've seen over time, and they're also most likely to have substantiated notifications and the highest admission out of all age groups into out of home care, and we also know that there's an over-representation of Aboriginal infants involved in child protection processes, which has been widely reported as well. So I guess in terms of that, we were particularly interested in this group because we know that infants who are entering out of home care are more likely to be born premature, have low birth weight, and also have attachment issues. So the aim of our research was to really address the gap in Australian research in regards to infants entering out of home care and really ensuring what we can do to optimise outcomes for this vulnerable group. We want to determine the prevalence of developmental vulnerability in Aboriginal and Non Aboriginal infants entering out of home care, the extent of service provision to these infants in relation to their developmental vulnerability, and investigate their developmental and child protection trajectories over time across the Waves of POCLS. So we identified children as being developmentally vulnerable on the standardised screening tool measures. So the child behaviour checklist, and as well as the ASQ and the BITSEA. So at the first wave, we only looked at ASQ domains and the BITSEA, and we also looked at the health flags as well in terms of preterm births, low birth weight, and children born with neonatal withdrawal syndrome. We also looked at disabilities and additional flag. So what we found was that in terms of the standardised assessments, so overall, we found that 70% of the infants were identified as developmentally vulnerable on the standardised screening tools. We also found that 36% were identified from the health data flags as well. So what is consistent with the evidence that we are looking at a higher risk infant vulnerable group. Interestingly, which has been said by some of the other presenters, we didn't find major differences between non Aboriginal and Aboriginal infants. They were pretty much similar across both groups. What was interesting though was that a carer who identified a child as being assessed by a health professional as developmentally vulnerable is much lower. So we are talking here about 12% of infants being identified by a professional. So it's much lower than what we found from the standardised measures. What we did find was that, in regards to those that had been identified by health professionals having developmental vulnerability, 60% of those carers were receiving services for those children, which is quite good, but for those 40% that didn't receive services, we tried to investigate why that was. What was interesting was that it wasn't really a good sample in regards to the comments on that variable, however, those that did respond said that they were on waiting lists, which we know is an issue across the board for a lot of children with developmental vulnerability. What we did find though was for those children who are identified on the standardised screening tools as developmentally vulnerable, only 20% of those children were receiving services, which is substantially lower. Interestingly though, developmental vulnerability did increase the odds of actually receiving professional services. They are two times more likely to be receiving services. Although the health indicators didn't seem to increase the odds of receiving services. Our third aim was to investigate the developmental and child protection trajectories of the infants over time. So the majority of the infants were still in care at Wave 3. So 80% of those infants were still in care. 13% were in kinship care, 78% were in foster care, and on average, they had three placements. The risk of physical and cognitive developmental concerns actually reduced over time, which was a good finding. So it reduced down to 36% at Wave 3, and service provision did increase over time to 45%, and the increase in service provision did coincide with a decrease in developmental concerns. So it really shows that providing services actually seem to be making a difference in terms of the proportion that are being assessed as developmentally vulnerable at Wave 3. Social emotional trajectories, however, differed, so they did rise over time with 30% assessed at risk at Wave 3. Our finding was that kinship care actually lowered the risk for social emotional difficulties, and so the risks that increased social emotional trajectories, as was mentioned before, was the increase in the number of placements, those that were in foster care and those that were identified as having a disability. So I guess our key findings in summary were that a high proportion of children who enter care as infants were identified as developmentally vulnerable on screening tools. However, only 20% were receiving services. So that's our concern that there's not enough being done early enough. There was a positive finding that those carers who identified the child as diagnosed by a health professional were receiving services at about 60%. However, given the large proportion of children identified as developmentally vulnerable on screening tools and the lesser amount receiving services, it really is important that ongoing monitoring is required for these infants and that not all needs are potentially being met, and that we really need to further examine this. We see that the role of caseworkers is really critical in working with carers to discuss developmental milestones, ensuring health checks with child health nurses, and also to get referral to services early. Also assessments and services need to be cultural appropriate, timely, and repeated over time. We know that the early years is integral to setting the foundation for children, which has been outlined in the first 2000 days framework, and we know that sustained efforts are required to optimise these developmental outcomes for children who are in out of home care, and we know that the out of home care health pathway program is really focused on this in terms of ongoing health management plans and sharing these plans with carers, as well as the developmental concerns that the child have to ensure that their health needs are met, and that they're successfully referred to services to meet their needs. I guess the issue of waiting lists is one that the entire country is having to deal with, but we see that as a real issue for infants who we know are quite have a high level of developmental vulnerability. Thank you.

[Stuart Malcher] Thanks again, Melissa. Again, a lot in there for us to kind of chew over throughout today's discussion. Again, keeping us moving on our Agenda, next I'm going to invite Professor Raghu Lingam who will be talking about optimising the mental health of children. Professor Raghu Lingam is a Professor in Paediatric Population Health at the University of New South Wales, Honorary Professor at the Black Dog Institute, and a Consultant Community Paediatrician in the Sydney Children's Hospital network. Raghu is a Senior Clinician academic with clinical and research interests in children, young people's health service research. And with that can I please invite Raghu.

[Raghu Lingam] Can you see my slides?

[Stuart Malcher] We can.

[Raghu Lingam] Yeah, perfect. I know others didn't do slides, but I'm really rubbish without some kind of video or a visual prompt. So, yeah, so I just wanted to highlight a couple of people that have worked incredibly hard on this piece of work, Nan Hu and Yalem Gelaw, from our research team. So if we just go through some of these slides and just think about what we already know and what this particular analysis adds, so we know that in 2019, there was 45,000 children out of home care in Australia, and this number is growing. These children have been identified of having higher risk of many mental health difficulties, many health difficulties, including mental health difficulties. These mental health difficulties have been associated with exposure to maltreatment, age of entry into care, placement stability, caregiver characteristics, and relationships with caregivers. However, we need more evidence on what these factors, what we can do to influence these factors and enable practitioners to better target limited resources. So what we found in our analysis of the POCLS data was that 21.7% of children within the cohort across age groups had mental health or social emotional difficulties defined using the CBCL and the BITSEA, but what was really interesting was the increase in prevalence both through age, entry into care, and age at first survey. We used a classification and regression tree analysis or CART analysis, which was able to group risk factors together, so previous analysis have looked at individual risk factors, whilst the CART analysis, as we know, children in out of home care have multiple risk factors, and we were able to group these risk factors together. We found particularly two high risk groups in terms of predictive factors for social emotional difficulties. 36% of children who were between three and five years of age who were living with a carer, who had themselves psychological stress, who had experienced more than three placements, the child had experienced more than three placements, had an increased risk of social emotional difficulties, and we also found that 39% of children age six to seventeen years old who lived with a carer, again, with high levels of stress were subject to substantiated allegations of abuse prior to entry into care and subject to social emotional abuse or multiple types of abuse were also at increased risk of social, emotional difficulties. What does this tell us that is different from our previous analysis? Well, I think what it tells us is that these individual risk factors are important in themselves, but actually we need to think of the entire population of children in out of home care as being at higher, much higher risk of social, emotional difficulties, and those children, especially those with these grouped risk factors are at particularly high risk, and we're talking up to 40% of this population having high risk of social emotional difficulties, and I'd say that was probably an underestimate for this population. We also then looked at, that was in the first three years, so that was a cross sectional study so we can't think about causality, but then we did a longitude analysis looking at the entire POCLS dataset across the different waves, and we did a second analysis using data from all four waves. We found 345 children within this analysis, and we looked at three particular trends or trajectories for those children, and we described those as resilient, normal, and clinically relevant social emotional difficulties, and we found that children that were placed in foster care were four times more likely to be in the clinical group compared to those in kinship care. This is hugely important from a policy perspective. Children placed with a carer who had high levels of stress were eight times more likely to be in the clinical group compared to children placed with a carer who had low stress levels. Is this cause or effect? Actually, I think this is bidirectional, so carers that are noted to have high levels of stress early on may be reporting high levels of stress from the child themselves. So actually, these carers need additional support, but also they need to support to be able to support the children and young people. So, what's next? Next steps. Longitudinal analysis and observational epidemiology is really helpful, but particularly within our group and others around us and within this group, that as you've mentioned the brains trust, we need to think about stop observing the problem and start doing something about it, and this is basically a study that we've, an ongoing study that we have done looking at behaviour change interventions to reduce substance abuse and improve mental health in children and young people, and this was a study that we undertook in the UK, but that whole concept of co-designing interventions with children and young people within the out of home care system maybe the next steps to be able to think about ways that we can enhance mental health services within the service. So thank you very much, and I'm happy to take questions at the end.

[Stuart Malcher] Well, thank you very much for that presentation. Just a minor apology. We're having a slight technical issue on our end. So our screens have just gone blank. So hopefully you can hear and see us better than we can see you all. Well, just bear with us while we get that small issue sorted. But yeah, thank you again, Raghu. Again, I think some pretty important insights there to help develop our understanding, and certainly it's firming up that the importance of kinship care if we didn't already know, but increasing the evidence is pretty important. Oh. Getting close, apologies. So look, with that, while we sort out our IT struggles, apologies again, can I please invite our last presenter for today? So we have Associate Professor Zhiming Cheng who will be speaking to us about children with a disability. Zhiming is an Associate Professor of Economics at the Social Policy Research Centre for Social Research in Health at the University of New South Wales, and prior to joining University of New South Wales, he worked in the Centre for the Health Economy at the Department of Management at Macquarie University and School of Economics at the University of Wollongong. So again, thanks for joining us, and over to you, Zhiming.

[Zhiming Cheng] Thank you, thank you very much. So today, I'm going to present some of the implications and findings from our research on children in out of home care with disability, so I have worked on this project with Professor Ilan Katz at SPRC at UNSW and also Max Tani from UNSW Canberra. So instead of going into a lot of details about our findings, I'm going to summarise some of the implications of our research to policy and practices. So we have analysed all four waves of POCLS data using random economic model to look at the prevalence, characteristics, and the determinants of the social emotional outcome of children with disability. So in general, we find that children with disability tend to have worse outcomes in out of home care than children without disability, and these outcomes are mainly driven by their disability status rather than the care factors, and the literature generally suggests that these outcomes are likely to be driven by a range of factors, which start very early in life, and this includes social structures, attitudes, resources, and expectations, and the implication from our research is that it's likely to be very challenging to alter the trajectory of children with disability in out of home care, and to do so, we require an intervention at different levels including the child themselves, the care placements group, and other contacts in which the child is engaging. So in terms of assessment of children with disability, our indication is very important for caseworkers to ensure that children are assessed as early as possible and receive the support they require at the earliest opportunity. In particularly, with the NDIS support where there is appropriate and reliable, as well as support in long day care, preschool, and so on, and disability should be assessed over time because it is not necessarily a permanent characteristic of children or young people, and they can become disabled or ceased to be disabled over the course of their time in out of home care. Some children can become typically developing after having an impairment, and others may become more disabled as they grow up. In that sense, the caseworkers should have access to information about a range of support available for children with disability in different contexts, as we said, in long day, preschool, and so on. An assessment of children's strengths and needs should conduct regularly, so that work with the child should focus on strengthening the protective factor, which are likely to support the children directly through the care system. Children’s need change over time, so that assessment should also be ongoing, and at the same time, we found children with disability, however, are very diverse group with differing level of types of impairments, so outcomes are associated with the types of impairment they experience. The finding from our research is that there were only a few demographic differences between children with disability and those without disability, and that means that it's not appropriate to focus on intervention or policies on a particular risk factor for disability, but that each child need to be assessed individually to identify whether they do have impairments in any of these wellbeing domains. According to the data collected by the POCLS study. So the programs for these children should be designed to focus on their specific needs, which can change over time as children progress through the care system. In terms of participation, we believe that care should be taken to label children and young people inappropriately or stigmatise them, and the barriers to participation and inclusion of children with disability should be recognised and addressed, including discrimination, lack of access to resources and schooling, inappropriate support, low expectation and so on. So it's very important that children with disability are involved in the discussion about their needs and the support they require. This might involve the direct work with the children. So that caseworker have a better understanding of how the children themselves understand their needs and capacities and what supports they might require. We also have some implications for the strategies to support and train caregivers. So caregivers should be provided with more information about the range of support and funding available for children with disability, including the NDIS and different inclusion support package from day care, preschool, and school, and caregivers should be supported to address issue, including gender, Aboriginality, cultural background, LGTBQIA status, which affect children with disability, and there are some strategies that we recommend to develop caseworker's skills and caseworker's supervision. It's very important to recognise children are disabled by society, and therefore that, to the extent the children in out of home care are not reaching their potential and not participating fully in school or others setting, this is not because their impairment, but because of their challenges they face and the lack of adequate support and services to enable them to participate fully and maximise their potential. So caseworkers should have an understanding of the social construction of disability, and caseworkers should not focus on children's impairment, but on their capacities and strengths and just seeing the barriers they face to participate fully. However, care should be taken not to label children and young people inappropriately. As indicate in our research, children's own views and that of their carer should inform whether and under what circumstances a child should have a disability label. A disability should be assessed over time, as we mentioned earlier, It's not a permanent characteristic of children necessarily, and they can become disabled or cease to be disabled over time. So we believe that it's very important to say that with appropriate needs assessment and intervention, guides could maybe make for child or young person with disability. Caseworkers, as we also stress, need to engage with children to discuss their own understanding of their impairment, how this affects their lives, whether and how they perceive themselves as having a disability, and what supports they need to participate fully in school setting or social life, and caseworkers should understand the social model of disability and the factors that prevent children with disability from reaching their potential. A key issue here, we believe that support should be co-ordinated and should be clear lines of communication between the different disciplines involving child care, and a clear multi agency plan to support the child in the placement in school and in the community. We also have, because we have used different definition of disability from the caseworker assessment from some of the question in the POCLS survey and also a set of question that the POCLS teams adopted from the ABS population census, we also have some strategies or recommendation to improve administrative data and research. So further research should be done to better understanding the diversity of the outcome amongst children with disability in care, and in particular, to examine the protective factors, which are associated with better outcomes for different groups of children with disability. And more importantly, there should be a consistent definition of disability applied to all children and young people in out of home care, and the definition of disability should differentiate between different types of impairment. In particular, cognitive impairment versus physical impairment. In that sense, more research should be done on the lived experience of children and young people with disability in out of home care and also their carers. More research should be done on the lived experience of children and young people with disability and their carers to understand their own wills and beliefs about disability. The supports which they experience as effective and barriers and facilitators to full participation and inclusion, and we recommend more research is required into the self-reporting assessment of disability for Aboriginal families of children and young people. This research can, for example, consider incorporating Aboriginal understanding of disability in the work with Aboriginal children and their family. More research can also be done on the lived experience of children with their carers, and also the voice and experience of children with disability outcome not well captured in some of the research on children in out of home care in New South Wales, and we also recommend to get a better understanding of the definition of disability across different families across different culture context. Because we have a very diverse group in New South Wales, and some of them have overseas background and culture and linguistically diverse people. That have a very different culture and understanding of disability, and just one minor point at the end regarding the data we use. At the moment, we have different definition in the dataset and the various definitions seem to rely on the carer's observation and caseworker's assessment, but there should be some scope to link the data of children in out of home care to NDIS, to Medicare records, and other administrative data so we have the opportunity to know the exact nature and seriousness of the effecting disability, and then also, there might also be some scope to develop specific training on disability for caregivers and other people involved in the system, including academic. Thank you. That's some of our recommendation indication from our research.

[Stuart Malcher] Thank you, Zhiming, for presenting those findings, and can I just take one moment again, just to thank our five presenters today. Joanna, Paul, Melissa, Raghu, and Zhiming, and obviously the teams that have helped pull those research and those findings together today.