ACIL Allen Consulting

Options Paper to Department of Social Services

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Health Assessments and Interventions For Children and Young People in the Child Protection System

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Executive Summary

Context

In 2012 there were almost 40,000 Australian children and young people in out-of-home care (OoHC), nearly doubling over the past decade. The majority of this group were under 14 years of age and just over one third was Aboriginal and Torres Strait Islander. Entry rates outstrip exit rates from the system with children remaining longer in OoHC (AIHW 2013).

Children and young people in OoHC are vulnerable and diverse. They exhibit increasingly complex behaviours and often have high unmet health needs and poor access to health services.

The National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (Commonwealth 2011) (the National Clinical Assessment Framework) provides a blueprint for early identification, referral and ongoing health care for children and young people in OoHC. The National Clinical Assessment Framework is designed to facilitate state and territory compliance with the National Standards for Out-of-Home Care (Commonwealth 2010) (the National Standards), specifically the requirement to assess and attend to the physical, developmental, psychosocial and mental health needs of children and young people.

In this regard, the National Clinical Assessment Framework also supports improved outcomes consistent with the objectives of the National Framework for Protecting Australia's Children 2009-2020 (COAG 2009) (the National Framework for Protecting Australia's Children). The National Framework for Protecting Australia's Children represents the first national collaborative effort between Commonwealth, state and territory governments, and the non-government sector designed to address child abuse and neglect.

Purpose

The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), on behalf of the Standing Council on Community and Disability Services Advisory Council (SCCDSAC), tasked ACIL Allen Consulting with a comprehensive analysis of the range of health assessments and interventions for children and young people in the state and territory child protection systems, and examination of effective mechanisms to track their health histories.

Based on the findings of this analysis, options were required for national consideration by Community and Disability Services Ministers on approaches to ensure ongoing and substantive health assessments and interventions, and effective mechanisms to track health histories.

Method

The methods used to implement the project included consultation with jurisdictional child protection and health agencies, and community service organisations supporting carers. In addition, a questionnaire was developed for jurisdictions to complete describing their respective approaches to health assessments and implementation experiences, and a targeted literature review was undertaken on the evidence of health need in the OoHC population. The project was also informed by a national Expert Reference Group with expertise in paediatrics, research, primary health and child health policy. The project was

guided by a project working group and a national health working group of Commonwealth, state and territory representatives of Child Protection and Health nominated by the Children, Youth and Community Services Policy and Research Working Group.

Findings

State and Territory approaches mapped against the National Clinical Assessment Framework

- Awareness of the National Clinical Assessment Framework, which was endorsed by Health Ministers and noted by Community and Disability Services Ministers, was patchy across jurisdictions. Nonetheless, jurisdictional approaches to health assessments and interventions were evidence informed and generally could be mapped loosely to the key elements of the National Clinical Assessment Framework.
- State and territory approaches aligned most consistently to the National Clinical Assessment Framework's preliminary health check but in many instances did not follow through on mandating a subsequent comprehensive health and developmental assessment, relying instead on referrals arising from the preliminary health check or equivalent.
- A Care Coordinator Health role existed in some jurisdictions where it operated at system level and in others had also been rolled out at regional level. The role was usually included in both the child protection and health systems and in some instances extended to the education system. Funding for these positions was lapsing in a number of jurisdictions with little or no prospect of renewal. Generally, however, it fell to child protection practitioners and community service organisations to navigate the health system and broker local access.
- Tracking health histories was influenced by carer and placement instability, parental neglect, new primary health care providers, inadequate reporting of health assessment outcomes, and incomplete transfer of information from child protection to community service organisations supporting carers. Assembling health histories often relied on records associated with past use of public health services and a complete history was difficult to compile. A range of approaches existed for generating and maintaining paper-based personal health records.
- Innovative practice and fostering of good practice was evident and broad ranging. In some jurisdictions, public hospital clinics provided a focus for comprehensive health assessments while older youth were referred to youth health programs. Area based trials of dedicated health services were underway and multi-disciplinary health teams offering trauma-informed services were operating. Substantial work had been undertaken to build the skills and understanding of General Practitioners including written material, web-based training and clinical practice guidelines. Data management was receiving attention with enhancements to health information capability in existing child protection databases, the development of an inter-agency data strategy and the piloting of a web-based system with ability to generate reports for different stakeholders and purposes.

Strengths of state and territory approaches to clinical assessments

- Formal mechanisms to establish inter-agency collaboration which existed in some jurisdictions had provided significant impetus to coordinated action on health assessments and interventions. These included whole-of-government commitment in some states to priority access to health services for the OoHC population, legislation to enable sharing of health information, memorandum of understanding to clarify roles and responsibilities of health and child protection agencies and coordinator roles to bring a focus to health assessments and support staff within and across agencies. Community service organisations with case management responsibilities were also effective in building local knowledge about health services and supporting the carer to access services in a timely manner.
- Developing the understanding of health service providers about trauma-informed services and child protection staff about the value of early intervention to improved health outcomes has been essential to building capability for consistent and sustainable health assessment.

Challenges to an effective response

While it has been possible to interpret a variety of different arrangements as loosely following the tiered health assessments and referrals, a greater level of consistency with the National Clinical Assessment Framework is indicated as a guide to achieving an effective response to the health needs of children and young people in OoHC. For many jurisdictions, further progressing action aligned to the National Clinical Assessment Framework has implications for the level of priority given to improved health outcomes for the OoHC population and decisions that support early intervention efforts requiring increased system capacity. Challenges faced in implementing approaches for sustained and comprehensive clinical assessments included the following.

- The absence of a wider enabling environment that can facilitate access to health services through high level direction for inter-agency collaboration and joint accountability.
- The lack of clarity around roles and responsibilities of government agencies leading to inefficiencies in planning, communications, and gaining an understanding of issues and work practices.
- Timely and equitable access to quality services because of: structural gaps in health service provision; lack of skills, understanding and cultural competences among service providers; and disincentives for participation of health service providers because of inadequate remuneration levels.
- Resourcing to roll out good practice to provide state-wide coverage.
- Constraints on inter-agency information sharing and information management capability that mitigates against efficient and effective health assessments and interventions, tracking of health histories, monitoring of health outcomes, assessment of program performance and maintenance of child health management plans and personal records.

Conclusions

Options to better address the health needs of children and young people in child protection

A range of options have been identified that build on the early experiences of states and territories to enable more consistent and sustainable responses to the health and developmental needs of children and young people in OoHC in the child protection system.

Generally, any increased effort to ensure a comprehensive approach to clinical assessments as envisaged in the National Clinical Assessment Framework, has the significant potential benefit of contributing to improved life outcomes for a growing number of vulnerable and disadvantaged children and young people. The benefits to the individual, family and society accrue over a lifetime and include avoidance of costs associated with support services including correctional facilities, increased resilience and a fuller, more productive life.

The following options for an enhanced response to clinical assessments are aimed at an increased focus on early intervention efforts through strengthened enabling environments, collaboration, capacity building and dedicated resources. Not all options would require action by all jurisdictions where the initiative has already been taken by states and territories.
Improved access to health services for children and young people in OoHC

1. Inter-sectoral agreement that establishes a whole-of-government commitment in each state and territory to priority access to health services for children and young people in OoHC (states and territories).

2. Dedicated coordinator role at a system and regional level that facilitates integration across health, child protection and education sectors (states and territories)

3. Medicare Locals engaged to secure the mix and quality of primary health care services (Commonwealth, states and territories).

4. A dedicated MBS item for the preliminary health check accompanied by supporting information and tools to address issues associated with the complexity of the service response required (Commonwealth, states and territories).

- Improved continuity of health care, health safety and optimal use of resources through more effective tracking of health histories

5. Prioritising development and implementation of national eHealth technology tailored to the health information needs of children and young people in OoHC (Commonwealth, states and territories).

- Improved knowledge and understanding among health care staff and service providers, including carers

6. A national competency framework setting out roles and competencies for health care staff involved in delivery of health assessments and interventions for children and young people in OoHC (Commonwealth, states and territories, and national health professional associations including the Royal Australasian College of Physicians).

7. Trauma-informed healing approaches developed for health service providers working with Aboriginal and Torres Strait Islander children and young people in OoHC (Commonwealth, states and territories, the National Aboriginal Community Controlled Health Organisation, the Secretariat of National Aboriginal and Islander Child Care and the Healing Foundation).

8. Mechanism for jurisdictional information exchange for policies, protocols and training materials related to the implementation of the National Clinical Assessment Framework (Commonwealth, states and territories).

1 Background

1.1 Health needs of children and young people in the child protection and out-of-home care system

The particular health needs of children and young people in the child protection and out-of-home care systems are well documented. The impact of trauma, abuse or neglect on childhood and adolescent development, usually coexistent with a range of parental risk factors and societal disadvantage, means children and young people entering out-of-home care (OoHC) are far more likely to have 'poorer physical, mental and developmental health than their peers' (RACP 2006).

Child protection and OoHC in Australia

In 2011-12 there were over 250,000 child protection reports or notifications about the safety and wellbeing of 170,000 Australian children and young people. During the same period nearly 50,000 investigations into allegations of abuse, neglect and trauma were substantiated by child protection authorities (AIHW 2013).

Responsibility for statutory child protection rests with individual state and territory governments. Child protection practitioners are responsible for receiving reports and notifications about children and young people who may be at risk of harm; investigating and substantiating reports where appropriate; and undertaking appropriate protective intervention to secure the safety and wellbeing of the child or young person.

Where it is determined that children and young people can no longer live at home with their parents, protective intervention can include placement of children and young people into OoHC. Placement options available for children and young people typically involve:

- **Home Based Care:** the placement is provided by a carer in their own home. The placement is either:
- **Kinship care:** provided by a family member or friend. In statutory arrangements the carer is eligible for reimbursement of expenses associated with providing the placement
- **Foster care:** provided by a volunteer caregiver who has undergone training and assessment and may provide their services directly to government or a non-government organisation. Caregiver reimbursements are also available for foster carers
- **Residential care:** the placement is within a group home, typically staffed by paid workers
- **Other forms of OoHC:** there are a range of other living arrangements, such as lead tenant, health or disability facilities that can be used to place children or people in care.

Across Australia, OoHC services are provided by both government agencies and non-government organisations, though there is some variation in the extent to which non-government organisations are involved.

On 30 June 2012 there were 39,621 children and young people in OoHC across Australia. Key features of this cohort include the following.

- Relatively even gender divide (52 per cent were male, 48 per cent female)
- Nearly 3 per cent were infants less than one year of age
- Nearly a quarter of the population were under 5 years of age
- 32 per cent of the population were aged between 5 and 9 years
- 30 per cent of the population were aged between 10 and 14 years
- 15 per cent of the population were aged between 15 and 17 years.

Significantly, of these 39,621 children and young people in OoHC, just over one third were Aboriginal and Torres Strait Islander children and young people (AIHW 2013).

Figure 1 charts the total number of children and young people – as well as the subset of this population who are Aboriginal and Torres Strait Islander children and young people – who were in OoHC over the past decade. It also tracks the entry and exit rates from statutory OoHC.

Figure 1 Children and young people in OoHC, including entry and exit rates from OoHC

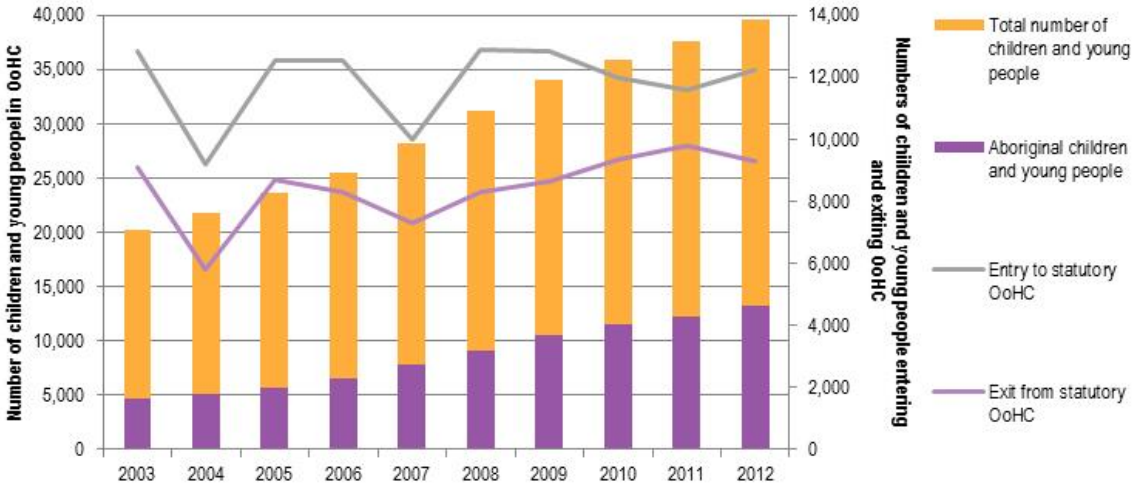

Figure 1 describes the total number of children and young people in Out of Home Care (OoHC) in Australia, and entry and exit rates into OoHC. In 2003, there were approximately 20,000 children in OoHC in Australia, which steadily rose each year to 2012. In 2012 there were 40,000 children in OoHC in Australia. Entry rates into OoHC over that people were always above exit rates, fluctuating year to year to be slightly lower in 2012 than 2003.
Note: 2004 data excludes NSW and Tasmanian input; 2007 data excludes QLD input

Source: Australian Institute of Health and Welfare. Child protection Australia reports 2002-03 to 2011–12. Child Welfare Series. Canberra: AIHW

As demonstrated in the data above, there has been significant growth in the number of children and young people in OoHC, with the population nearly doubling over the past decade. Entry rates into OoHC have been consistently higher than exit rates over the past decade, driving the growth in OoHC, and also serving to highlight the considerable flow into and out of the system.

The growth in numbers of children and young people in OoHC is attributed to a number of interrelated factors, including the following.

- Increasing client complexity – in most instances children and young people enter OoHC having experienced significant trauma and disruption during their lives. As a consequence they present with increasingly complex needs, manifesting in poor educational, behavioural and social outcomes (Osborn & Bromfield 2007; Tarren-Sweeney & Hazel 2006).
- Length of stay – reflecting the increasing complexity of the OoHC population, time in OoHC placement is lengthening. In the ten years from 2003 to 2012, the proportion of children and young people who have been in continuous placement in OoHC for longer than 2 years has grown from around 50 per cent to nearly 70 per cent of the overall OoHC population (AIHW 2013).
- Over-representation of Aboriginal children and young people – the numbers of Aboriginal children and young people in OoHC has more than doubled in the past decade. Rates of representation in the OoHC system are 10 times greater for the Aboriginal and Torres Strait Islander communities than for the broader population.

Another important consideration is the extent to which the health needs of children and young people in OoHC have been identified and managed.

There is evidence to suggest that children and young people who enter statutory OoHC have had generally poor engagement with the primary health care system before entering OoHC (Nathanson & Tzoumi 2007; NSW DoH 2011; Ford 2007). Further, access and engagement of health services once in OoHC can be varied and uncoordinated, with health records and histories often incomplete, and health planning not routinely incorporated into broader care planning and case management (Ford 2007; NSW DoH 2011; QCPCI 2013).

Poor engagement of health services both before and after entering OoHC is a particular issue given the emerging evidence about the particular health needs of this population group.

Particular health needs of children and young people in OoHC

In a significant review of the evidence on this policy issue undertaken by the then Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee and the Nous Group, a number of key points were identified.

- Health needs for children and young people in the child protection system span the domains of physical health, developmental health and psychosocial health. They can often be unrecognised or poorly managed. Health needs and concerns for children and young people in OoHC are greater than that of the broader population (Nathanson & Tzoumi 2007; Tarren-Sweeney 2008).
- Even within this particular population group, the health of Aboriginal children and young people in OoHC is poor, with health needs also encompassing cultural and spiritual domains (Reynolds 2008; Yeo 2003).
- Timely access to health services is fragmented by a number of issues particular to OoHC systems, such as carer and placement instability and poor health records management, which inhibit continuity of care and treatment (Crawford 2006).

In recent years, a number of reports and inquiries into child protection systems have identified the shortcomings of previous ad hoc approaches to assessing and managing the health needs of children and young people in OoHC, and have recommended more

consistent and systematic approaches to ensuring health needs are more appropriately met (QCPCI 2013; PVVC 2012; SCICPSNSW 2008; and Ford 2007).

Accordingly, most state and territory governments are developing an increasingly systematic policy response to the issue.

1.2 National action

Since 2009, the Australian Government has led the development and implementation of the National Framework for Protecting Australia's Children 2009-2020 (the National Framework for Protecting Australia's Children) in partnership with state and territory governments and the non-government sector.

The National Framework for Protecting Australia's Children will deliver a more integrated response to the safety and wellbeing of children but does not change the responsibilities of governments. Statutory child protection responsibilities are appropriately retained by state and territory governments.

The National Framework for Protecting Australia's Children recognises that protecting children and young people, and promoting their health and wellbeing, are responsibilities that cross jurisdictional boundaries, professional disciplines and government and non-government sectors.

The six key outcome focus areas under the National Framework for Protecting Australia's Children are outlined in Box 1.

Box 1 Supporting outcomes of the National Framework for Protecting Australia's Children for protecting Australia's Children

The six supporting outcomes of the National Framework for Protecting Australia's Children

1. Children live in safe and supportive families and communities
2. Children and families access adequate support to promote safety and intervene early
3. Risk factors for child abuse and neglect are addressed
4. Children who have been abused or neglected receive the support and care they need for their safety and wellbeing
5. Indigenous children are supported and safe in their families and communities
6. Child sexual abuse and exploitation is prevented and survivors receive adequate support

Source: COAG 2009, Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020

The National Framework for Protecting Australia's Children is being implemented through a series of three-year action plans identifying national priorities and specific actions for implementation.

The First three-year action plan 2009-2012 (the First Action Plan) was endorsed by Commonwealth, State and Territory Governments in 2009 and was the first of a series of three-year action plans designed to drive initial activity under the National Framework for Protecting Australia's Children.

The Second three-year action plan 2012-2015 (the Second Action Plan) of the National Framework for Protecting Australia's Children was endorsed by the Standing Council on Community and Disability Services on 17 August 2012.

National Standards for Out-of-Home Care

A key achievement of the first action plan under the National Framework for Protecting Australia's Children (2009-12) was the development of National Standards for OoHC. The National Standards were endorsed in 2011 and are designed to drive improvements in the quality and consistency of OoHC across Australia.

Standard 5 of the National Standards for OoHC requires that:

Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way.

The standard is premised upon children and young people who enter care having their health needs assessed, in turn enabling access to specialist services and more comprehensive health and developmental assessment and treatment. The expectation is that children and young people will have an individual health record that moves with them.

Appropriate reporting arrangements to enable measurement of this standard are to be developed. Initially, they will report on:

the number and proportion of children and young people who have an initial health check of their physical, developmental, psychosocial and mental health needs within a specified period of entering out-of-home care

Reporting on the standard is scheduled to commence in 2014.

National Clinical Assessment Framework

To support achievement of this standard (and more broadly, outcome 4 of the National Framework for Protecting Australia's Children, see Box 1), the National Clinical Assessment Framework was developed by the then Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee.

The National Clinical Assessment Framework is designed to:

- improve consistency of health assessments and services for children and young people in OoHC;
- provide advice about the role of primary care practitioners and clinicians, and what may be appropriate assessment tools; and
- assist state and territory governments in the development of appropriate policy and practice to ensure health professionals are best placed to provide appropriate and required health care to children and young people in OoHC.

The National Clinical Assessment Framework was noted by the Standing Council on Community and Disability Services and released in 2011 through the Australian Government Department of Health and Ageing.

Improving health outcomes

The Second Action Plan for the National Framework for Protecting Australia's Children identifies a series of new national priorities to be explored. This includes undertaking work that builds on the National Standards for OoHC and the National Clinical Assessment Framework to further explore improved access to health services, including mental health services, for vulnerable and at risk children.

To progress this national priority, Australian Community and Disability Services Ministers agreed to:

- undertake a comprehensive analysis of current opportunities, supports and services, and provide options to Ministers for their consideration of approaches to:
- ensure ongoing, substantive health assessments and interventions for children and young people in the child protection system; and
- effective mechanisms to track their health histories

This project responds directly to this agreed priority.

1.3 This project

ACIL Allen Consulting was engaged by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to undertake comprehensive analysis of the range of health assessments and interventions for children and young people in the child protection system and examine effective mechanisms to track their health histories.

Specifically the project focussed on:

- collecting information on the different jurisdictional models and approaches to health assessments and interventions and methods used to track health histories;
- examination of strengths and best practice within jurisdictions;
- identification of gaps, barriers and opportunities; and
- development of options for health assessments and interventions, and methods to track health histories, that are robust, evidence-based, cost-effective and feasible, and underpinned by an analysis of their costs and benefits.

The results of the consultation and analysis informed the development of options for consideration by the Standing Council on Community and Disability Services to improve health outcomes of children and young people in the child protection system.

Project methodology

The review collected data and information through a number of methods.

- Interviews with representatives from Health and Community Services from each state and territory government.
- Distribution of a questionnaire to all states and territories to capture detailed information on jurisdictional practice, strengths, weaknesses and available data.

- Establishment and engagement of a national Expert Reference Group to provide expert advice and guidance to the project.
- Interviews with a number of nominated non-government organisations involved in the delivery of OoHC services.
- Review of select literature.
- Engagement and consultation with Commonwealth Government representatives from the Department of Health and Ageing (DoHA) and FaHCSIA.

Project support and oversight was provided by representatives from the Commonwealth, New South Wales and Victorian Governments.

Details on stakeholders engaged through the project, including membership of the Expert Reference Group and the project governance arrangements are provided at Attachment A.

Report structure

The subsequent sections of this report are structured as follows.

- **Chapter 2 – Current Approaches** Provides an overview of the key stages and enablers to providing health assessments and interventions, and tracking health histories, for children and young people in OoHC, as outlined in the National Clinical Assessment Framework. It then details the current approaches and practice across each jurisdiction.
- **Chapter 3 – What is working well** Reports on what is working well across different jurisdictions. It draws on consultation data and input from the Expert Reference Group.
- **Chapter 4 – Challenges, opportunities and options for improving health outcomes** Reports on the challenges and opportunities identified by jurisdictions. The experience of early implementation efforts has also helped identify potential opportunities for improved responses. Following this analysis, potential options for improved health outcomes are outlined for consideration.
- **Chapter 5 – Conclusion**

2 Current approaches

This chapter outlines current approaches to the provision of health assessments and interventions for children and young people in OoHC and the tracking of their health histories and records.

Key Points

- State and territory approaches to the provision of health assessments and interventions are varied. There are points of commonality but also divergence across and within jurisdictions.
- Program maturity of different models and approaches across jurisdictions is not well advanced or established.
- Despite local innovation, the tracking of health histories and records across the different jurisdictions lacks consistency.

2.1 Health assessments and interventions

The National Clinical Assessment Framework is designed to improve the range of responses and services available to address the health needs of vulnerable children and young people in OoHC across Australia.

The National Clinical Assessment Framework outlines a best practice approach to improving responses, proposing a tiered approach to age-appropriate assessments across the three domains of physical health, developmental, and psychosocial and mental health, and setting out key timeframes and responsibilities of professionals and carers. In doing so it provides a National Clinical Assessment Framework to guide health and child protection practitioners, and inform policy and system design.

Key stages and enablers to health assessments and interventions:

The following are the six core elements of the National Clinical Assessment Framework.

1. Preliminary Health Check to determine areas of immediate concern

2. Comprehensive Health and Developmental Assessment

3. Further assessments and management of health needs determined by earlier health checks and on a case by case basis

4. Development of a Health Management Plan including a personal health record

5. Follow up monitoring determined by clinical need

6. Identification of a Care Coordinator Health role to ensure continuity of services and information.

Figure 2 provides an overview of the National Clinical Assessment Framework covering each of the core elements and the recommended roles, responsibilities and timeframes.

Figure 2 National Clinical Assessment Framework – key stages and enablers

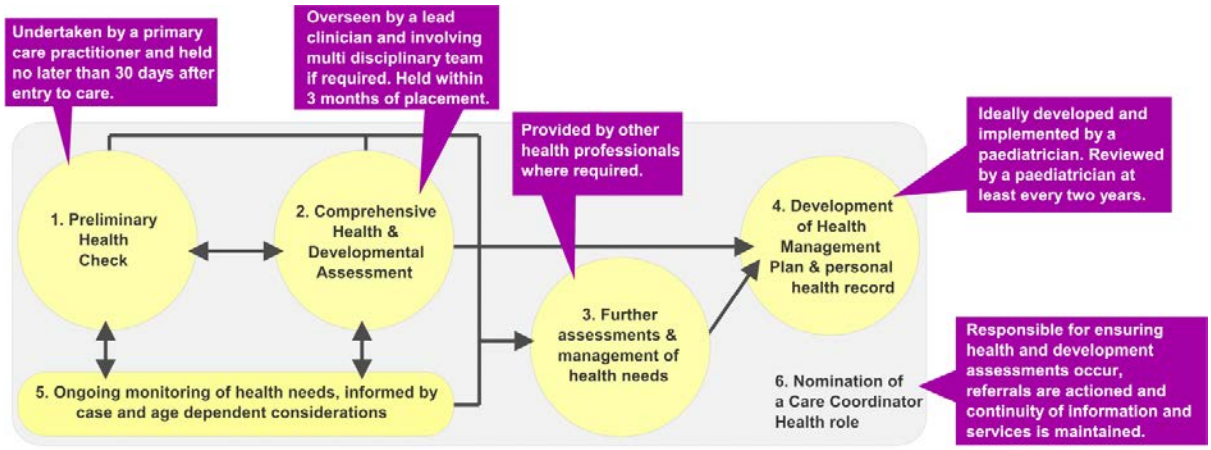

Figure 2 is a flow chart describing the National Clinical Assessment Framework covering each of the core elements of the process, recommended roles, process responsibilities and timeframes. The process starts with a preliminary health check or a comprehensive health and development assessment, which leads to ongoing monitoring of health needs informed by case and age dependent considerations. This leads to further health assessments by other professionals if required and the development of a health management plan and personal health record.

Source: Adapted from the National Clinical Assessment Framework

In outlining this best practice approach, the National Clinical Assessment Framework recognises that legislative structures and service systems differ across jurisdictions, and that these local factors will shape how the National Clinical Assessment Framework is used to inform practice.

Current state and territory approaches

High level overviews of the different approaches to responding to health needs of children and young people in OoHC currently in place across jurisdictions are provided below. These approaches have been mapped against the key stages and enablers of the National Clinical Assessment Framework for comparative purposes.

The description of different approaches does not cover those health services or assessments that may occur as part of statutory investigation procedures, but rather the approach taken once a court order has been finalised and a child or young person is placed into OoHC.

A more comprehensive description of each jurisdiction's approach and policy and legislative supporting environment is provided at Attachment B.

Australian Capital Territory

The Child at Risk Health Assessment Unit (CARHU) located at the Canberra Hospital is central to the Australian Capital Territory model. Children 14 years or younger must be referred to CARHU within 48 hours of coming into care.

CARHU provides a nurse led assessment of the child or young person that determines whether referral to other specialist health professionals is required.

Ongoing monitoring of children and young people is provided through an annual Health and Wellbeing Check.

Liaison roles have been established in both the Directorates of Health and Care and Protection Services to formalise the relationship between the two agencies. A CARHU clinic nurse works directly with case workers to coordinate the assessments.

For young people between 15 and 17 years of age, a youth focused health clinic has been established to provide a more age appropriate environment. Notwithstanding this service, engagement of older adolescents with appropriate health services was reported as an ongoing issue for the Australian Capital Territory.

Another key issue for the Australian Capital Territory is the high proportion of children and young people who are in OoHC in placements over the border. There are no formal or established pathways in place to ensure these children and young people's health needs are met in a consistent and systematic way.

An overview of the current approach in the Australian Capital Territory is provided in Figure 3.

Figure 3 Overview of the Australian Capital Territory approach

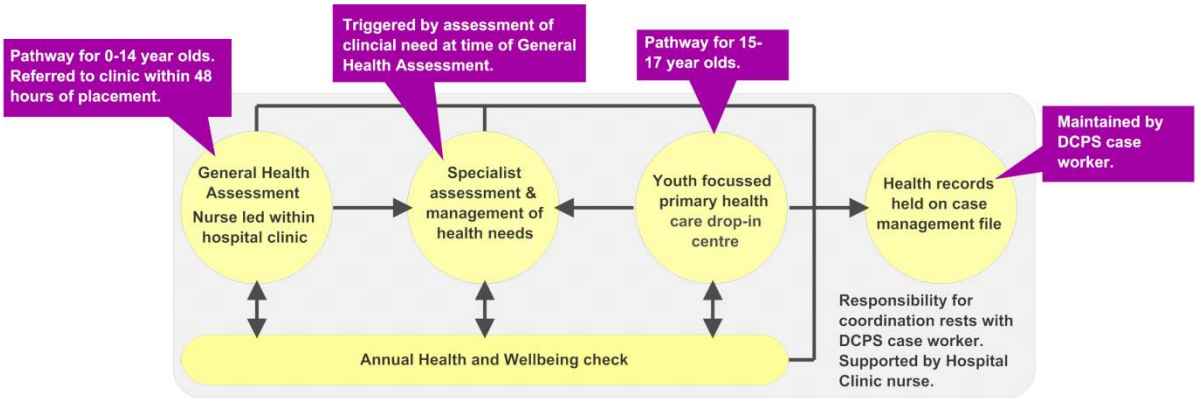

Figure 3 is a flow chart describing the Clinical Assessment Framework for the ACT, covering each of the core elements and the recommended roles, responsibilities and timeframes.

For 0-14 year olds, the process starts with a general health assessment, which is followed by specialist assessment and specialist management of the child's needs, if needed, or if specialist treatment is not needed, it is followed by an annual health and wellbeing check-up. For 15-17 year olds, the process starts with a youth focussed primary health care drop-in centre, which then leads to the general or specialist health assessments. Health records are kept on the case management file for both. Source: Adapted from ACT Consultation data

New South Wales

From 2010, New South Wales has been implementing the Model Pathway for the Comprehensive Health and Developmental Assessments for Children and Young People Entering Out of Home Care (Model Pathway).

Under the Model Pathway, all children and young people entering statutory care will undergo a primary health screening, which can be conducted by a range of health professionals including GPs, community based nurses or through Aboriginal Medical Services. If the health screening identifies particular health needs, the child or young person will receive a comprehensive health assessment provided by appropriate clinicians and other health professionals.

Following the screening and / or assessment, a Health Management Plan will be developed and incorporated into a child or young person's case plan. Review of client health needs is determined by the child's age and clinical needs. At a minimum, children under 5 years of age must have a health review at least every six months and children over 5 years of age must have a health review at least annually. The Model Pathway makes clear the need for the response to be mindful of appropriate cultural considerations.

The Model Pathway clearly outlines roles and responsibilities across the relevant agencies and professionals, New South Wales Health and New South Wales Family and Community Services, and funded organisations providing OoHC. It is underpinned by a Memorandum of Understanding between New South Wales Departments of Health, and Family and Community Services that clearly establishes the different but integrated roles and responsibilities across the two sectors.

Implementation of the Model Pathway across the different area based health districts in New South Wales was supported through the establishment of coordinator roles across agencies, specifically Health OoHC coordinators employed by New South Wales Health and Interagency Pathway Coordinators employed by New South Wales Family and Community Services.

Implementation of the Model Pathway has given rise to a number of emerging issues. These include increased workload for child protection practitioners and growing demand on health professionals in facilitating appropriate information gathering and access to health services. This will be an ongoing issue as children and young people already within OoHC are brought into scope. Lapsing funding for coordinator positions is also a concern and the impact of this change on the ongoing success of the OoHC Health Pathway will be monitored.

Availability and access to health professionals is also reported as an emerging barrier to implementation of the Model Pathway. There is variable access across NSW to appropriate allied health, paediatric and mental health services Access to these services is a particular issue for children and young people placed in OoHC in rural and remote parts of New South Wales.

An overview of the New South Wales Approach is provided in Figure 4.

Figure 4 Overview of the New South Wales approach

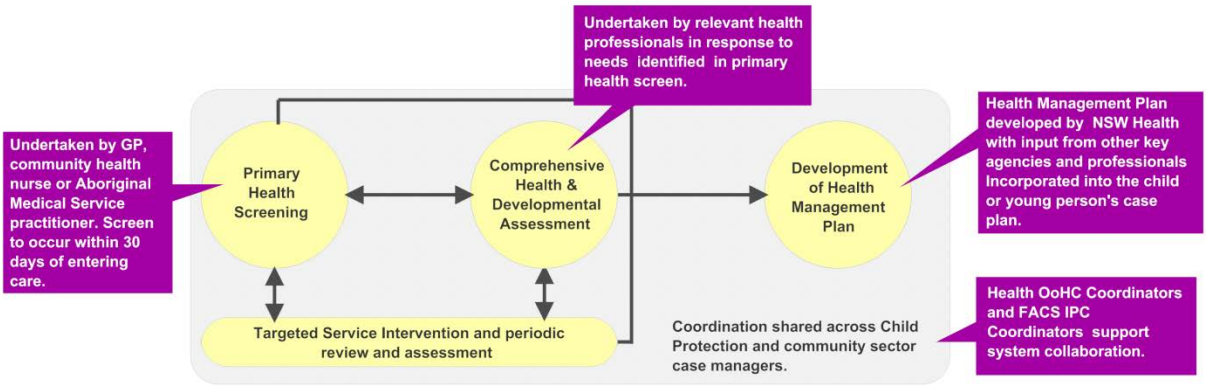

Figure 5 is a flow chart describing the Clinical Assessment Framework for the NSW, covering each of the core elements and the recommended roles, responsibilities and timeframes.The process starts with a primary health screen undertaken by a GP, which leads to targeted health service interventions or a comprehensive health and developmental assessment, and then target health service interventions. The development of health management plans also feed into the process.

Source: Adapted from NSW consultation data

Northern Territory

The Care and Protection of Children Act 2007 requires each child in care to have a care plan that is reviewed initially at two months and thereafter every six months. The Act also stipulates other circumstances where a care plan must be reviewed. This includes when there is a change to the child's placement arrangement or when a young person is leaving care. The Care Plan must identify and address the needs of the child.

The Care Plan tool requires that all of the domains relating to a child's health and wellbeing are addressed.

When a child initially enters care a baseline assessment is undertaken within three months.

Information gathered from the child's family and health professionals will inform what is required to complete the baseline assessment. Once the baseline assessment is completed the child's health needs are continually addressed through the care planning process.

A recent development in the Northern Territory has been the formation of Department of Children and Families (DCF) Multi-Agency Assessment and Coordination Teams in Darwin and Alice Springs to respond to children and young people with very complex needs. These teams allow for multi-disciplinary approaches to highly vulnerable children and young people.

The ability to access timely paediatric assessments or obtain the required follow up services once an assessment has been completed is an ongoing issue for the Northern Territory. Remote parts of the Northern Territory can only access visiting specialists at certain times which can impact on the availability and coordination of appointments. Transport and accommodation costs to access services in urban areas can be significant

An overview of the current approach in the Northern Territory is provided at Figure 5.

Figure 5 Overview of the Northern Territory approach

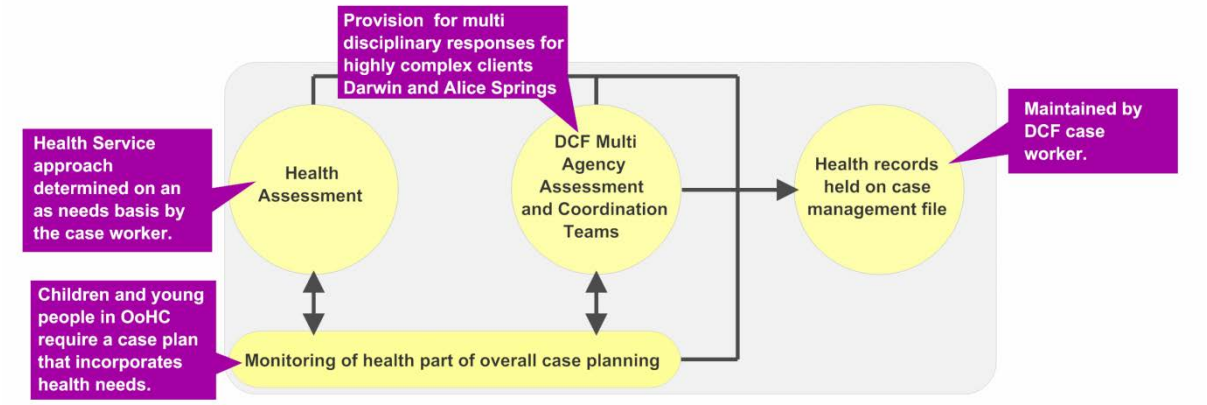

Figure 5 is a flow chart describing the Clinical Assessment Framework for the Northern Territory, covering each of the core elements and the recommended roles, responsibilities and timeframes. The assessment process starts with a health assessment initiated by the caseworker with a health service. This either leads to ongoing assessment and treatment as a part of a case plan, or to multiagency assessment and coordination for highly complex clients. This is then followed by monitoring and treatment. Health records are held on case management file. Source: Adapted from NT consultation data

Queensland

All children entering OoHC in Queensland are required to have either a health appraisal or health assessment completed.

Health appraisals are provided when the child or young person has been seen by a health professional in the past 12 months and that professional has enough information to provide a report on their day to day health needs.

Health assessments are undertaken when a child or young person has not been seen by a health professional in the past 12 months or if a health professional cannot provide a comprehensive report on the child or young person's health. Where appropriate the assessment will be undertaken by an Aboriginal Health Service or other culturally appropriate service provider.

The health appraisal or assessment summary informs the need for any ongoing specialist support and the development of the child or young person's Child Health Passport. The child or young person's health information is also linked to their strengths and needs assessment and the development and ongoing review of their case plan.

There has been significant change in Queensland in this policy space recently. Queensland has previously piloted an approach modelled closely on the National Clinical Assessment Framework. However, there were issues identified regarding cost and the extent to which a heavily prescribed approach for health professionals was appropriate. There is a view within the jurisdiction that a dedicated MBS item could address some of the issues that impacted the pilot.

Given these issues, Queensland moved to the health appraisal / assessment model, which builds on prior history of assessment described earlier. The recently released report from the Commission of Inquiry into Child Protection is likely to lead to further policy work in this space.

Other issues reported by the jurisdiction included limited access to health services in rural and regional areas and the impact on the timeliness of response for children when information, such as birth certificates, cannot be located by child protection practitioners.

An overview of the current approach in Queensland is provided at Figure 6.

Figure 6 Overview of the Queensland approach

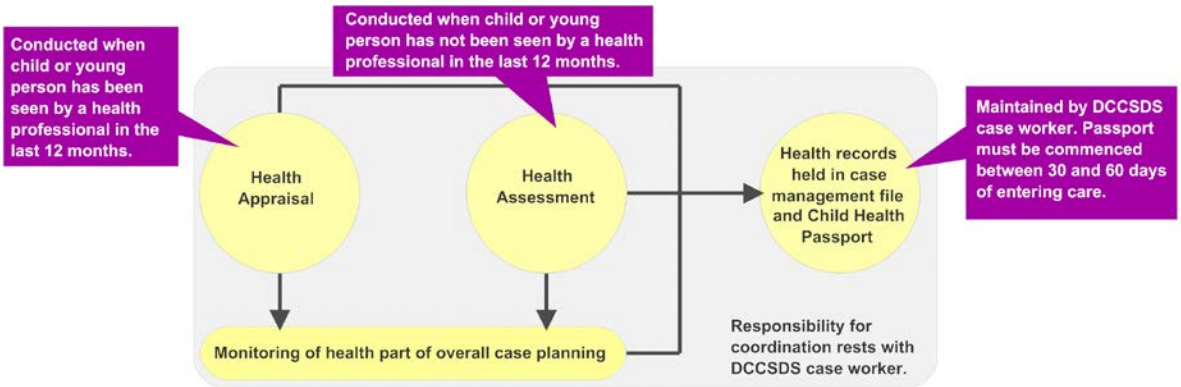

Figure 6 is a flow chart describing the Clinical Assessment Framework for Queensland, covering each of the core elements and the recommended roles, responsibilities and timeframes. The assessment process starts with a health assessment/appraisal, depending on whether the client has been seen by a health professional in the last 12 months. This leads to the monitoring/treatment of the client's health as part of the overall case plan. Health records are held in case management file and Child Health Passport. DCCSDS – Department of Community, Child Safety and Disability Services

Source: Adapted from QLD consultation data

South Australia

In South Australia, all children and young people entering care are required to undergo a comprehensive health assessment, conducted by a paediatrician or health professional of equivalent skill and expertise. The assessment is to occur within three months of entering care.

Under the Rapid Response Framework, there are prescribed roles for South Australia Health and Families SA practitioners. Rapid Response also ensures priority access to public health services for children and young people on Guardianship and equivalent court orders.

Ensuring equity of access is identified as a key issue in South Australia. Access to GP and specialist services in rural and remote areas is limited and is usually provided on a sessional or visiting basis which can impact on the timeliness of the response. The need for GPs and paediatricians with an informed understanding of trauma and its impact on children was another identified issue.

An overview of the current approach in South Australia is provided at Figure 7.

Figure 7 Overview of the South Australian approach

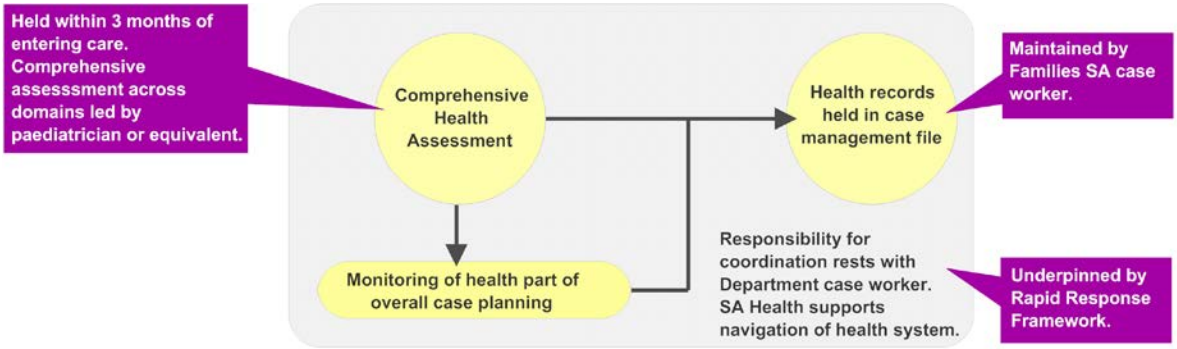

Figure 7 is a flow chart describing the Clinical Assessment Framework for South Australia, covering each of the core elements and the recommended roles, responsibilities and timeframes. The process starts within 3 months of entering care with a comprehensive health assessment led by a paediatrician or equivalent. This leads to the monitoring/treatment of health as part of an overall case plan. Health records are always held on case management file. Responsibility for coordination rests with Department caseworker. Source: Adapted from SA consultation data

Tasmania

There are two models operating in Tasmania. Common to both models is the requirement for children and young people entering care to be seen by a GP or other health professional within two weeks of placement. This is followed by dental review within four weeks of placement. Health pathways beyond this point then differ for Southern and Northern Tasmania.

In the Southern Tasmanian model, comprehensive health assessment for children and young people aged 0 to 14 is undertaken in a paediatrician led, multidisciplinary OoHC hospital clinic. For children and young people older than 15 years of age, assessment is undertaken in a youth focused health service. Review of health needs is then required annually.

In Northern Tasmania, health needs are managed beyond the initial assessment on an as needs basis. Work is underway on the development of an OoHC clinic based on the Southern Tasmanian model.

Resourcing is identified as a key factor contributing to this current difference of approach between the two regions in Tasmania. Under existing resourcing arrangements, a consistent state-wide implementation has not been possible. This in turn impacts on carers who face extra financial costs and logistical difficulties accessing medical services for children and young people across the North West of the state.

An overview of the current approach in Tasmania is provided at Figure 8

Figure 8 Overview of the Tasmanian approach

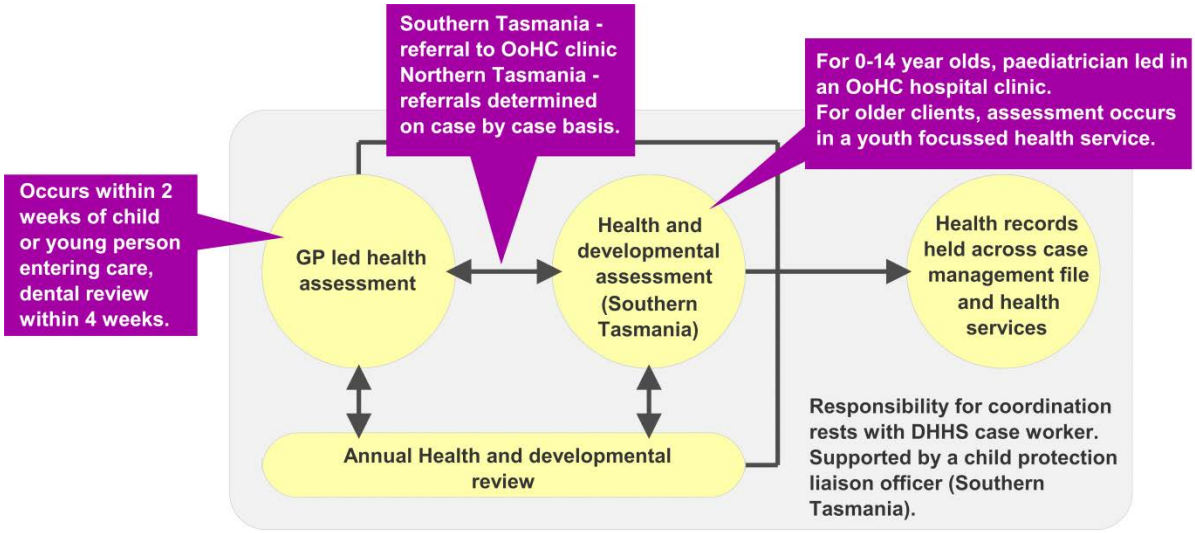

Figure 8 is a flow chart describing the Clinical Assessment Framework for Tasmania, covering each of the core elements and the recommended roles, responsibilities and timeframes. The process starts within 2 weeks of child entering care with a GP led health assessment. The next step is monitoring/treatment of health as part of the overall case plan or a specialist referral. Health records are held in case management file. Source: Adapted from Tasmania consultation data

Victoria

In Victoria, two models are currently being implemented. These include the Pathways to Good Health model, a pilot program in the north and western suburbs of Melbourne, and the rollout of the Statewide Health and Education Assessments project, which focuses on the health and educational needs of the children and young people in residential care. These two models do not yet cover all of the jurisdiction's OoHC population.

Key features of the Pathways model include an initial health check by a nominated GP within two weeks of entering care, with referral to specialists if required over the course of the next two weeks. A referral to one of four multidisciplinary clinics follows, with comprehensive assessment to be undertaken within 60 to 90 days of entering care. Following the assessment, the clinic develops a health management plan to inform overall care planning. Review of the health management plan is to occur annually.

Key features of the Statewide Health and Education Assessments project include an initial health check of the child or young person to occur within one month of entering residential care, with specialist health services on referral from a GP if required. Accompanying the initiative are dedicated Health and Education Assessment Coordinators and brokerage funding for each eligible child or young person to facilitate access across the health service system (both public and private).

OoHC provider funding program guidelines underscore the Victorian approach, requiring that providers ensure a child entering care has their health needs met.

Coordination of service response elements across multiple platforms of child protection, out-of-home care service providers and public and private health providers was identified as an on ongoing issue experienced in the roll out of the two programs. The importance was

highlighted of overcoming fragmented information gathering processes and access to health records and health information.

The skills and capacity of carers and residential care staff were seen as important factors in engaging and supporting children and young people to participate in the assessment and treatment of their health needs. This is considered particularly important for children and young people with highly complex needs who may require ongoing treatment and follow up work.

Access to specialist health professionals in the rural areas of the state was identified as problematic.

Victoria reported that the current suite of Medicare funded items does not adequately recompense GPs and other health professionals for the time, skill and effort involved in assessing and managing the health needs of the OoHC population.

An overview of the current approaches in Victoria is provided at Figure 9.

Figure 9 Overview of Victorian approaches

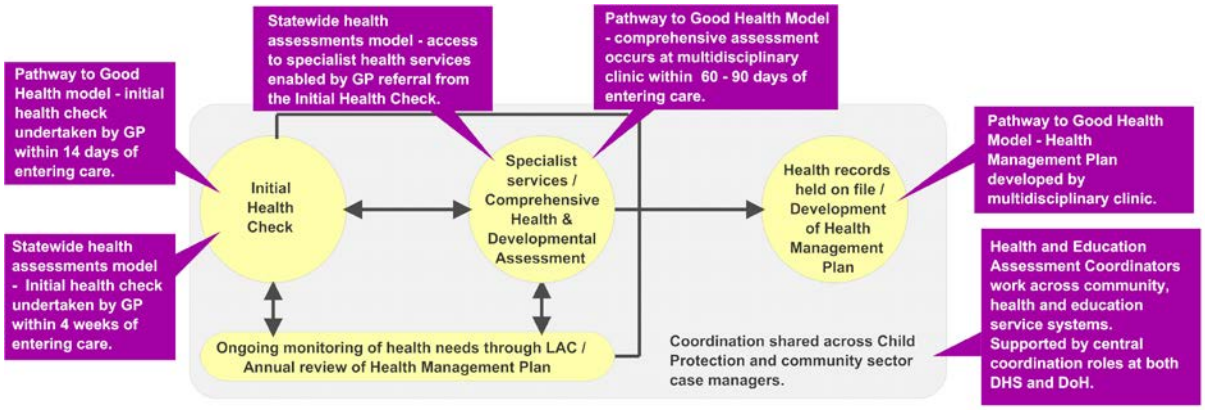

Figure 9 is a flow chart describing the Clinical Assessment Framework for Victoria, covering each of the core elements and the recommended roles, responsibilities and timeframes. The process starts within 2 weeks of child entering care with a GP led health assessment. The next step is monitoring/treatment of health as part of the overall case plan or a specialist referral. Health records for this process are held in case management file. Source: Adapted from Victorian consultation data

Western Australia

In Western Australia, all children and young people under the care of the Department for Child Protection and Family Support (CPFS) are required to have a health assessment to inform case planning. The Western Australian model, Health Care Planning for Children in Care, outlines pathways for assessment and management of health needs for children and young people entering care, and for those already in care.

The key features include a health examination by a GP or other health professional within 20 working days of the child or young person first entering care, followed by an age appropriate health and developmental assessment by a GP, community child or school health nurse, or Aboriginal health service. The outcomes of this assessment then inform the development of

the child or young person's overall care plan. The health and developmental assessment is also undertaken annually for children and young people already in care.

Differing expectations and structural differences between child protection and health agencies were seen as complicating factors impacting on the exchange of information and referral between the two agencies, and in turn, access to appropriate health services.

Limited access to health services and professionals in the rural and remote communities of Western Australia was also identified as an ongoing issue. This was compounded by the need to coordinate the diverse range of skills and professionals required to respond appropriately to the complex needs of children and young people in OoHC.

An overview of the current approach in Western Australia is provided at Figure 10.

Figure 10 Overview of the Western Australian approach

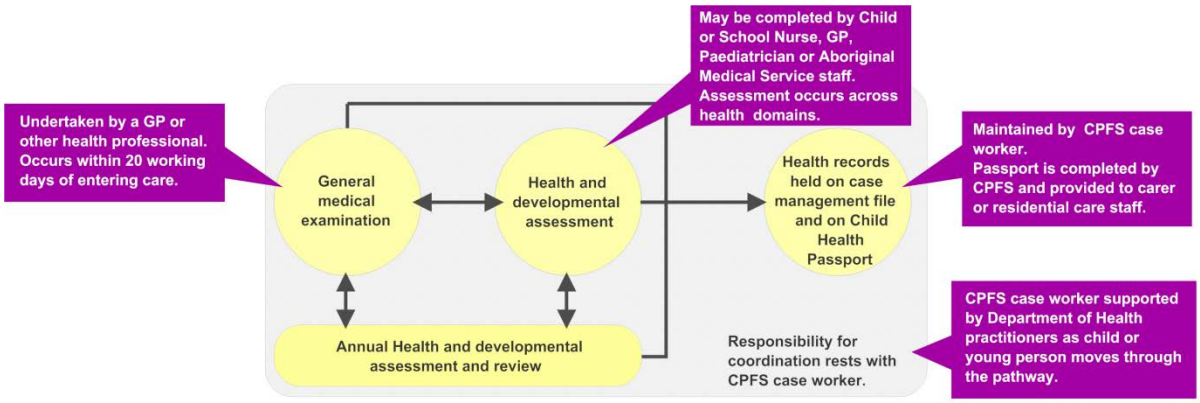

Figure 8 is a flow chart describing the Clinical Assessment Framework for Tasmania, covering each of the core elements and the recommended roles, responsibilities and timeframes. The process starts within 20 workdays of child entering care with a general medical examination. The next step is the monitoring/treatment of health as part of the overall case plan or a specialist referral. Health records for this process are held in case management file and on Child Health Passport. Source: Adapted from WA consultation data

2.2 Tracking health histories

The development of a Health Management Plan is a key component of the National Clinical Assessment Framework. It underpins coordination among services and professionals and enables continuity of care for the children and young persons in OoHC.

Key enablers for tracking health histories

The National Clinical Assessment Framework outlines the following key enablers to successfully developing and implementing Health Management Plans and tracking the health histories of children and young people in the OoHC system.

- Health Management Plans are regularly completed and updated by health practitioners
- Health Management Plans should sit within the overall care planning for each child and young person
- Health Management Plans are carried by the child or carer

- Clear policy and guidelines allow for the appropriate collection, sharing and storage of health information
- Health Management Plans should eventually be incorporated into an electronic health record.

Current state and territory approaches

High level overviews of the different approaches to tracking the health histories of children and young people in OoHC currently in place across jurisdictions are provided below.

Australian Capital Territory

Australian Capital Territory Care and Protection Services maintain a child or young person's health records on their case management system; Children and Young Person's Service record (CHYPS). It is a requirement that health information is documented in Care Plans, which are reviewed annually.

Under Australian Capital Territory legislation, Care and Protection Services can access health records for children under court orders from any health service.

Work is underway through the Australian Capital Territory Health Directorate's Health Infrastructure Program to support the National eHealth Strategy and rollout of electronic personal health records.

New South Wales

Under the Model Pathway, Health Management Plans are required to be developed for all children and young people entering care. Current practice is for the Health Management Plans to serve as a portable health record that is provided to the child and young person's case worker, health professionals and any other appropriate professionals involved in their life.

In terms of tracking health histories, Interagency Pathway Coordinators are monitoring referrals and outcomes from health screens and assessments to track progress of clients.

As part of overall case management, New South Wales Community Services child protection practitioners continue to record health and other medical information and outcomes on the New South Wales case management system; Key Information Data System (KiDS). Under existing legislation, New South Wales Community Services are able to request information from a number of agencies and departments, including New South Wales Health.

The development of centralised health records is being pursued in New South Wales, with New South Wales Health leading development of an electronic personal health record as part of the National eHealth Strategy.

Northern Territory

Health histories for clients of the Northern Territory's Department of Children and Families (DCF) are recorded by DCF case workers. This includes maintaining the case files on the DCF's case management system, Community Care Information System (CCIS), and a hard copy paper file that holds the original copies of reports and assessments.

In addition to these records, the Northern Territory Government's Department of Health also maintains eHealthNT which has capacity for shared electronic health records.

Queensland

Queensland's Department of Communities, Child Safety and Disability Services records health histories centrally on the Department's Integrated Client Management System (ICMS) and within a hard copy Child Health Passport that is provided to carers at commencement of placement. The passport is also provided to parents and the young person if they return home or transition from care.

All relevant health information is recorded by the Department's case workers on a health page of the ICMS record. All original documentation is kept on a paper based hard copy file. The passport contains copies of the health appraisal or health summary letter and any other information that would assist the carer with managing the child or young person's health needs. Any serious conditions or other health alerts are also detailed in the passport.

South Australia

Referrals, assessment outcomes and other health history are recorded on the Families SA case management system; C3MS. This data is held by Families SA and dependent on Families SA case workers for input and updating. Health professionals do not have access to this data unless provided by the Families SA case worker.

Under South Australia's Rapid Response Framework, children and young people on Guardianship court orders are flagged on South Australia Health's IT platform indicating that the child or young person should receive priority access.

Tasmania

In Tasmania data exchange protocols between agencies has enabled the production of individualised profile reports for each child or young person in OoHC. These reports capture information across health domains, education and community services.

Formal data exchanges between the Royal Hobart Hospital and the Department of Health and Human Services' case management system allows for the sharing of data across public health services and child protection authorities.

Victoria

The collection of health histories and information is shared between Department of Human Services (DHS) practitioners and community sector funded organisation case workers. DHS practitioners record all relevant data and information on their case management system; Client Relationship Information System (CRIS).

In addition to this internal client record, the Looking After Children (LAC) framework is used by the Department and funded community sector providers to underpin collaborative care team planning. LAC provides for the collection and sharing among the care team of information across different domains, including health and developmental domains.

As part of the Pathway to Good Health model, Health Diaries are to be provided to participating children and young people (or their carers) to serve as a portable health record.

In addition to these methods of recording and tracking health histories, the Pathway to Good Health model is piloting a web-based electronic record that participating health professionals can use to upload comments, outcomes and referrals for children and young people they are treating. The program also has reporting functions that can produce management plans for

multiple audiences. The program is designed to be compatible with the National eHealth Strategy.

Western Australia

In Western Australia, health histories and information of children in care is recorded in both a Child Health Passport that is provided to the carer and/or young person, and through the care planning and case management records.

The Child Health Passport is designed to contain all the information required by carers and health professionals to manage the day-to-day health needs of the child or young person.

Copies of all reports and relevant information are kept in hard copy by the Department with the intent to release the file to the child or young person when they leave care.

Health planning is also documented in the overall care plan. This document is shared with the child and young person and other appropriate adults and professionals in their life.

Work is also underway in Western Australia to develop a centralised electronic health system for children and young people, at least across metropolitan Perth.

2.3 Summary

As the National Clinical Assessment Framework recognises, different legislative frameworks and service system architecture across jurisdictions has influenced implementation of the National Clinical Assessment Framework. Accordingly there are points of commonality across jurisdictions, but also considerable variation in how states and territories assess and manage health needs of children and young people in the child protection system.

Key findings from this comparative analysis show:

- Consistent design and intent for a preliminary health check upon entry to OoHC
- Noticeable variation from the National Clinical Assessment Framework beyond the preliminary health check, particularly relating to the provision of a subsequent comprehensive health and development assessment by multidisciplinary teams
- Significant use of the public health system but also considerable effort to incorporate General Practice into the policy response
- Considerable responsibility on child protection practitioners for the navigation of the health system, coordination of health responses, and monitoring and updating of health records
- Different levels of program maturity among jurisdictions, with most approaches still relatively new and not yet properly implemented or evaluated
- In the absence of a centralised personal health record system, a number of different hard copy, portable health record arrangements have been implemented across jurisdictions.

This comparative description provides a foundation for the review and analysis of what is working well across jurisdictions, what is challenging jurisdictional approaches, as well as an identification of opportunities for how the health needs of children and young people in the child protection system can be better assessed and managed. This discussion forms the basis of the next two chapters.

3 What is working well

This chapter reports on what is working well across different jurisdictions. It draws on consultation data and input from the Expert Reference Group.

Key Points

There are instances of good practice in the implementation of state and territory approaches to assessing and managing the health needs of children and young people in OoHC.

These instances have included:

- providing for more coordinated and integrated responses, with clearly established roles and responsibilities at a strategic level, as well as the deployment of key coordinator roles to drive operational coordination between child protection and health services;
- planning for area based approaches of service provision that reflect local need and demand;
- prioritising of health access for the OoHC population; and
- engagement of health professionals and General Practitioners with appropriate communication, resources and training.
- Instances of good practice in the tracking of health histories has included:
- enabling robust information sharing regimes between sectors;
- clear case management arrangements; and
- providing support and training for child protection practitioners.

3.1 Health assessments and interventions

As outlined in the previous chapter, jurisdictions have implemented, or are implementing, locally determined approaches to providing health assessments and interventions for children and young people in OoHC. From the consultation data collected through the project, a number of instances of good practice and enablers for good health outcomes were identified. These practices can be grouped under the following categories.

- Coordination and integration
- Differentiated area based responses
- Prioritisation
- Engagement of health professionals.

Coordination and integration

Provision of health assessments to children and young people necessitates a degree of coordination between the child protection practitioners and health professionals. If this is to occur beyond just a localised level, it also requires a degree of deliberate coordination at a policy and systems level.

Discussion of the extent to which coordination and integration at a policy and systems level, and at an operational level is occurring, is provided below.

Policy and systems coordination and integration

Clearly established leadership, governance and accountability are critical enablers to a coordinated policy response to health assessments and interventions. This is evident in those jurisdictions where policy responses have moved beyond a case by case or ad hoc approach to a more systems-wide approach. Distinguishing features of coordinated and integrated policy and systems responses include the following.

- Establishment of senior interagency bodies to ensure leadership and authority, promote communication, and to drive reporting and accountability mechanisms.
- Outlining of clear roles and relationships between child protection and health departments. In some jurisdictions this has involved the development of jurisdictional specific clinical practice guidelines.

One jurisdictional example of efforts to underpin policy and systems coordination and integration is provided in Box 2.

Box 2 Supporting coordination, responsibility and accountability

The memorandum of understanding (MoU) between the New South Wales Departments of Health, and Family and Community Services, provides principles and direction to staff across both agencies to facilitate timely access to appropriate health services for children and young people in OoHC.

Key features of the MoU include:

- outlining key guiding principles that clearly establish a shared responsibility among government and non-government agencies, and the community, including parents and carers;
- establishing agreed processes for referral pathways, communication across services, sharing of information, as well as monitoring and review of client progress through the service system;
- agreement on the approach to implementing and reviewing Health Management Plans, ensuring that Health participate in the coordination and planning of responses to health needs; and
- strong governance arrangements to ensure the MoU is implemented, monitored, and reviewed.

Source: MoU between NSW Department of Family and Community Services and NSW Health on health screening, assessment, intervention and review for children and young people in statutory OoHC

Operational coordination and integration

At an operational level, it is clear that dedicated liaison and coordinator roles are key to giving effect to the intent of different jurisdictional approaches. While there is some variation in their role and remit across those jurisdictions where they are employed, the intent is essentially the same namely, working across both service systems to make the connections necessary for a coordinated response.

Key features of these roles include:

- Established points of contact for child protection practitioners or health professionals to liaise with
- Ability for regional coordinators to work across local service systems and commence and support appropriate relationships between health services and child protection practitioners
- Enabling of appropriate information sharing across service systems
- Provision and capacity for monitoring and collection of data and evidence on health outcomes
- Capacity for training and awareness raising across service systems.

The recent introduction of regional coordinators in Victoria is of interest for its systematic and regional approach as well as the opportunity to facilitate assessments and interventions through these positions (see Box 3).

Box 3 The value of coordinator roles

In Victoria, regional Health and Education Coordinators have recently been appointed across the state to facilitate education and health assessments for children and young people currently placed in residential care. The coordinators play a role in:

- coordination of different service systems;
- monitoring and tracking; and
- capacity to facilitate more timely access to health services and treatment.

The coordinators work across the local health, child protection and non-government service systems in their region, engaging relevant stakeholders and their capacity and appropriateness to work with the client group, and facilitating connections between them.

Though they are a relatively new position, the coordinators are in a position to track and monitor client access and progress through the health system. They are well placed to collect data and information on the clients and health outcomes, informing the evidence base.

The coordinators also manage an allocation of brokerage funds that can be used to fund follow up treatment arising from health assessments, as well as accessing private practitioners to ensure a more timely access of health services.

Source: Victorian consultation data

Among non-government organisation providers of OoHC services who were consulted with during the project, the extent to which case management roles and responsibilities are clearly established appears to be the major enabler to their involvement in addressing and managing health needs of children and young people.

In those jurisdictions where non-government organisations have a lead or critical role in case management, it was evident that there was:

- Greater engagement and collaboration between child protection workers and non-government organisation case managers
- Supporting case management approaches and tools, such as the Looking After Children (LAC) Framework

- Strong local relationships with health services accustomed to working with children and young people who have experienced trauma, abuse or neglect.

For non-government organisations responsible for the placement of Aboriginal children and young people, Aboriginal Health Services are key platforms for providing a range of services to Aboriginal children and young people. In one sense they represent a far more established service option and pathway than the various models that jurisdictions are currently developing. There is also significant use of existing MBS items (including population specific items) to enable appropriate health assessments and interventions.

Differentiated responses

Where they exist, the appointment of regional coordinators has also led to improved capacity for area based and differentiated responses, informed by the capacity of the local service systems and local arrangements. They reflect a ground up approach, seeking to build or leverage off existing service capacity rather than impose a prescribed and inflexible response.

In Victoria, a trial model using an identified network of local GPs and health services is being implemented in the north and western suburbs of Melbourne. Box 4 outlines the key features of this service delivery model.

Box 4 Area based and differentiated responses

Victoria's Pathway to Good Health Model provides a clinical pathway that has been tailored to the specific health needs of vulnerable children and young people in OoHC. It utilises local health professionals and infrastructure in the area to provide a tailored but systemic response for this population group.

The clinical pathway of care has been modelled on evidence and the National Clinical Assessment Framework, and comprises:

- utilisation of the local General Practice platform for the initial health check;
- comprehensive multi-disciplinary health assessment led by a paediatrician;
- development of a Health Management Plan; and
- regular and ongoing review of the child's health needs.

The model is being trialled in the North-West of Melbourne, and has strong links to existing health infrastructure including the Royal Children's Hospital, and has engaged with each of the four different Medicare Locals that comprise the trial site catchment. The area also has a significant cohort of OoHC clients.

General Practitioner engagement has been sustained through extensive work from the Health and Education coordinators employed through the Department of Human Services, and a project coordinator that sits within the Department of Health.

Source: Victorian consultation data

Another variation on differentiated responses is the provision of health service environments tailored to the needs of adolescents in OoHC. This client group was seen as particularly difficult to engage with relevant health treatment and services. In some jurisdictions, specific multidisciplinary drop in health centres have been established or existing youth health

services utilised in an attempt to address this issue. These are youth friendly environments where adolescents are able to engage with a range of different health services and treatment in the one visit.

Prioritisation

Reflecting the established evidence on the particular health needs of children in the OoHC system (RACP 2006), some jurisdictions have embedded the OoHC population as a health priority group, making provision for priority access to the public health system or to particular parts of it, like child and adolescent mental health services, or public dental services.

The South Australian model of priority access, enabled through 'rapid response' is outlined in Box 5.

Box 5 Prioritising the health needs of children and young people in OoHC

South Australia's Rapid Response Service Framework was released in 2005 and is designed to ensure children and young people placed in OoHC on guardianship orders are prioritised for the services and supports that most families are able to access.

Rapid Response draws on research and evidence that demonstrates children and young people removed from their biological parents are likely to have experienced significant trauma, abuse or neglect leading to significant disadvantage and poor life outcomes.

Accordingly, Rapid Response provides for a coordinated response between Families SA and Health SA that prioritises access to public health services within prescribed timeframes, enables appropriate information sharing, provides for holistic and multidisciplinary responses, and for services to be provided in a manner that is tailored to specific health needs and to the child or young person's background and circumstances.

Sources: South Australian Government 2007. Children, Youth and Women's Health Service. Health standards for children and young people under the guardianship of the Minister; consultation data

Engagement of health professionals

In most jurisdictions, there has been significant effort to engage health professionals, particularly General Practitioners, in the development and implementation of jurisdictional approaches.

Where this has met with success, it has been underpinned by the identification of GPs who are prepared to engage and work with children and young people who have experienced trauma, abuse or neglect, and the provision of training and resource guides to support them to work effectively with this client group.

3.2 Tracking health histories

A number of jurisdictions indicated that they are currently exploring the potential of electronic health records for children and young people in OoHC. As described in the previous chapter, each jurisdiction has developed an approach to tracking health histories that uses a mixture of paper-based health records and modification of child protection case management systems.

Without commenting on the overall efficacy of these hybrid approaches, instances of good practice identified among some states and territories are detailed below.

- Information sharing – a number of jurisdictions have clearly established legislative and policy frameworks to enable timely sharing of health information and records across agencies.
- Clear case management – where case management responsibilities are clearly established, there is evidence of good case work and practice. This includes the establishment of regular case conferencing involving health professionals in collaborative decision making discussions about the health needs of children and young people, and the shared management of their health records.
- Support and training – child protection practitioners are trained and skilled in the conduct of forensic investigation of suspected child neglect or abuse, not necessarily in the maintenance and tracking of health records and histories. Accordingly, some jurisdictions have established specific training and support for their workforce to support this activity.

3.3 Summary

Implementation of the various state and territory approaches to assessing and managing health needs of children and young people in OoHC is varied, and ongoing. While jurisdictions continue to experience a range of significant issues (examined in the next chapter) in implementing health assessments and interventions, there have also been important policy and service successes. These include the following.

- The establishment of clearly articulated structures and mechanisms to underpin service system coordination and integration.
- New resources and capacity to drive operational, on the ground coordination and collaboration which is essential to give effect to systems coordination. Health and child protection responses operate in resource constrained environments. The capacity to work together effectively is unlikely to occur without additional and dedicated effort to operationalise coordination.
- Differentiated area based responses enable localised responses that build and leverage off the existing service system.
- Non-government organisations are well placed to at least assist and potentially lead the management of health needs of their clients. They have a different operational focus to statutory child protection agencies, but need clearly defined case management roles and responsibilities, and appropriate tools and processes to support them.
- There are models of priority access that have been implemented successfully across some jurisdictions.
- Training and support can enable greater engagement and buy in of health professionals and General Practitioners.

These key learnings should be used to further inform and improve policy and operational responses.

4 Issues and options

This chapter reports on the challenges and opportunities identified by jurisdictions. It draws on consultation data and advice of the Expert Reference Group.

Key points

- Attempts to implement approaches to assessing and managing the health needs of children and young people in OoHC have shown a range of issues and challenges. Fundamental to these are systems design and capacity issues.
- There are a range of options to improve consistency in providing the scope of recommended health assessments in a timely and effective manner. These include options to improve:
    - access, including equity of access, to health services;
    - continuity of health care, health safety and optimal use of resources through more effective tracking of health histories; and
    - knowledge and understanding among health care staff and service providers, including carers.

4.1 Key themes

While there is evidence of good practice outlined in the previous chapter, a range of issues continue to challenge state and territory implementation of consistent policy and practice that best addresses and manages the health needs of children and young people in OoHC.

There are a number of different approaches currently implemented or being implemented by individual jurisdictions, however, there are fundamental systems design and capacity issues common to many of the states and territories that impact on effective implementation of the Framework.

These issues fall under a number of key themes that have arisen in particular from consultation feedback and the input of the project Expert Reference Group (see Attachment C for a summary of outcomes from the Expert Reference Group meeting). These themes are concerned with:

- Access to health services, including equity of access
- Tracking health histories
- Workforce skills and training.

The following discusses the issues under each of these themes and presents options for addressing the issues. The themes are not discrete and options proposed in one area may also have an impact on other areas, for example, improvement of skills and training is likely to underpin system capacity and capability benefitting service access and ability to track health histories. . An assessment of the feasibility and resource implications of the options is provided for the more ambitious or resource intensive propositions. For some options requiring further investigation an indication is provided of the further work that might be undertaken.

4.2 Access to health services

The coordination and design of a policy response that in effect attempts to replicate the role of an informed and capable parent or caregiver looking after their own child is challenged by the structural and system differences between child protection agencies and the health

sector. The National Clinical Assessment Framework anticipates a need to ‘broker’ the interface between the sectors with the inclusion of the role of Care Coordinator Health in the core elements of the approach to health assessments and interventions.

Attempts to coordinate an effective and timely response between the health and child protection service systems are impacted in practice by the following key issues.

- Navigation between and through each service system – The structure of child protection and health service systems are very different to each other. At a structural level, child protection regimes are traditionally centrally coordinated and controlled, whereas public health service systems are more devolved. The private health system is even further removed from direct intervention and coordination. For practitioners and professionals, each service system is largely alien to the other. The consequences of these structural differences can include poor navigation of the health system and referral pathways by child protection practitioners and carers, and inadequate sharing of information and health histories between the two service systems.
- Disconnect between design and practice – The experience of professionals and practitioners working on the ground, is one where there appears little understanding at a policy making and design level, of the operational issues associated with collecting health histories and coordinating health assessments for children and young people in OoHC. Some of the difficulties experienced by child protection practitioners and health professionals include finding the time and resourcing to conduct required administrative work, collaborate with other health professionals, undertake and monitor referrals, and document outcomes from assessments and interventions.
- Operational barriers – Significant reforms over the past decade across Australia have seen child protection operating systems become increasingly attuned to more holistic practice, incorporating concepts such as ‘cumulative harm’ into operational frameworks has extended the focus of child protection work, much of which is on the investigation of allegations of harm or abuse, the collection of evidence and ultimately the protection of children and young people from harm. However, in the course of an investigation and subsequent placement, indicators of health issues or health needs of a child or young person may not be immediately apparent to a child protection practitioner or carer. This may occur because of difficulty in locating or transferring a child’s health information or because of a tendency to under-report health concerns or needs (CHWS 2011).
- Demand and workload issues – The demands made on child protection practitioners are well documented. Across jurisdictions, heavy workloads and significant staff turnover issues can contribute to stressed work environments and inhibit the ability of child protection practitioners to move beyond responding to immediate safety concerns.
- Timeliness and responsiveness – Children and young people in OoHC can experience significant wait times in accessing specialist and allied health services. There are a number of reasons contributing to this. The most significant is the availability of health professionals able to work with children and young people who have trauma-related behavioural issues. This is a particular issue in rural and remote parts of Australia, where costs and timing factors associated with travel,

accommodation, and outreach and sessional visits can all impact on the timeliness and responsiveness of health treatment.

The need to coordinate multidisciplinary responses and treatment adds another layer of complexity that impacts how quickly children and young people can access services.

The capacity of the public health sector, particularly in some specialist and allied health service areas, to respond in a timely and responsive manner was questioned by some stakeholders engaged during the project, with significant wait times reported across many jurisdictions, including those that prioritised access to the public health system.

Equity of access

Equitable access to health services challenged implementation of the National Clinical Assessment Framework. The following barriers to implementation were sighted.

- Cost – There are significant cost issues associated with accessing some health professionals and specialists, such as dental care. This is a particular issue for foster and kinship carers who will have limited resources and capacity to access some treatment, particularly from private practitioners.
- Access to services in rural and regional Australia – Adequate and appropriate health services for children and young people living in regional and remote areas of Australia are being particularly impacted by the health workforce issues experienced by many professions across the health industry. Where special arrangements have been made to enhance access to certain categories of health professionals, these should also be considered for their relevance to the needs of the OoHC population and the importance of retaining/enhancing access.
- MBS items – There is varied use of MBS items by health professionals in the provision of health checks and assessments. This is influenced in part by arrangements in place to secure access to health assessments and interventions as well as the availability of health professionals sufficiently skilled to work with the OoHC population. Notwithstanding the mapping of relevant MBS items in the National Clinical Assessment Framework, it is not clear how effective this has been in driving awareness and use of the items for the particular purpose of providing health checks and assessments for children and young people in OoHC. The issue of a dedicated MBS item is discussed under option 4 below.
- Access to treatment service – opportunity afforded through the roll out of the National Broadband Network should be explored to consider the appropriateness of models of telehealth that could be offered for rural and remote clients. Skilling up of the allied health platform is another option to consider in expanding access options for children and young people living in regional and remote parts of Australia.
- There is an opportunity to achieve greater consistency in implementation of the National Clinical Assessment Framework by building on what has worked well in some jurisdictions to reinforce the priority of early intervention in health. In this regard, enablers have included whole-of-government policy that reinforces the state's commitment to prioritising health access for this defined group of vulnerable and disadvantaged children and young people, additional capacity to coordinate health care within and across sectors and strengthened planning to secure access to appropriate services at the local level.

Option 1: Implement an inter-sectoral agreement that establishes a whole-of-government commitment in each state and territory to priority access to health services for children and young people in OoHC.

Problem

Most states report difficulties experienced in accessing health services especially specialist health services that can impact on timely health assessments and interventions for children and young people in OoHC. Access problems can relate to long wait times in the public health system and to insufficient treatment services. Delays in accessing services can range from 6 to 18 months or longer. Access issues are especially problematic in rural and remote areas that rely on services provided on a sessional or visiting basis.

Jurisdictions have responded in a range of ways to access issues including establishment of dedicated hospital clinics, provision for brokerage to secure private health services in some circumstances, dedicated multi-disciplinary clinical support teams to receive referrals for severe and complex needs, and testing of service models that tailor integrated and coordinated health services. Many of these initiatives require further development to provide coverage state-wide and across the continuum of care.

The delay in obtaining access to health services for the child or young person has the potential to undermine ongoing efforts to support placement stability and reunification with parents.

Importance

A key objective of the National Clinical Assessment Framework is to improve the consistency of health care assessments and services for children in OoHC provided by states and territories. A tiered approach to comprehensive and timely assessment, treatment and management has been developed that aligns to the public health model that underpins the National Framework for Protecting Australia's Children. The approach is informed by the evidence about the high prevalence of health problems among children and young people in OoHC that is often 'unrecognised and unmet' (CHWS 2011).

Effective implementation of the National Clinical Assessment Framework, therefore, requires timely access to a range of health services appropriate to the physical, developmental and emotional health problems prevalent in this vulnerable group.

Formalising arrangements that facilitate action across sectors will provide mechanisms to support access to appropriate services and give effect to early and quality health interventions. Under these arrangements it is possible to clarify the role and responsibility of agencies, give effect to development and monitoring of initiatives through inter-sectoral governance arrangements and critically, establish a level of health priority for children and young people in OoHC.

Implementation responsibility

Intention to seek a whole-of-government commitment to underpin implementation of the National Clinical Assessment Framework could be a collective undertaking of Community and Disability Services Ministers with action to be taken at the individual state and territory level, where a jurisdictional policy is not already in place.

Implementation

There was support from stakeholders consulted and from the Expert Reference Group for a whole-of-government arrangement in each state and territory that reinforces the continuing commitment of governments to the National Framework for Protecting Australia's Children for Protecting Australia's Children 2009-2020 (COAG 2009) and specifically facilitates access to health services by children and young people in child protection. Such an arrangement exists in South Australia and Western Australia under their respective Cabinet-endorsed Rapid Response policies. These policies vary in their specificity about the nature of the health service but share a focus on ensuring timely and coordinated access to government services needed by children and young people in care and recognise the need for comprehensive and quality assessments.

The joint agreement would include areas of government with an involvement in implementation of the National Framework for Protecting Australia's Children including child protection, health and education.

All jurisdictions will benefit from a joint policy statement on this matter, where a policy is not already in place. For some jurisdictions it will reinforce existing joint work enabled, for example, through memorandum of understanding or specialist health teams. For others it has the potential to provide the stimulus for greater consistency of effort across the jurisdiction and integration with the wider needs of the OoHC population and their carers.

Timeframe

With the growth in OoHC placements and the increase in complex behaviours of children and young people in OoHC, it would be beneficial for governments to give effect to a whole-of-government agreement in the short term.

Option 2: Provide a dedicated coordinator role at a system and regional level that facilitates integration across health, child protection and education sectors.

Problem

Working across different sectors to enable referral, assessment, treatment and ongoing management of a child or young person in OoHC has been problematic where this has been left to be absorbed into existing responsibilities. Implementation challenges have included work priorities, understanding of service systems, communication breakdown due to changes in the child's case worker or placement, poor transfer of health history and assessment outcomes, and referrals not followed through.

Based on the experiences of a number of jurisdictions about what works well, it is evident that the roll out of coordinator positions has been instrumental in building system capability in the health, child protection and education areas. The coordinator role effectively gives priority attention to implementation of the National Clinical Assessment Framework in an environment where carers, case workers and health service providers are time poor and not well placed to forge the pathways needed to implement consistent and sustainable health assessments and interventions.

Importance

Limited coordination and information sharing between service providers was identified in the development of the National Clinical Assessment Framework as a contributor to the inadequate health care received by children and young people in OoHC. To overcome this problem, the National Clinical Assessment Framework approach to health assessments specifies a nominated position with the responsibility for ensuring 'assessments occur, referrals to specialist services are made and that there is continuity of information and services following placement change'. Collecting and sharing of information is important to quality of assessments, development and maintenance of a child or young person's Health Management Plan and assessment of improved health outcomes.

The National Clinical Assessment Framework calls for active coordination to support complementary and systematic planning amongst key parties that include the agency case worker, carer, child or young person, care coordinator and the school principal and teachers where appropriate. The different models for OoHC provide an added layer of complexity to interactions between child protection, health and education sectors, and the development of effective pathways to health services.

The need for an efficient and effective way of facilitating access to health assessments and follow up services is recognised by jurisdictions. This has implications at system and regional levels in strategic service planning and in matching need to local resources. Providing this additional coordination capacity has the potential to extend the child protection response to support the medium and longer term health needs of children and young people, to better leverage health services to ensure access to appropriate assessments and interventions, and to facilitate timely access to services.

Where designated coordinator positions exist, they have provided a consistent, single point of contact and are better understood as a change agent and coordinator rather than service provider. The Expert Reference Group assigned a higher priority to coordination that established shared ownership and accountability for the OoHC population across child protection, health and education with coordinator positions to be identified in each of these sectors.

Implementation responsibility

There would be value in Community and Disability Services Ministers reaffirming the central importance of active coordination to facilitate health assessments and interventions, and agreeing that dedicated positions for this purpose are desirable to drive improvements.

Individual states and territories will be responsible for reviewing and making any changes necessary to their current arrangements. This review should be led by community services in conjunction with health and education sectors.

Implementation

Current approaches to coordination vary across jurisdictions and in some instances, within jurisdictions.

Coordination may occur through an inter-government steering committee or working group and may engage a range of agencies or be restricted to health and family/community services. Other models include a health-led coordination once a GP has made a referral to a comprehensive assessment and use of a virtual or generic child protection liaison officer.

Coordination also occurs through local networks associated with multi-disciplinary health teams.

A comprehensive whole-of-jurisdiction approach is taken in the Australian Capital Territory, New South Wales and Victoria. In the Australian Capital Territory, this approach provides for a coordinator or liaison role in both the health and child protection areas.

In Victoria, specialist positions exist within community services at the area or regional level supporting interagency collaboration, development of local service delivery models and promoting good practice. The model includes brokerage funds supplementing existing system supports. The additional brokerage funds provide the child or young person with access to the private sector as necessary and cover the cost of out-of-pocket expenses associated with follow-up specialist treatment. In addition, central office coordinator roles exist in community services and health associated with a Victorian pilot program modelled on the National Clinical Assessment Framework but with the functions absorbed into existing positions.

In New South Wales, specialist positions were established at the regional level within health and community services to support interagency collaboration and the implementation of the health assessment and intervention process at the local level. The Interagency Pathways Coordinator positions within the Community Services sector existed in New South Wales until recently. FACS districts developed transition plans for embedding the work of their coordinator positions into local practice. The NSW Health OOHC Coordinator positions remain in place.

The coordinator role should include planning the process of health assessments and interventions, supporting implementation (including through training), monitoring and reporting. Ideally coordination should occur in and across the health and child protection sectors, connecting to other related areas such as education, and have a dedicated capacity at area or regional levels in each of the health and community services sectors.

Implications

Using the example of the State-wide Health and Education Assessments Project operating in Victoria ($12 million over four years), the equivalent of 0.5 EFT has been funded by the Victorian Government to coordinate health assessments and interventions in each of eight community services locations across the state. The positions have annual brokerage funds of $1,500 per child with the total budget calculated for each location according to the average number of children in residential care over a three-month period. The funding for the local coordinators includes resources for research and evaluation associated with the project.

The New South Wales model, Model Pathway for the Comprehensive Health and Developmental Assessments for Children and Young People Entering Out of Home Care, had specialist coordinator positions at the local level in both the health and community services areas. The NSW Government allocated $3 million in 2010 and $12 million over four years to the coordination of health assessments and interventions. Funding for community services positions ceased in June 2013. The funding had allowed for nine full-time interagency coordinators to be located in the seven community services regions across the

state, with an annual salary of approximately $82,000 to $91,000. Eleven coordinators remain employed in the health sector.

There remain substantial challenges to implementing the National Clinical Assessment Framework. An effective response will require additional system capacity in most jurisdictions to coordinate multiple stakeholders and issues. This investment has the potential to deliver significant benefits as a key enabler in securing access to health assessments and quality health care, and promoting a culture of collaboration to protect the rights of children and young people in OoHC.

Timeframe

This option has resource implications and is likely to be achievable in the medium term.

Further work

Consideration of this option will require that jurisdictions assess their current arrangements for coordination of health assessments and interventions with a view to determining an appropriate model consistent with the role envisaged in the National Clinical Assessment Framework, where this is not already in place. The aim of any new model would be to ensure that it delivers a sufficient coverage and that the role is clearly dedicated to building system capacity.

Option 3: Medicare Locals are engaged to assist in securing the mix and quality of primary health care services required for effective implementation of the National Clinical Assessment Framework

Problem

While the National Clinical Assessment Framework provides a structured approach to comprehensive health assessments and referrals, it does not account for the potential difficulties inherent in the layers of system responsibility for child protection, processes for health treatment approvals, health practitioner competency and geographical variation in provider availability.

Consultation feedback from agencies supporting carers and from community services officers in a number of jurisdictions indicates that individual agencies are sometimes negotiating urgently required specialist services and more generally, that there are long wait times for specialist services, such as paediatricians, psychologists and speech therapists.

For some jurisdictions, the community services sector has struggled to find appropriate entry points to discussing local health care needs with representative organisations, such as Medicare Locals. These needs also include a systematic approach to identifying general practitioners to undertake the initial assessment, which may extend over several appointments, and appropriate arrangements for children or young people from families with culturally and linguistically diverse backgrounds for whom mainstream services may not be acceptable.

In addition, equity of access is a problem in rural and remote areas, in particular for some specialist services. Telehealth and strengthening of allied health to provide a platform for health assessments and interventions are strategies supported by the Expert Reference Group to address the poor access to these services.

Importance

Ensuring a clear pathway to the suite of services required to systematically and equitably offer quality, consistent and appropriate health care for children and young people in child protection is essential to achieving the objectives of the National Clinical Assessment Framework and the National Standards for Out-of-Home Care.

Medicare Locals potentially provide a key point of reference to improving access to health practitioners, skills development and prioritising of children and young people in the child protection system. While Medicare Locals are in the early stages of establishment, they represent an important network for harnessing resources to meet the health needs of the OoHC population. They also offer a potential platform for improving access to the suite of services needed to implement the National Clinical Assessment Framework, especially in regional and remote communities. A bottom up as well as a top down approach will be important to realising and building on local innovation while wider system enablers are being explored.

There have been differing levels of awareness and success experienced in engaging with Medicare Locals on the responsiveness of primary health care to local need. For example, work is underway in Victoria on the development in conjunction with Medicare Locals and General Practice Victoria on the provision of training for GPs in an accessible format regarding children at risk. The broader opportunity to incorporate the health needs of the OoHC population into mapping of local primary healthcare needs, service planning and capacity building would support local priority and facilitate access to health assessment and interventions.

The Expert Reference Group gave a high priority to exploring the potential of Medicare Locals as a platform to drive education, awareness and training requirements, and promote local collaboration between the primary health care sector and child protection agencies.

Responsibility for implementation

Discussions about engagement with Medicare Locals would be led by the Australian Government Department of Health and Ageing in collaboration with the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs and in consultation with the Australian Medicare Local Alliance.

Implementation

There are opportunities to leverage from existing health planning mechanisms and innovative solutions to support the development of accessible quality services in primary health care that are differentiated and area based. These mechanisms would support the work of coordinators aiming to identify health care service providers able to respond to the needs of the OoHC population. Such a response would have regard for the supply of health services and the level of understanding and competencies of available providers to meet diverse and complex needs.

The Medicare Local network of primary health care organisations across Australia has the potential to drive planning for local health care pathways to effective implementation of the National Clinical Assessment Framework. Medicare Locals have a National Compact with the Australian Medicare Local Alliance, which provides a leadership and advocacy role and the opportunity to provide consistency in ‘generating and advocating new policy and program

solutions'. A shared goal under the National Compact is a commitment to 'improving access and reducing inequity'. The Australian Government has established 61 Medicare Locals in Australia to plan and fund extra health services.

Recognising the initial collaborations in some jurisdictions with Medicare Locals and the importance of further exploring these opportunities, in the first instance, there would be value in national engagement with Medicare Locals through the Australian Medicare Local Alliance. Such an engagement could scope the nature of the health service needs for the OoHC population, highlight the emphasis of the National Clinical Assessment Framework on early and sustainable intervention, and describe the access and equity issues for carers and support agencies. These discussions could explore the nature of the Alliance's potential involvement, such as advocacy within the network for local teams to facilitate comprehensive assessments.

Implications

A national, state-wide and regional approach to accessing Medicare Locals has the potential to ensure an efficient approach to planning and innovation to overcome health service gaps and improve service responsiveness. Medicare Locals have the potential to offer significant local support in ensuring pathways to services that map to the National Clinical Assessment Framework.

Timeframe

Exploratory discussions could commence in the short term. Implementing alliances, establishing pathways and investigating access solutions would take place over the medium to longer term.

Option 4: Establish a dedicated MBS Item for the preliminary health check to address issues associated with the complexity of the service response required.

Problem

The need for a dedicated MBS item for health checks and assessments was a consistent point of discussion throughout the project.

A number of jurisdictions have reported that the level of reimbursement for health assessments currently available under MBS items has not been sufficient to recompense GPs and others in the public system for the extra time and skill involved in assessing and managing the health needs of the OoHC population. This has resulted in one state experiencing difficulty in recruiting health professionals to programs designed to facilitate access to health assessments and interventions.

Financial costs are cited by a number of jurisdictions as presenting barriers to engagement of private practitioners to conduct medical assessments. In some instances this has required the jurisdiction to support the carer by meeting the gap between fees charged and reimbursement under the MBS. The comparison is provided of the discretion available to the health professional providing an assessment for an Indigenous child or young person to bulk bill using either of the enhanced care items available for this purpose, as opposed to assessments provided for a non-Indigenous child or young person of a similar age range because of a lack of an equivalent or dedicated MBS item.

Impediments to a dedicated MBS item would appear to centre on the maturity of the model for health assessments and interventions, especially the need to demonstrate effective referrals of OoHC children and young people to the health system and a sufficient supply of trained GPs to take up the item. There is also little evidence of the value of health assessments to the long term health outcomes of the OoHC population, which limits the economic argument for potentially incurring increased costs through a dedicated item.

The National Clinical Assessment Framework outlines an approach to clinical assessments and interventions for the OoHC population, however, jurisdictions highlight the need for greater consistency in the level and type of assessment undertaken by GPs and in reporting. There is a strong view that a specific MBS item would take into account the complexity of the service response required and provide a consistent approach in this area both within and between jurisdictions, and enable effective and evidence-based approaches to implementation of the National Clinical Assessment Framework.

Importance

The National Clinical Assessment Framework responds to the evidence that children and young people in OoHC 'are a highly vulnerable group with increased physical, mental and social health needs and with limited access to resources'. The advice provided under the National Clinical Assessment Framework describes complex behaviours and circumstances that need skilled, comprehensive and timely health intervention. The approach set out in the National Clinical Assessment Framework is based on good practice with a view to delivering improved health outcomes and life opportunities to children and young people in OoHC. Many jurisdictions maintain that a dedicated MBS item would contribute to the effective implementation of the National Clinical Assessment Framework and strengthen the engagement of health practitioners.

Implementation responsibility

Further consideration of this option would need to be agreed by the Standing Council on Community and Disability Services and the matter referred to the Standing Council on Health.

Implementation

There are a number of precedents for a population based rather than illness/disease based approach under Medicare. A selection of MBS items targeting specific population groups and cohorts includes:

- Aboriginal and Torres Strait Islander Child Health Check
- Health Assessment for Refugees and other Humanitarian Entrants
- Helping Children with Autism
- Better Start for Children with Disability.

This approach recognises the priority given by governments to the health needs of certain vulnerable and disadvantaged population groups and reinforces the likely established health needs of these groups. They may also suggest a degree of complexity and skill associated with effective service response to potential health needs.

Based on the experiences of jurisdictions during the initial implementation phase of the National Clinical Assessment Framework, a dedicated MBS item would potentially improve

equity of access where level of reimbursement is acting as a disincentive to GP participation. Such an item would also have the potential to encourage development of nationally consistent tools to support quality assessments and require the skills to manage the health needs of the OoHC population.

A dedicated MBS item would be one of a suite of strategies to support effective implementation of the National Clinical Assessment Framework, however, with other strategies relating to: education and training of all stakeholders; a systemic approach to priority for health assessments and interventions; an efficient and effective approach to providing, reporting and maintaining health records; and generating the evidence to demonstrate impact of assessments on longer term health outcomes.

A dedicated MBS item would be scoped by the National Clinical Assessment Framework and allow for the preliminary health assessment on entry to OoHC. A fact sheet and tools to use in reporting on the assessment outcome would accompany the item and facilitate a consistent assessment process and reporting arrangement.

Implications

The cost of the dedicated MBS item can be estimated from the reimbursement currently available for a prolonged consultation associated with a health assessment, on the basis that costs are higher to provide the service to the OoHC population. The unit cost is $263.55 and the numbers accessing the assessment is estimated at 12,240 representing the full number of children admitted to OoHC in 2011-12. Assuming all assessments are undertaken by a GP (an inflated assumption), this suggests that the annual cost to Medicare of reimbursement for a preliminary health assessment could be of the order of $3.2 million annually. This cost is partially offset as a new cost if the existing use of MBS items by GPs providing health assessments to children from OoHC is taken into account. Extending preliminary health assessment to all children in OoHC would be phased and have a one-off effect. There are approximately 40,000 children and young people in OoHC.

Timeframe

Should this option have merit it would be achievable in the medium term. Progress would require further work through the Expert Reference Group.

4.3 Tracking health histories

Availability of health histories is an important contributor to health assessments and interventions. Health histories support continuity of health care, health safety, making the best use of health and child protection resources, responding appropriately to the child or young person and involving them and/or their carer in decisions about management of their health needs. Similarly, whilst residing in out-of-home care, a seamless generation, recording and transfer of health information is required to track the initial health assessments, facilitate referrals and monitor annual check ups. Such a comprehensive and current record will also provide the basis for the personal health record to accompany the child or young person.

All jurisdictions have a central administrative child protection database that includes health information. However the range of health information captured varies, as does the consistency in data entry. Health histories are maintained by child protection practitioners who may not have all of the relevant health information on hand. There is no capacity for

child protection and health information systems to interact with each other. Accordingly the health histories recorded in the child protection databases can often be incomplete.

In Queensland and Western Australia, a child health passport is provided to carers at the commencement of placements and in some other jurisdictions, forms containing health information are completed for placements supported by non-government agencies. This information can be limited and can require follow up with carers and the health sector by the agency to enable effective monitoring of health needs.

A number of strategies have been adopted by jurisdictions to improve routine access to health histories and assessment outcomes. For example, Tasmania has put in place data exchange protocols to share data across public health services and child protection authorities. In a number of jurisdictions, such as the ACT, there is enabling legislation to allow access to health information for children and young people under court orders. In New South Wales, a Health Referral form has been agreed between community services and health, with mandatory fields. There is also legislative provision requiring prescribed bodies (including NSW Health) to communicate with each other to facilitate the provision of services to children and young people, which can assist in tracking medical histories of children and young people in OoHC.

There are a number of trial programs to overcome problems of capture, consistent recording and retrieval of health information. These include work in Victoria to develop a web-based electronic record for participating health professionals to upload comments, outcomes and referrals for OoHC children and young people they are treating. The program functionality includes the generation of management plans for differing audiences. In Western Australia, a centralised electronic health system is being developed for children and young people, initially in the metropolitan area.

Option 5: Priority development and implementation of national eHealth technology tailored to the health information needs of children and young people in OoHC.

Problem

A key issue for tracking health histories is gaining a comprehensive health history of a child or young person before, during and after their time in OoHC. In practice, this can be a significant challenge because of the child or young person's history of neglect when entering OoHC and the reliance on reporting of the outcomes of health assessments and any follow up treatment.

While the health history relates to the delivery and outcomes of health services, there are multiple methods and sources for capturing and recording this information within the child protection system with a high probability of information gaps. Any written records of preventative health services such as immunisation and dental health care are likely to be unavailable for transfer to case workers or agencies whee these services might have been accessed. Where the public health system has been utilised, there may be records that can be compiled for the case worker. In most instances, however, this is not a straightforward process and can hamper effective health assessments.

Recording, sharing and maintaining health history while the child or young person is in care may be hampered by child protection and health system limitations, the lower priority given to a comprehensive history in part because of a lack of understanding and time constraints, and mobility of the child or young person including placement breakdown.

Incidences were reported of young adults previously in care returning to care support agencies to access their files for information about decisions made on their behalf including their health history.

Importance

A key principle of the National Clinical Assessment Framework is that health information is recorded and accessible to the child or young person, health providers and carers. It is intended that this information inform future health assessments and contribute to placement decisions.

The National Clinical Assessment Framework also recommends that each jurisdiction develops a Health Management Plan to form part of the child's overall care plan. The Plan is seen as a 'key component to facilitate coordination and continuity of care' and represents a comprehensive health record of the child or young person's health status and identified needs, as informed by clinical assessments

Performance on effective implementation of the National Clinical Assessment Framework needs to be measured as a significant national initiative in early intervention to improve outcomes for children and young people in child protection. Standard 5 of the National Standards for out-of-home care (FaHCSIA 2011) is focused on professional assessment of health needs (both preliminary and comprehensive), referral to specialist services as appropriate and a written health record that accompanies children and young people. The proposed measure for the Standard is the number and proportion of those entering out-of-home care who have an initial (preliminary) health check within a specified period. This measure is to be reported from 2014, based on 2012-13 administrative data and agreed definitions, data collection and reporting arrangements for at least four jurisdictions. Further development of measures for the National Standards foreshadows proposed new measures relating to comprehensive health assessments and attention to identified health needs. A proposed broad (and longer term) measure for development relates to reporting on health outcomes.

The data system to monitor implementation is effectively a subset of the overall care tracking system.

Implementation responsibility

Subject to the agreement of Ministers, implementation of this option could be through a joint reference of the Standing Council on Community and Disability Services and the Standing Council on Health to the Standing Committee on Child and Youth Health (SCCYH). The project could be oversighted by the SSCYH and implemented by a lead jurisdiction with suitable supporting project governance arrangements.

Implementation

There would be value in giving priority to development and implementation of national eHealth technology and generation of eHealth Records for the population of children and young people in out-of-home care. This approach has the potential to accommodate the range of health service providers, minimise the consequences of placement breakdown on continuity of information, embed the clinical assessments required under the National Clinical Assessment Framework and enable appropriate access to health histories to support care of the child or young person within the community services sector.

The eHealth Record can be populated by Medicare Australia information related to MBS items, medications and immunisation record. Registered health care providers can access the Record. There are currently 5,000 registered provider organisations. Some Medicare Locals and community health services are among the registered providers. All existing and future functionality would be available, such as the current development of nationally consistent tools to support national child health records.

A trial of eHealth technology for the OoHC population could be linked to current efforts in a number of jurisdictions relating to implementation of health assessments and interventions, such as the pilot of a web-based health information system in Victoria and the joint data strategy currently being developed in New South Wales. There may also be interest in this work in other jurisdiction where eHealth technology and the roll out of electronic personal health records is being pursued.

Similar eHealth trials have involved a governance group including a DoHA representative. Interested states and territories could form a reference group for the project. The trial would effectively build on the existing eHealth technology functionality to tailor priority information needs, identify common tools, such as reporting on health status and referrals, map the information flow and the group of potential providers and identify access issues. A lead agency would nominate to implement the pilot. There would also be value in exploring the opportunity to involve Medicare Locals to trial eHealth in specific locations.

Implications

EHealth is an innovative strategy that is in the early stages of development. Focussing on children in OoHC as a priority group for development and implementation will require commitment of additional dedicated resources. Initially this could be implemented as an extension to an existing jurisdictional electronic information development project. This would enable leverage from existing OoHC coordinator and/or project roles with additional funding for an expanded role and health based establishment support at least during the implementation phase.

There are significant benefits to be derived from enabling an accurate and comprehensive system of recording and tracking health histories for OoHC children and young people. This group is highly disadvantaged with increased vulnerability through gaps in their health information. Increased effort is required to provide improved health information that has a central point of access and is able to provide the best possible foundation for children and young people when they leave care. Investment in eHealth solutions for this priority population also has the potential to support better outcomes, for example, through electronic tag of records for those who have ever been placed in OoHC.

National consistency in reporting and storage of health information through the information required to populate an eHealth Record will benefit jurisdictions and program monitoring and review.

Timeframe

Given the opportunity to build on current efforts to improve tracking of health histories for children and young people in OoHC, and the considerable benefit to be gained from an effective process for recording and sharing health assessment and intervention outcomes, it is suggested that the developmental work for the eHealth trial be undertaken in the short term for implementation in the medium term.

Further work

There are a range of matters for further discussion if there is merit in this option. This includes hosting of the trial, funding and project governance arrangements.

Some of the 'technical' issues associated with the trial include the need to determine the circumstances in which the jurisdiction could either initiate an eHealth Record for a child under its care or obtain authority to be a nominated person and the extent to which that authority should extend to carer and carer support agencies.

4.4 Workforce skills and training

Health system capacity

Key challenges associated with the capacity of the current health system include the following.

- Adequacy of current and future skill sets – There is concern over the extent to which the current skill set of many General Practitioners, paediatricians and practice nurses, is sufficient to enable understanding, engagement and work with children and young people who have experienced trauma, abuse and neglect. There is also considerable concern about the ability of the current Medicare payment schedule to encourage and enable the development of the skills necessary to work with this client group.
- Engagement of children and young people who have experienced abuse, neglect and trauma – The extent to which health professionals effectively engage with children and young people with a history of trauma is dependent on more than just the skills of the practitioner. The health service setting and environment, and the skills and attitude of other staff, including practice nurse and reception are also critical determinants in how comfortable and willing children and young people will be to engage with the health service.
- Capability and skills – The non-government organisation sector is playing an increasingly significant and important role in the delivery of OoHC services. Staff and volunteer foster carers supported by these organisations have a critical role to play in supporting children and young people with a history of trauma, to engage and participate with health professionals and treatment. However the skills and capability of this workforce can be challenged by the increasingly complex children and young people in their care.
- Skills and training

- The unique needs of children and young people who have experienced trauma and neglect is demonstrated in the literature and accepted by Australian Governments. Accordingly the skills and training required to appropriately manage and address these needs should continue to inform ongoing policy development and implementation. Skills and training need opportunities are considered below.
- Aboriginal and Torres Strait Islander OoHC population – Given the over-representation of Aboriginal children in OoHC, and the demand placed on Aboriginal Community Controlled Organisations by mainstream service providers there is cause to investigate the development of trauma informed Indigenous healing approaches to health and wellbeing in consultation with Aboriginal health services providers.
- Health professional skills base – To ensure that the skill sets and competencies of the current health workforce are expanded on (or at the very least maintained), there was support from the Expert Reference Group for the development of health practitioner competencies that would support specialist training in the needs of children and young people in OoHC, and trauma informed health practice, and at the very least maintain a child centred focus among General Practitioners. The development of a professional framework to support clinical specialisation in these areas could also enable the accessing of new MBS items, should dedicated items be pursued.
- Support for carers and agencies – The training needs of carers to enable reparative and holistic approaches to health and treatment is critical. While the provision of treatment and therapy is essential, building the capacity of the home environment to support treatment and healing is equally important. The recent evaluation of the New South Wales Reparative Parenting Program for carers found that consistent with Program aims, carer stress reduced significantly during the course of the group program, placement breakdown during the program was very low and many carers reported significant increase in confidence in managing disruptive and aggressive outbursts, which are significantly correlated with placement breakdown.

A number of options are canvassed to address the skills development needs of a range of service providers in the health, community services and education sectors that support the priority given to the primary health care needs of children and young people in out-of-home care. These options range from the more rigorous specification of competencies to establishment of a national clearinghouse to enable sharing of existing training materials and approaches. It is also proposed that there be specific investigation of training that will better orient service providers to the needs of Aboriginal and Torres Strait Islander children and young people.

Option 6: Development of a national competency framework for health care staff providing health assessment and intervention to children and young people in OoHC.

Problem

Concurrent with giving priority to the health and wellbeing of children and young people in OoHC is the need to ensure the supply of a health workforce with the skills set to provide and effective response to children and young people who have experienced trauma, abuse and neglect. Feedback from carer support agencies in particular indicate the breadth of skills deficit among health service providers and the impact that this has on the self-esteem of the

child or young person, the willingness to participate in initial or ongoing contact with the health provider and the quality of health assessments and interventions. The need for skills tailored to the OoHC population includes receptionists in medical practices, practice nurses, general practitioners, paediatricians and other specialist and allied health service providers.

Importance

The National Clinical Assessment Framework identifies the need for flexibility in the determination of a particular health discipline to complete assessments and identifies that a key consideration relevant to the selection of a suitable practitioner is that they should possess 'subject specific clinical expertise, interest and cultural competency'.

These competencies would provide rigour and national consistency in responding to the principles of the National Clinical Assessment Framework that call for practitioner clinical and cultural competency to complete assessments, an awareness of particular risk factors relevant to the individual and their circumstances and the need to be mindful of the potentially complex needs of a diverse population.

The Expert Reference Group identified the need to ensure quality health assessments and interventions by building health practitioner competencies related to the needs of children and young people in child protection.

Implementation responsibility

The lead role in progressing the competencies development would be the Department of Health and Ageing in conjunction with states and territories and at the direction of Health Ministers. The competencies could be developed though a collaboration of relevant health professional associations led by the Royal Australasian College of Physicians.

Implementation

To clarify the specific skills required by health care staff to provide quality health assessments and interventions to the OoHC population, a suite of competencies aligned to implementation of the National Clinical Assessment Framework could be developed. This resource would provide greater direction around the nature of skills development, guide the development of nationally consistent teaching and learning materials, and differentiate between the roles of staff. While the competencie**s** would be specific to enabling implementation of the National Clinical Assessment Framework, there would be benefits to service providers in supporting the wider population of vulnerable and disadvantaged children and young people. The approach would be modelled on that undertaken in the UK in 'Safeguarding Children and Young People: roles and competencies for health care staff' (September 2010).

The UK approach establishes a competencies framework and outlines key issues relevant to obtaining and maintaining education and training. The competencies were developed in response to reviews that highlighted the need to improve the skills and understanding of health care staff and their access to training. Importantly, the competencies identify different staff groups and six levels of competence for non-clinical staff, professionals and experts. The UK Royal College of Paediatrics and Child Health produced the competencies framework in collaboration with a wide range of contributing agencies. This document would inform the similar exercise envisaged for health assessments and interventions under the National Clinical Assessment Framework. New South Wales is shortly to release the Clinical

Practice Guidelines for the health assessment of children and young people in OoHC, which would assist in adapting competencies to the Australian context.

Implications

New resources would be required to support the development of a competency framework for health care staff. Through the work informing the development of the National Clinical Assessment Framework, and expertise among health practitioners, there is a considerable body of knowledge to inform a competency framework.

The imperative for this investment is the priority given to effective and efficient approaches to child protection and improved health outcomes for children and young people.

Timeframe

There are a range of discussions and stakeholders to be engaged in the scoping and development of a competency framework. Further would be required through the ERG with a view to implementation in the medium term.

Further work

There may also be merit in reviewing the existing skills development programs addressing the needs of the child protection parties with a view to promoting improved understanding and knowledge about the benefits to the child or young person of comprehensive health assessments and follow up treatment.

Option 7: Development of Aboriginal and Torres Strait Islander trauma-informed healing approaches to improve the response of health services to Indigenous children and young people in OoHC.

Problem

The rate of growth of Indigenous children and young people on care and protection orders continues to rise in Australia. This is affecting OoHC in all jurisdictions and warrants consideration of appropriate approaches to health assessment and interventions specific to the needs of Indigenous children and young people.

Importance

Aboriginal and Torres Strait Islander children and young people are overrepresented in OoHC and in 2012 were reported to be at the rate of 55.1 per 1,000 children. Nationally, this was 10 times the rate for non-Indigenous children (AIHW 2013).

Availability of Aboriginal Medical Services has provided effective access to preliminary health assessments for many Indigenous children and young people in OoHC, and in some instances, a setting for provision of specialist health care. However, the growth in numbers of Indigenous children and young people in OoHC, the complexity of behaviours and location, necessitates access to mainstream health services. For these services to effectively respond, cultural competence of service providers needs to be enhanced by Indigenous trauma informed healing approaches.

Implementation responsibility

The Department of Health and Ageing and states and territories in conjunction with the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the National Aboriginal and Community Controlled Health Organisation (NACCHO) and the Healing Foundation.

Implementation

Trauma-informed and trauma-specific care models should be explored further through the ER to ensure that Indigenous Australian children and young people in OoHC have access to services that are culturally appropriate and address the healing process.

Timeframe

If this option has merit, it should be progressed with priority with a view to clarification of approaches and development of associated training programs, if indicated, for implementation in the medium term.

Further work

SNAICC, NACCHO and the Healing Foundation could be approached in the first instance for advice about the most appropriate way of progressing skills development in this area. There is an imperative to ensure that a culturally competent approach is taken to appropriate forms of support for Indigenous children and young people in OoHC.

Issues for clarification include the maturity of approaches amongst Indigenous service providers, how these approaches might be adapted to mainstream service providers, the context in which such approaches might be used and the supports that should be available.

Option 8: Jurisdictional information exchange for policies, protocols and training material related to National Clinical Assessment Framework implementation

Problem

There are a wide range of materials being developed in states and territories that could be better shared with other jurisdictions, avoiding duplication of effort.

There was widespread interest from states and territories in sharing information with jurisdictions about program developments and innovations relating to implementation of the National Clinical Assessment Framework.

Importance

Achieving a more consistent national response to implementation of health assessments and interventions is a key objective of the National Clinical Assessment Framework.

There is considerable investment by jurisdictions in meeting the objectives of the National Framework for Protecting Australia's Children and specifically in implementing effective responses to comprehensive and consistent health assessments and follow up treatment and review. While there is a range of approaches being pursued, there is opportunity for a greater level of information exchange about evidence informed policies, programs and support materials to foster good practice.

Implementation responsibility

The option could be progressed through the Standing Council on Community and Disability Services Advisory Council (SCCDSAC).

Implementation

A range of informal and formal approaches could be explored for information exchange primarily between governments on information relevant to implementation of the National Clinical Assessment Framework. This could include a regular teleconference of senior managers to update on new developments and circulate material of interest to the group, or a more widely accessible repository of information, such as a clearinghouse.

An electronic repository for key documents relating to aspects of implementation of the National Clinical Assessment Framework by state and territory governments would provide an important source of information for jurisdictions as well as a measure of progress. A number of web based child protection sites already operate, such as the Australian Institute of Family Studies. An additional topic of information could be bolted on to an existing clearinghouse leveraging from the core infrastructure.

The clearinghouse function would benefit jurisdictions in keeping abreast of developments to progress the National Clinical Assessment Framework. Potentially, the function would also foster national consistency with the opportunity to adapt material to meet jurisdictional needs. Importantly, the clearinghouse would also serve to refresh awareness and reference to the National Clinical Assessment Framework and disseminate the document to a wider audience involved in child protection.

Timeframe

Depending on the vehicle agreed for information exchange, this option could be developed in the short term.

Further work

Further discussion is required to determine the most efficient and sustainable way of enabling exchange of information in a timely and practical fashion to inform implementation of the National Clinical Assessment Framework.

There may be a suite of methods to achieve strategic discussion and information exchange rather than a single solution.

4.5 Summary

The coordination of policy response across the child protection and health service system is an ongoing challenge for states and territories.

Entrenched system design and capacity issues are major inhibitors to the development and roll out of appropriate models of service delivery to meet the health needs of children and young people in the Child Protection and OoHC system. But the issues are not intractable. There has been significant innovation and advances in this space in a relatively short amount of time. There are a broad sweep of ideas and opportunities that could be considered to provide a more nationally consistent response to addressing and managing the health needs of this vulnerable population group.

Key considerations from these opportunities include:

- Formalising mechanisms to ensure priority attention to the health needs of the OoHC population and investigating sustainable health service models that could be offered for rural and remote clients

- The value of coordination across system layers and the ability to facilitate movement of the client population and health information between child protection and health systems.
- The importance of recognising the special needs of the client population and the implications for the competencies required of health professionals, child protection carers and supporting agencies, such as trauma informed health practice including Indigenous specific approaches.
- Developing a tailored and local health response to implementation of the National Clinical Assessment Framework.
- Improving capacity for establishing, maintaining and monitoring health histories and the need for preparedness in the provision of nationally consistent data and the generation of evidence to demonstrate achievement of the objectives of the National Clinical Assessment Framework and performance against the National Standards.
- The role of a dedicated MBS item as a part of a set of strategies to support equitable access and the effective implementation of the National Clinical Assessment Framework.

These opportunities have been framed as options for consideration in progressing implementation of health assessments and interventions for children and young people in OoHC.

Table 1 Options for progressing implementation

1. Priority of access to health services for children and young people in out-of-home care

Whole-of-government commitment in each state and territory to give priority access to children and young people in out-of-home care.

Responsible jurisdiction: States and territories.

Timeframe: Short term implementation (6-12 months)

2. Coordination between child protection, health and education (ERG priority)

Commitment to implement and maintain the Care Coordinator Health role outlined in the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care to work across the child protection, health and education systems at the regional and system level.

Responsible jurisdiction: States and territories

Timeframe: Medium term implementation (2-3 years)

3. Engaging the Medicare Locals network (ERG priority)

To incorporate the health needs of children and young people in out-of-home care into regional health service planning and capacity building (including telehealth initiatives), and to facilitate better access to primary health care services, including in rural and remote areas.

Responsible jurisdiction: Commonwealth, states and territories

Timeframe: Short term development (6-12 months); Long term implementation (4-5 years)

4. Dedicated Medicare Benefits Schedule (MBS) item for children and young people in out-of-home care

This will provide health care professionals with more adequate reimbursement to reflect the complexity of the work involved in providing a service for this high needs group.

Responsible jurisdiction: Commonwealth, states and territories

Timeframe: Medium term (2-3 years)

Progress would require further work through the ERG

5. Prioritising development and implementation of national eHealth records for children and young people in out-of-home care (ERG priority)

This will enable better tracking of the health history of a child before, during and after their time in out-of-home care and provide for consistent data collection across the country.

Responsible jurisdiction: Commonwealth, states and territories

Timeframe: Short term development (6-12 months); Medium term implementation (2-3 years).

6. Development of a competency framework for health care staff

Responsible jurisdiction: Commonwealth, states and territories, and the Royal Australasian College of Physicians

Timeframe: Further work required through the ERG; Medium term implementation (2-3 years)

7. Development of trauma-informed Aboriginal and Torres Strait Islander healing approaches

Responsible jurisdiction: Commonwealth, states and territories, the Secretariat of National Aboriginal and Islander Child Care, National Aboriginal Community Controlled Health Organisation, and the Healing Foundation; Further work required through the ERG.

Timeframe: Medium term implementation (2-3 years)

8. Jurisdictional information exchange for policies, protocols and training material related to implementation of the National Clinical Assessment Framework

Responsible jurisdiction: Commonwealth, states and territories

Timeframe: Short term development (6-12 months)

5 Conclusion

All states and territories are progressing and improving their implementation of processes to attend to the health needs of children and young people in OoHC. With the National Clinical Assessment Framework as a guide to recommended good practice, jurisdictions generally are providing for a substantial preliminary health check and follow up treatment as necessary. Achieving the next tier of health assessment to provide a comprehensive health and developmental assessment is less consistently achieved, which also impacts subsequent regular review cycles.

There are many examples of action to enable coordination across sectors and innovative practice to construct new ways of responding to the wider needs of children and young people in OoHC. Some jurisdictions have invested significant effort in frameworks, capacity building and inter-sectoral collaboration that recognises the potential benefit of early intervention to improved health and wellbeing outcomes.

Further work is required to mature and refine these processes. This work needs to ensure a common understanding across sectors of the value of health assessments, the importance of active coordination within and across sectors to benefit from referrals, and a national response to secure a skilled health workforce. There are opportunities to build on existing networks and mechanisms to improve access to appropriate health services and an imperative to provide national solutions to support sustainable and robust arrangements for tracking of health histories and monitoring of outcomes.

All governments give a high priority to securing the safety and improving outcomes for children and young people in the child protection system. Implementation of the National Clinical Assessment Framework is an important contribution to this effort.

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Attachment A Stakeholders consulted

Table A1 Stakeholders consulted

Elizabeth Findlay, Health Liaison Officer, Community Services Directorate, 8 May 2013, ACT
Bronwyn Roberson, Child Protection Liaison Officer, Division of Women, Youth & Children Community Health Programs, Health Directorate, 5 June 2013, ACT.
Adele Clifton, OoHC Clinic Nurse, Child At Risk Health Unit (CARHU), Division of Women, Youth and Children Community Health Programs, Canberra Hospital, 5 June 2013, ACT
Deborah Beasley, Manager, Child and Family Health Unit, Maternal, Child and Family Health Team, NSW Kids & Families, Department of Health, 6 May 2013, NSW.
Deirdre Young, A/Director, OOHC Service Improvement, Policy, Programs and Strategy, Department of Family and Community Services, 6 May 2013, NSW.
Anna Yusef; Dr. S Heriot, A/Principal Policy Officer, Divisional Policy and Resource Management, Department of Family and Community Services, 8 May 2013, NSW
Dana Clarke, CEO, Burrun Dalai Aboriginal Corporation, Inc. 29 July 2013, NSW
Margot Beach Director, Business Strategic Support, Benevolent Society 30 August 2013, NSW.
Jill Jackson, Senior Manager – Care and Protection, Policy and Programs, Office of Children and Families 24 May 2013, NT.
David Pugh CEO, Anglicare NT; Terry Cleary OoHC manager – Catherine, Anglicare NT; Julie Rothall, OoHC manager – Darwin, Anglicare NT, 17 July 2013, NT.
Belinda Mayfield - Director, Child Protection Development, Child Safety Programs; Susan Richardson, Department of Communities, Child Safety and Disability Services, 22 May 2013, QLD
Jennifer Harvey, Manager, Strategic Policy and Intergovernmental Relations, Families SA; Sue Foster, Manager, Child Protection Program, SA Health; Lisa Henderson, Senior Policy and Program Officer, Families SA; Leon Doecke, Project Manager, Families SA; Lian Coyles, Senior Policy and Program Officer, Families SA , 9 May 2013, SA.
Julie Dini, Area Clinical Services Manager, Life Without Barriers; Merike Mannik, Manager Carer Support, Life Without Barriers, 25 July 2013, SA.
Nicole Hunt, Senior Manager, Connecting Chilldren and Young People, Anglicare SA, 31 July 2013, SA.
Dr Susan Diamond, Director Strategy, Program Development and Evaluation, Department of Health and Human Services; Angela McCrossen, Manager of Quality and Safety, Department of Health and Human Services; Marie Rauter, Paediatrician, Royal Hobart Hospital; Louise Newberry, Manager Performance and Evaluation, Department of Health and Human Services, 7 May 2013, TAS

Sue Hildebrand, A/Assistant Director OoHC, Service Development and Design, Statutory and Forensic Services Design Branch, Department of Human Services; Ruth Champion, Senior Program Officer, OoHC, Service Development and Design, Statutory and Forensic Services Design Branch, Department of Human Services, 15 May 2013, VIC.

Vicki Horrigan, Senior Project Officer, Vulnerable Children, Department of Health, 16 May 2013, VIC.

Gerard Jones, Executive Director Operations, MacKillop Family Services 19 July 2013, VIC.

Connie Salamone, Executive Director, VACCA.

Vicki Ross, Kinship Care Manager, VACCA, 26 July 2013, VIC.

Kay Benham, Executive Director, Policy and Learning Directorate, Department for Child Protection; Kelly Colledge, Director, Children and Young People in Care, Policy and Learning Directorate, Department for Child Protection, 9 May 2013, WA

Elizabeth Cramer, Placement Service Team Leader, Yorganop Association Inc, 18 July 2013, WA.

Charlotte Cain Operations Manager Out of Home Care, Wanslea, 17 July 2013, WA.

Penny Dakin A/Director, Prevention and Child Policy Section, Health in Social Policy Branch, Department of Health and Ageing; Brooke Alexander, Medical Benefits Division, Department of Health and Ageing; Sue Purtell ,Health in Social Policy Branch, Department of Health and Ageing, 19 June 2013.

Kerry Burden Director Compliance, Operations Branch, eHealth Division, Department of Health and Ageing, 19 June 2013.

Table A2 Expert Reference Group membership

ERG participants 4 July 2013

Professor Graham Vimpani - Conjoint Professor at School of Medicine and Public Health, Head of Paediatrics and Child Health, University of Newcastle, and part-time Senior Clinical Adviser, Child Protection and Wellbeing, NSW Health Departmen - Chair of the Expert.Reference Group.

Professor Fiona Arney - Chair of Child Protection and Director of the Australian Centre for Child Protection, University of South Australia.

Dr Diane Lawrence - Consultant Paediatrician at Flinders Medical Centre and representative of the Royal Australasian College of Physicians.

Dr Melissa Kaltner - Allied Health Research Coordinator (Research Fellow), Darling Downs Health Service District (QLD Health).

Dr Elisabeth Murphy - Chair of the Child Health Wellbeing Subcommittee - Alternate for Dr Jenny Proimos.

Associate Professor Jill Sewell - Deputy Director, Centre for Community Child Health, Royal Children's Hospital, Melbourne - Alternate for Professor Oberklaid.

ERG apologies 4 July 2013

Professor Frank Oberklaid - Centre for Community Child Health and Professor of Paediatrics at the University of Melbourne.

Dr Jenny Proimos - Representative of the Child Health and Wellbeing Subcommittee.

Susan Webster - General Practice and Primary Health Care Academic Centre, University of Melbourne Interviewed separately.

Table A3 Project governance arrangements / ERG attendees

Project lead members (and observers at ERG meeting 4 July 2013)

Helen Bedford; Margaret Fisher - Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

Lyn Manitta - New South Wales Government Department of Family and Community Services

Karen Mapleston - Victorian Government Department of Human Services

ACIL Allen Consulting project consultants and attendees at ERG meeting 4 July 2013

Karen Roger; Garth Lampe; David Griffith - Project consultants, ACIL Allen Consulting.

Attachment B Summary of state and territory policy and practice

B.1 Australian Capital Territory

Contributors	Community Services Directorate ACT, Care and Protection Services ACT Health Directorate, Women Youth and Children's Division, Child Health Targeted Support Services

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation
ACT Children and Young People Act 2008

Policy
The ACT Government is 'One Government – One ACT Public Service'.

1. CPS Policy & Procedures – Chapter C Emergency Action (C9.5)

2. CPS - Policy & Procedures - Chapter D - 'Out of Home Care'

CPS case workers must refer all children and young people being placed in out of home care for the first time to the Child at Risk Health Assessment Unit (CARHU) at The Canberra Hospital within 48 hours of placement. CARHU undertakes a developmental and general health assessment of the child or young person, often identifying additional medical needs to be addressed and about which relevant parties must be advised and/or consents for treatment sought.

CPS workers should also obtain as much information as they can about the child or young person's health history and potential future health care needs. Ideally medical information will include:

- Medicare details (where these are not available make an application);
- Immunisation record, commonly referred to as the "Blue Book";
- essential medical history such as childhood illnesses, conditions that impact on the child or young person's daily life and/or care;
- treating physicians, contact details, upcoming appointments; and
- current medications and information about these.

3. Foster Carer Handbook: Health and Medical Care.

Currently all CPS policies and procedures are under review and being re written into an Integrated Management System.

ACT Health Directorate policy:

Standard Operating Procedure Child at Risk Health Unit (CARHU) Out of Home care Clinic Health Check

Research that has informed policy and practice

Practice has been guided by a number of national and international publications. The available literature widely acknowledges that children and young people in Out of Home Care (OOHC) are a highly vulnerable group with increased physical, mental and social health needs and with limited access to resources.

Other significant documents that are guiding this work are:

- The National Framework for Protecting Australia's children 2009- 2020
- National Standards of Out of Home Care (2011)
- The National Clinical Assessment Framework for children and young people in Out of Home Care 2011.

Provision of health assessments

Jurisdictional approach to providing health assessments to children and young people

Care and Protection Services (CPS) case workers must refer all children and young people being placed in out of home care for the first time to the Child at Risk Health Assessment Unit (CARHU) (for children aged 14 years and under) at The Canberra Hospital within 48 hours of placement. The referral form for this assessment is available as a CHYPS template "CARHU – Out of Home Care Clinic Referral" (November 2011).

CARHU will undertake a general health assessment of the child or young person. This is a nurse led assessment conducted by specialist Maternal and Child Health Nurses with extensive paediatric experience and skills. The Health and Wellbeing screen is a baseline evaluation of the child and young person's health not a full paediatric assessment.

The Child at Risk Health Unit (CARHU) based in the grounds of the Canberra Hospital provides specialist health services to children, young people and their families or carers who have been affected by abuse or neglect. A review of CARHU's role, 2003-2005, within the broader ACT Child Protection system services, provided the capacity to develop an enhanced model of service that included nursing. The nursing position was created to fill a gap in services provided by CARHU, to offer all children entering out of home care a Health & Wellbeing screen.

In 2006 a Protocol was established between the ACT Health Directorate Child, Youth and Women's Health program and Care and Protection Services regarding Health Assessments for children entering out of home care. In 2006 a nursing position was created at the Child at Risk Health Unit (CARHU) to provide Health and Wellbeing Screens for all children aged between 0-14 years entering OOHC and referrals to medical officers, clinics etc where appropriate.

For young people aged 15 – 17 years the screen can be undertaken at The Junction Youth health Service. If the young person wishes to see their regular doctor for a health screen this can be arranged.

The Junction Health Service provides a holistic and flexible approach to primary health care and support services for young people aged 12 years to 25 years and their dependents living in the ACT and surrounding areas, with a focus on at risk and homeless youth, funded by the ACT Government Health Directorate. The Junction supports young people in all aspects of

their health and wellbeing. The service offers several clinics and liaises with external health and community services to provide referral, support and advocacy. The GP clinic consists of general practitioners and nursing staff. The clinic provides primary health care services to clients and their children. The service is provided at no charge to clients as all consultations are charged directly to Medicare Australia.

The CPS caseworker is responsible for follow up and referral for all children placed in OOHC for the first time. Children and young people who remain in OOHC require an annual Health and Well being screen. The CPS caseworker is responsible for follow up and referral in conjunction with the carer or OOHC agency.

Bimberi Youth Justice System is the ACT's youth custodial facility. The centre is managed by the ACT Government though the Community Services Directorate. The centre can accommodate up to 40 young people aged 10-18 years. A Significant number of young people in Bimberi are under the care of The Director General. Care and Protection Services are advised when a young person is admitted to Bimberi. Young people have access to health services and have their health needs met while residing in Bimberi. The Health services are provided by the ACT Health Directorate.

Outcomes of assessment

From July 2012 – April 2013 there were 82 children and young people aged 14 years and under entering care who were eligible to undergo health assessments. Of these children 80 received a health assessment.

CARHU Health and Wellbeing Screen for children aged 14 years and under is a holistic nursing assessment encompassing physical, dental, developmental and behavioural domains. The Health and Wellbeing Screen is a baseline evaluation of the child and young person's health not a full paediatric assessment. If the screen reveals that the child or young person has a medical need a referral will be made to a Community Child Health Medical Officer, the child's own G.P. or the carers G.P. and/or other health care professionals.

Possible pathways to health assessments

CPS case workers must refer all children and young people being placed in OOHC for the first time to the Child at Risk Health Assessment Unit (CARHU) (for children aged under 14 years).

For young people aged 15 – 17 years the screen can be undertaken at The Junction Youth Health Service. If the young person wishes to see their regular doctor for a health screen this can be arranged.

The CPS caseworker is responsible for follow up and referral for all children placed in OOHC for the first time. Children and young people who remain in OOHC require an annual Health and Wellbeing screen. The CPS caseworker is responsible for follow up and referral in conjunction with the carer or OOHC agency.

The (CPS) Health Liaison Officer monitors the data maintained on children and young people placed in OOHC and can assist the CPS caseworkers to progress this work.

The CARHU nurse attends CPS offices once a fortnight to be available to CPS caseworkers to discuss Health & Wellbeing screens and other CARHU related matters.

The current agreement is that CPS – Data Management team provide a weekly list to CARHU of children placed in OOHC. CARHU completes a monthly report to CPS that reflects when a referral is received from CPS; when a Health &Wellbeing Screen has been undertaken; any outstanding referrals or screens; if a child will not be having a Health &Wellbeing Screen and reasons why.

Screening and assessment tools utilised
CARHU Health Assessment documents have been developed by CARHU staff for use in the CARHU OOHC Clinic.

There have been difficulties sourcing an appropriate evidence based screening and assessment tool for use in the OOHC Clinic. Evidence based tools currently available e.g. Ages and Stages Questionnaire (ASQ) require detailed information from the carer / parent who hold extensive information regarding the child's health, behaviour and development. In the OHCC Clinic setting this detailed parent/carer provided information is not often available as the carer attending with the child may not be familiar with the child nor have detailed, historical knowledge of the child.

For some children entering OOHC, their health needs have not been addressed, or inconsistently met, with inadequate/lost parental record keeping. This historic health information may not be able to be accessed or obtained.

Barriers and enables to the provision of health assessments
Reported barriers:

- Children placed Interstate – access to OOHC Health and Wellbeing Screens.
- Young People aged 15 – 17 who are not in a stable placement and do not engage with Health Services.
- No standardised health assessment screening tool in the ACT for 15- 18 years.
- Reported enablers:

There is a well established, collaborative system for referral from CPS to Health. Regular fortnightly visits to CPS by CARHU nurse to follow up on OOHC Clinic referrals. Data sharing between Health Directorate and CPS regarding numbers of children and young people entering OOHC and completed health assessments. The Child Protection Health Liaison positions have assisted in establishing and supporting this collaboration.

Health interventions for children and young people

Range of health interventions available
Children and young people in the child protection system in the ACT may access the same health interventions as all children in the ACT. A comprehensive range of Government and private health services are available in the ACT, key services of relevance to children and young people in the child protection system are listed below:

The Canberra Hospital (TCH) is a major provider of high-quality general and specialist care to people of the ACT and the surrounding region. Canberra Hospital delivers a full range of medical, surgical and obstetric services, including complex procedures such as cardiac surgery and neonatal intensive care. Integrated maternity and paediatric services are also provided, including neonatal intensive care.

Calvary Health Care ACT is a 250 bed public hospital. Services include Emergency Department, Intensive and Coronary Care Unit, medical and surgical wards, maternity unit, a voluntary psychiatric ward, and ambulatory and outreach facilities and services.

The Division of Women, Youth & Children Community Health Programs offers a range of services to meet the health needs of children in the community. Services are provided at various locations across Canberra including Clinics, Health Centres, schools, outreach locations and in homes to increase accessibility to members of the community.

The Child at Risk Health Unit (CARHU) is part of the Division of Women Youth & Children Community Health Programs. The unit provides medical examinations, health screens, education, consultation and therapy for children and their families/carers, where there are concerns of abuse and/or neglect.

Community Paediatric and Child Health - Child Health Medical Officers (CHMOs) / Community Paediatricians provide specialised secondary medical services to children and adolescents who require: medical and/or developmental assessment and management; case management which includes liaison with or referral to other medical services, Education, Care and Protection Services and others.

The Child, Youth and Dental Service provides children and young people with dental care from community based clinics. The service provides children and young people with comprehensive assessment, oral health plans, general preventative and restorative treatment and emergency treatment.

Child & Adolescent Mental Health Services (CAMHS) provides assessment and treatment for children and young people under 18 years who are experiencing mental health problems. CAMHS clinicians assist in the management of serious and complex problems in children and adolescents through their comprehensive assessment and treatment program.

The Mental Health, Justice Health and Alcohol & Drug Services Division delivers services at a number of locations and in varied environments, ranging from hospital inpatient and outpatient settings, community health centres, detention centres including the Bimberi Youth Justice Centre, other community settings and the consumer’s home.

Junction Youth Health Service Provides a holistic and flexible approach to primary health care and support services for at risk young people aged 12 – 25 years and their dependents.

Winnunga Nimmityjah Aboriginal Health Service (AHS) is an Aboriginal community controlled primary health care service operated by the Aboriginal and Torres Strait Islander community of the ACT.

General Practitioners and private paediatricians are also available.

Child and Family Centres are a division of the Office for Children, Youth and Family Support within the Community Services Directorate. The centres are a one stop shop supporting families during the early years of a child’s life. There are three centres are staffed by professionals including social workers, psychologists, and maternal and child health nurses, and are designed to provide a range of support programs to assist parents and young children (pre birth to 8 years). All services available at the Child and Family Centres are free to ACT residents.

ACT Government Community Services Directorate: Therapy ACT provides services to children with developmental delays and people with developmental disabilities who are residents of the ACT.

Effectiveness of referral pathways from health assessment to interventions
The Health care needs for children aged group 0 -14 placed in OOHC is very effective – as described above. The referral pathway jointly established across the Community Services Directorate and ACT Health Directorate is entrenched in practice by both agencies. Following the Health Assessment referrals are made by the CARHU nurse for further health interventions if required. Follow up health interventions are documented in the Health and Wellbeing Screen report. The CPS case worker is responsible for monitoring that the Health interventions occur.

Informal assistance is available to case workers through the Liaison Officers and the CARHU Nurse. This assistance may include facilitation of health appointments, linking with health services and navigation of the Health system.

For young people aged 14 – 17 the young person themselves may choose not to engage with Health Services. This can be a challenge for both carers and services supporting the young person. There are appropriate Health services available to this group through General Practitioners or the ACT Health funded services such as The Junction (described as above in question 9) and other community based services.

Barriers and enables to accessing health interventions

Reported barriers:
Interstate Placements - there are significant numbers of children placed in OOHC Interstate. In September 2012 there were 169 children and young people in Out of Home care out of the Territory. Of this 169 there were 141 in NSW. The remainder were spread across Victoria, Queensland, South Australia and Western Australia. Currently there are no formal pathways or agreements in place between the ACT Child Protection Service and other jurisdictions to ensure these children and young people's Health needs are met that includes an initial Health and Wellbeing screen. CPS caseworkers work closely with young people and their carers to discuss Health care needs and means to address these in the area they are located. Some of these resources accessed interstate may include General Practitioners and local Aboriginal Medical Services.

Young people disengaged from Services: For young people aged 14 – 17 the young person themselves may choose not to engage with Health Services.

Assessments may be delayed if it is identified that this is in the child's best interest. E.g. the child is acutely unwell.

Reported enablers:

For those children placed in NSW areas surrounding the ACT, every effort is made to support the carer to access CARHU, for a Health Screen.

There is good communication between agencies in identifying children that may require a priority health assessment.

Medical histories

Current approach to recording and tracking medical histories

For Care and Protection Services:
The OOHC referral document for a Health & Well Being screen is completed and recorded on the child /young person's electronic client file (CHYPS) as well as in the paper file. The CARHU nurse completes and provides to CPS a copy of the Health and Wellbeing Screen once the assessment is completed. CPS administration receives and scans these onto the child/young person's CHYPS record as well as a copy is kept on the client paper file.

Any medical reports for children/young people obtained by CPS caseworkers are scanned onto the child/young person's CHYPS records, for e.g. Immunisation records, Medical reports, CARHU reports, Counselling reports, mental health assessments. A paper copy is also included in the child/young person's paper file.

Medicare card: CPS case worker apply for an individual Medicare care when a child/young person enters out of home care.

The ACT Health Directorate Dental Health Program: A worker from this service will contact the CPS caseworker if a child/young person in OOHC does not attend their booked appointment. The Health liaison Officer can assist with facilitating contact between CPS caseworker and the Dental Health worker.

In CPS the health care needs of children and young people are documented in their Care Plan. This is developed upon entry into care, is updated every year or when there is a significant event within the child's life. The child or young person's health circumstances are recorded in their Annual Review Report which is provided to the Court and other Parties.

The Children and Young People Act 2008, enables CPS to request a child's medical records from any health facility.

For ACT Health Directorate

- Personal Health Record (PHR) if available/Child Health Record;
- Australian Childhood Immunisation Register (ACIR) as appropriate;

ACTPAS the Health Directorate Patient Administration system can be accessed by the health treating team to track the child's appointments, referrals and contact with Health Directorate Services. The child's Health Directorate medical records may be accessed electronically by members of the Health treating team.

Effectiveness of these methods

In May 2012 the Public Advocate highlighted in a report 'Who is Looking out for the Territory's children' ACT Public Advocate May 2012 the need for improved record keeping and development of a good case plan. To address the elements of the Public Advocate recommendation a Project is underway to develop a process for this that will address various systems improvements. Children and young people in care will have their own written Health record which move with them if they change placements.

ACT Health Directorate clinical records are currently held across acute, primary and community based services in both paper based and electronic forms. This poses access

issues for clinicians gathering information and tracking medical histories. The Health Directorate has a long term plan known as Health-e Future to address this. Health-e Future aims to improve continuity of care and availability of information to support clinical decision making, by ensuring that the right information is available to members of the treating team, regardless of where healthcare services are delivered. This $90M investment in information and communication technology (ICT) forms a key part of the Health Infrastructure Program and supports the National EHealth Strategy that was announced by the Commonwealth Government in 2008.

Barriers to implementing effective tracking of health records
Reported barrier – the current CPS - CHYPS system is cumbersome and not user friendly. The child/young person's health history is recorded in chronological date order rather than in one document. A project outcome of the 'Child Health Passport' is to amend the client electronic record and develop CHYPS tools to record information. A further outcome is that the Organisation will implement training for all CPS staff around these changes.

Other related matters

Funding of health assessments and interventions

- The Junction Health (for young people) service is provided at no charge to clients as all consultations are charged directly to Medicare Australia.
- General Practitioners fees apply at the discretion of the G.P. or Medical Centre.
- Health Assessments for 0-14 years conducted at CARHU are part of the ACT Health Directorate Services funded by the ACT Government. The Health Assessments are conducted by the CARHU Nurses and Salaried Medical Officers as deemed appropriate. MBS items are not used to fund these assessments.

Recording and reporting of information on client health needs and outcomes
The Health Directorate Annual Report reports data via an Accountability Indicator (1.6.c) – Proportion of children aged 0-14 who are entering OOHC within the ACT who have been referred to CARHU's OOHC Clinic and who have received a Health and Wellbeing Screen.

Coordination between departments and agencies
The Pathway between Care and Protection and ACT Health Directorate to offer all children entering substitute care a Health & Wellbeing Screen is the key coordination element between the agencies.

Practitioner collaboration
There is a high level of collaboration between case workers and health practitioners in enabling health assessments for children aged 0-14 years in the child protection system. The Pathway between Care & Protection Services was established in 2006. It is entrenched in practice between the two agencies.

The CARHU nurse and Liaison Officers monitor the progress of Health & Wellbeing screens for children entering OOHC and address issues as they arise. The CARHU nurse attends CPS offices every fortnight to meet with CPS caseworkers to discuss referrals to the OOHC Clinic and Health & Wellbeing screens.

The CPS employed Health Liaison Officer supports CPS caseworkers to progress OOHC referrals and assist with any other related Health Care enquiries. The Health Directorate

Child Protection Liaison Officer is available to assist the CPS case workers to navigate the Health system and to support collaboration between the agencies.

Workforce and training issues
Information and/or training is provided to CPS workers when any new process such as a Policy/Procedure is introduced.

A tour of the Canberra Hospital is organised by the Liaison officers for all new CPS caseworkers as part of their induction to the Directorate. The tour includes a visit to the Child at Risk Health Unit (CARHU), opportunity to meet the staff and a discussion about the OOHC Health clinic and resources of the Unit.

The CARHU nurse attends CPS offices every fortnight to meet with CPS caseworkers to discuss referrals to the Out of Home Care Clinic and Health & Wellbeing screens

B.2 New South Wales

Contributors: New South Wales Department of Family and Community Services

New South Wales Ministry of Health

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation
Children and Young Persons (Care and Protection) Act 1998 contains provisions regarding the delivery of services that foster the health of children and young people in the child protection system in NSW, that account for the safety, welfare and wellbeing of the child or young person.

Policy

National Policy Framework

- National Framework for Protecting Australia's Children 2009–2020.
- National Clinical Assessment Framework for Children and Young People in Out-of-Home Care
- National Standards for OOHC. Standard No 5 states: "Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way."

NSW Policy Framework
The NSW Standards for Statutory Out-of-Home Care are used by the Children's Guardian for the accreditation and quality improvement of statutory out-of-home care services in NSW. Standards 8 and 9 require OoHC placements to meet the emotional, social, health and developmental needs of children and young people in OoHC.

Keep Them Safe: A shared approach to child wellbeing (KTS) is the NSW Government's five-year (2009-14) action plan to re-shape the way family and community services are

delivered in NSW to improve the safety, welfare, and wellbeing of children and young people. KTS committed the NSW Government to the delivery of comprehensive multi-disciplinary health and developmental assessments for children and young people entering and in OOHC.

NSW Health and the Department of Family and Community Services, Community Services (FaCS-CS) developed an interagency framework to support the health assessment process. The "Model Pathway for the Comprehensive Health and Developmental Assessments for Children and Young People Entering Out of Home Care" (Model Pathway) provides the policy framework for the OOHC Health Pathway in NSW. The journey of the child is at the core of the model, which also promotes close collaboration between NSW Health, FaCS-CS and OOHC service providers. The role of health professionals, other government agencies, non-government agencies and carers is also articulated.

The Purpose of the Model Pathway is:

- early identification of health, development and wellbeing needs
- child focused approach to health assessment and intervention which places the child at the centre and supports carers in decision-making about health care needs
- targeted and culturally appropriate heath interventions and resultant improved long-term health outcomes, including for Aboriginal and Torres Strait Islander children and young people
- continuity of care, particularly for those with multiple, ongoing and complex conditions
- over the longer term, improved health outcomes for children and young people in out of home care
- better management of client health information, through the use of a heath referral form, and integration of the health management plan with the OOHC case plan
- collaborative and sustainable service system reform with stronger links between child protection practice, health care providers, carers and Non-Government Organisations providing OOHC.

A Memorandum of Understanding between NSW Health and FaCS-CS on Health Screening, Assessment Intervention and Review for Children and Young People in Out-of-home-care has been developed to support this interagency collaboration. The MoU between FACS-CS and NSW Health on Health Screening, Assessment, Intervention and Review for children and young people in statutory Out-of-Home Care provides the roles and responsibilities of each agency in facilitating access to health assessment and intervention for children and young people in OOHC.

NSW Health has developed NSW based Clinical Practice Guidelines for the health assessment of children and young people in OOHC (yet to be endorsed). The NSW Health Guidelines were developed in consultation with an Advisory Committee comprising professionals from NSW Health, FACS (Community Services and Ageing, Disability and Home Care), Department of Education and Communities, NSW Office of the Children's Guardian, Royal Australasian College of General Practice, NSW Centre for the Advancement of Adolescent Health, the Aboriginal Child, Family and Community Care State Secretariat (NSW) and Association of Children's Welfare Agencies. The Clinical Practice Guidelines for the health assessment of children and young people in OOHC will outline best practice for the provision of health assessments and interventions for children and young

people in statutory OOHC and will identify and provide health professionals with clear, high quality evidence based approaches to guide consistent service delivery for the OOHC population.

Research that has informed policy and practice

In developing an agreed approach to the provision of health assessments and interventions for children and young people in statutory OOHC, including the Model Pathway, the following research was considered.

- The NSW model of health assessments is aligned with the National Clinical Assessment Framework for Children and Young People in OOHC.
- Prevalence study on the health care of children in OOHC in NSW undertaken in December 2009 - June 2010 and published in 2011. This study provides useful baseline information for the NSW Government's Keep Them Safe reforms aimed at improving the health of children and young people in OOHC.
- Royal Australian and New Zealand College of Psychiatrists. The Mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry. RANZCP, Melbourne. 2008
- Royal Australasian College of Physicians, 2006, Health of children in "out-of-home" care. Sydney: RACP.
- Social Policy Research Centre at the University of New South Wales undertook a longitudinal study of wards leaving care. This research - NSW Longitudinal Study of Wards Leaving Care, Judy Cashmore and Marina Paxman, January 1996 and the subsequent report Wards Leaving Care: four to five years on published in 2007 identified the long-term health needs of this cohort, including the prevalence of mental health issues and the need for access to physical and mental health services,
- The children in care study led by Michael Tarren-Sweeney reported on the mental health of children in court ordered foster and kinship care in NSW. The study found that children in OOHC had exceptionally poor mental health and social competence relative to the general population.
- NSW conducted a range of consultations regarding the development of an agreed approach to the provision of health assessment and interventions for children and young people in statutory OOHC, including the Model Pathway. Parties consulted with included the NSW Health Centre for Aboriginal Health.
- FACS-CS is undertaking Pathways of Care, a large-scale representative longitudinal study that will follow children and young people aged 0 to 17 years entering OOHC on Children's Court orders for the first time. The aim of the study is to provide the knowledge needed to strengthen the OOHC service system in NSW in order to improve the outcomes for children and young people in OOHC. These outcomes include children's and young people's permanency, safety and wellbeing (including their physical health and socio-emotional and cognitive/learning development). Further information on the study is available at: http://www.community.nsw.gov.au/pathways/index.htm.

Provision of health assessments

Jurisdictional approach to providing health assessments to children and young people

Community Services responds to the health, medical and dental needs of children and young people in care through a continuum from initial assessment through to case closure and across program areas including Child Protection and OOHC. Community Services works in partnership with other government departments and service providers, including the NSW Health system and allied health workers who play a key role in assisting children and families to achieve optimal health and wellbeing. Decisions about a child or young person's health, medical and dental needs are made in consultation with the child or young person, their family, carers, Aboriginal or other culturally appropriate services, and mandatory reporters where involved, in an interactive and dynamic way to ensure the needs of the child or young person are met.

- Where a child or young person enters OOHC under an order from the Children's Court, Community Services or the service provider with case management responsibility is to:
- provide the carer with information about the child or young person's health, medical and dental needs, including emotional, social and educational needs, and any information relating to disability, challenging behaviour, or drug and alcohol issues
- make referral(s) and begin arranging for a multidisciplinary health and development assessment of the child or young person within 30 days of entering OOHC
- support the authorised carer with arranging health, medical and dental check-ups and treatment as per the approved case plan, or with the approval of the designated agency with case management responsibility
- develop wraparound services to help achieve a stable and quality placement, and to ensure the developmental, emotional and physical wellbeing of the child or young person, see: wraparound services model
- complete regular case plan reviews

NSW Health and FACS-CS jointly agreed upon a staged approach to the implementation of a coordinated, state-wide model for the provision of health assessments for children and young people in statutory OOHC. Stage 1, implemented from July 2010, specified that all children and young people entering statutory OOHC, and anticipated to remain in care for more than 90 days, should receive a coordinated health assessment. Stage 2, completed from July 2011 – July 2012 with one off funding, aimed to offer health assessments to those children 0-5 years of age that had already entered statutory OOHC prior to the commencement of Stage 1. NSW Health is now considering options for the next stages of implementation.

Each Local Health District (LHD) in NSW has established service delivery models for the coordination, delivery, monitoring and reporting on OOHC health assessments. Local partnerships between LHDs and Community Services seek to support timely referrals to the health assessments for children and young people entering out of home care.

Local OOHC Co-ordinators (appointed by NSW Health) and Interagency Pathway Coordinators (appointed by FACS-CS) supported the implementation pf the Pathway and the provision of health assessments to children and young people entering statutory OOHC.

The Model Pathway maps the journey of a child or young person who has entered OOHC through the process of health screening, assessment, intervention, and review. Stages of the health assessment process are provided below:

Prior to entry into care

- Step 1: Initiating a health assessment and information gathering
- Step 2: Comprehensive health assessment (referral within 14 days)
    - 2a: Primary health screening (to be completed within 30 days of entering statutory OOHC)
    - 2b: Comprehensive health assessment (if required)
- Step 3: Development of a health management plan
- Step 4: Targeted services intervention
- Step 5: Periodic review and assessments.

A 2a Primary Health Screening can be conducted by a range of health professionals including General Practitioners, Child and Family Health Nurse, and Aboriginal Medical Services. The screening may include: physical examination; growth and development check; vision; hearing; dental screen; immunisation check; nutrition; and / or responding to any concerns raised by carers.

If the need is identified during the 2a primary health screening/consultation, a child or young person will receive a comprehensive health assessment. A 2b comprehensive assessment will likely involve a range of health clinicians including: physical health; developmental health; mental health, including impact of abuse and neglect (e.g. attachments disorders); and specialist needs as required (e.g. oral health, speech).

Outcomes of assessment

A formative evaluation commissioned by NSW Health is currently underway which aims to identify effective service delivery models and assessment processes implemented across NSW to support improved access and coordination of health services for children and young people in OoHC. The formative evaluation will provide further detail on how OoHC Health has been implemented, areas of good practice and areas requiring further development or refinement. It is anticipated that improved access to health assessments and interventions will improve the short and long-term health, development and wellnbeing outcomes for children and young people in OOHC and support greater placement stability.

Possible pathways to health assessments

All children and young people entering statutory OOHC, and anticipated to remain in care for more than 90 days, are referred for a health assessment.

Screening and assessment tools utilised

NSW Health is currently seeking endorsement of the Clinical Practice Guidelines for the health assessment of children and young people in OOHC which include guidance as to appropriate screening and assessment tools and the development of templates for primary and comprehensive assessment in four age groups – under 1 year, 1-5 years, 6-11 years and 12-18 years.. In the absence of formal guidance regarding appropriate tools, clinicians in NSW continue to use clinical judgement in line with the National Clinical Assessment Framework. Current screening and assessment tools used by NSW Health professionals

include the Ages and Stages Questionnaire and the Strengths and Difficulties Questionnaire for children aged 4-17 years.

Barriers and enablers to the provision of health assessments

Reported barriers:

Timely completion of health assessments for children entering OOHC is in the best interests of the child. Timeframes for the Model Pathway have been established to support best practice, However, FACS-CSand NSW Health professionals can experience delays in their referral or assessment processes under the Model Pathway for the following reasons:

- The 14 day time frame (from when the child/ young person enters statutory OOHC) for the completion of the Health Referral Form (HRF) can be difficult for FACS-CS caseworkers to meet due to competing casework priorities and the extent of information gathering required. The majority of HRFs are completed after 30 days of the child / young person entering statutory OOHC.
- FACS-CS is unable to refer a child or young person for a health assessment without the child's Medicare number. If a child or young person's birth parents have not registered the child's birth, the relevant caseworker must register the child's birth with Births Deaths and Marriages which is a time consuming process. Following receipt of a birth certificate the caseworker can then applies to Medicare Australia for the child's Medicare number for the child, which is also a time consuming process.
- Cross-border issues arise when a child in OOHC moves to a different state or territory.
- Delays in receiving HRFs from FACS-CS creates difficulties for NSW Health staff in meeting the 30 day timeframe for the completion of the 2a assessment, which is a best practice standard.
- Carer availability to attend appointments for health assessments can also cause delay.
- The increasing number of children and young people entering the Model Pathway overtime has increased demand for NSW health staff to complete health assessments and reviews. This increasing demand on NSW Health professionals can compromise timely assessments or reviews.
- Children and young people can experience changes in placement during their first 3 months in OOHC, resulting in transitions between LHDs. Placement changes can disrupt or delay a child's health assessment or ongoing health care provision.

The boundaries of NSW Health LHDs and FACS Regions were aligned on 9 September 2013 as a result of FACS Localisation initiative. Prior to this alignment caseworkers sometimes experienced difficulty in making referrals to the appropriate OOHC Health Coordinator. Prior to localisation, caseworkers were required to refer children in OOHC within their region to a number of different LHDs which involved liaising with multiple professionals from surrounding LHDs. Reported enablers:

- Strong leadership from the NSW Government to enhance a shared approach to child wellbeing through the development of an interagency plan. Keep Them Safe: A shared approach to child wellbeing 2009-14 (KTS) committed the NSW Government to the delivery of comprehensive multi-disciplinary health and developmental assessments for children and young people entering and in OOHC. Responsibility for

the reforms was shared across a range of NSW Government agencies including FACS and NSW Health. Annual reporting on this plan is provided by the NSW Department of Premier and Cabinet.

- The NSW Government allocated $3 million in 2010 and $12million over four years for the coordination of health assessments for children and young people in care.
- Clear and efficient pathway processes are in place to enable assessments for children and young people in OOHC.
- Roles and responsibilities of staff from FACS-CS and NSW Health are clearly outlined and well understood.
- Strong working relationships between Senior Officers in Community Services staff and Senior Officers in NSW Health.
- Strong working relationships between Interagency Pathway Coordinators in Community Services and OOHC Coordinators in NSW Health and FACS-CS caseworkers and health professionals.
- Strong communication to carers, caseworkers, and NGO OoHC service providers, around their roles and responsibilities in implementing the pathway.
- From 9 September2013, FACS localisation initiative wasimplemented aligning the new FACS Districts with Local Health Districts. FACS expects this will improve communication and relationship building between FACS and Health professionals within each district and will enable more streamlined service delivery.

Health interventions for children and young people

Range of health interventions available

The MoU developed between FACS-CS and NSW Health indicates that health interventions are to be provided based on clinical need. The range of health interventions available may differ across geographical locations, however the Model Pathway outlines the suggested domains for assessment for 2a and 2b assessments for those children and young people on the Pathway.

Under the Health Pathway, a Health Management Plan (HMP) is developed for each child or young person that identifies their state of health, targeted intervention and appropriate review process. The HMP is developed by health professionals. Carers, caseworkers and children and young people are involved in the development of the Plan and are provided with a copy. The HMP is integrated in the child's case file and education plan (where appropriate). A process to action and report health management plan reviews has been agreed between Health and FaCS-CS.

Provision of targeted health interventions is based on assessment outcomes and clinical need. Examples of types of services which may be accessed are provided in the Model Pathway. Health interventions may involve but are not limited to the following.

- Paediatric specialist care
- New Street or Rural New Street Adolescent Services, services for children under 10 with sexually abusive behaviour
- Dental, vision or hearing interventions
- child and adolescent mental health services including child and adolescent psychiatry
- Immunisation catch up program
- sexual health

- Developmental assessment and intervention
- drug and alcohol services
- Allied health services: hearing, oral health, optometry, speech pathology, dietician, occupational therapy, physiotherapy
- youth mental health services, including psychiatry
- Psychological services
- specialist programs for families where parents have mental health and/or drug and alcohol problems
- Child Protection Counselling Services (previously PANOC).
- foster family systems psychological interventions e.g. Reparative Parenting Training Program, Karitane and Foster Care Support Group
- sexual assault services

Children and young people who are not eligible for the Model Pathway, but who are assessed as being in need of care and protection or in out-of-home care will have a case plan developed. The child or young person's case plan addresses each of the eight measures of child wellbeing, including health. The health domain addresses the health of the child or young person and seeks to ensure that health assessments, review and follow up occur as necessary.

Effectiveness of referral pathways from health assessment to interventions
The effectiveness of referral pathways will be assessed in the independent formative evaluation of the NSW health assessment and coordination processes for children and young people entering OOHC. To date, frontline staff have advised that the referral pathways from health assessment to health intervention for children and young people in OOHC on the Model Pathway are effective, provided the referrals are timely.

Barriers and enablers to implementing referrals

Reported barriers and challenges

- Variable data systems across the state, complicates sharing of information between private, public and NGO health services.
- The increasing number of children and young people entering the Model Pathway overtime has increased demand for NSW health staff to complete health assessments and reviews. However, the number of Health professionals who complete these assessments remain static. This can compromise their ability to oversee timely health interventions or update HMPs after a health review.
- Each LHD provides a varying suite of services, ranging from comprehensive allied health services, paediatric services and hospital facilities, while other districts, especially those in rural and remote areas have limited access to these services, and long waiting lists for public health services.
- The availability of health professionals within LHDs can delay interventions, for example a lack of available paediatric staff or speech pathologists. This creates difficulties, particularly in rural/remote areas, for practitioners responsible for ensuring health assessments and interventions are provided.

- There is also a particular issue concerning access to forensic medical health services for children in the child protection system. Children who have encountered serious abuse and require a forensic medical examination, primarily in response to sexual abuse, often encounter long waiting times for consultations or are required to travel up to four hours to receive appropriate forensic medical services. These issues are outlined in detail in the NSW Ombudsman's December 2012 report on Responding to Child Sexual Assault in Aboriginal Communities. The Ombudsman made extensive recommendations to the NSW Government relating to NSW Health regarding forensic and counselling and support services including:
    - NSW Health nominating an organisational unit to be responsible for providing education material to mandatory reporters in the broad health system including information about reporting STIs and sexual activity in children.
    - NSW Health ensuring that its new database for capturing Sexual Assault Service data includes collection of data regarding the number of aboriginal children referred for counselling and the number that received this service.
    - NSW health developing a policy that provides for equal access to transport options regardless of which agency has first contact with the victim about the reported sexual assault
    - NSW Health review the capacity of the New Street Adolescent Service and Rural New Street which provides a service to children and young people who sexually harm and their families.

Reported enablers

- Health's OOHC Coordinators and FACS-CS's Interagency Pathways Co-ordinator positions were extremely significant in providing local, consistent, single points of contact, tasked with supporting the implementation of the health assessment and coordination process. OOHC Coordinators and FACS-CS IPC positions also monitored progress against a child's HMP.
- Strong interagency collaboration (FACS-CS and Health) with the development of documentation to support the collaboration e.g. the MoU, and the Model Pathway.
- Development of an agreed interagency data reporting framework and the recent enhancements to CS's KiDS database
- Agreement between FACS-CS and Health to mandate the use of an agreed Health Referral Form, with agreed mandatory fields
- Greater information is available about a child or young person's health status. HMPs clearly identify a child's needs and required interventions for the information of the child, their carer, caseworker and relevant health professionals. HMPs provide a comprehensive and transportable record of the health assessments and referred interventions the child or young person receives whilst in statutory OOHC.
- Good relationships at the local level between FACS-CS caseworkers and local health providers. Health services prioritise children based on clinical need.
- Carers support for the child or young person's health interventions and their willingness to transport and attend appointments with the child or young person.

Medical history

Current approach to recording and tracking medical histories
The Wood Special Commission of Inquiry into Child Protection Services in NSW recommended (recommendation 16.7) that:

"The introduction of centralised electronic health records should be a priority for NSW Health. Given that this is likely to take some time, an interim strategy should be developed to examine a comprehensive medical record or a transferable record for children and young persons in OOHC, which should be accessible to those who require it in order to promote or ensure the safety, welfare and wellbeing of the child or young person."

This recommendation was supported by the NSW Government and appointed NSW Health as the lead agency for implementing this recommendation. The NSW Government supports the introduction of centralised electronic health records, and is pursuing the development of this in conjunction with the national e-Health strategy.

Following the recommendations of the Wood Special Commission, Chapter 16A was inserted into the NSW Care Act to facilitate the provision of services to children and young people by agencies that have responsibilities relating to their safety, welfare and wellbeing. The Chapter authorises or requires prescribed bodies (NSW Health being one of them) to communicate with each other to facilitate the provision of services to children and young people. This permits FACS-CS to track medical histories of children and young people in OoHC to create a comprehensive medical record for the child or young person however this is contingent on FACS knowing where to track the information.

NSW Health has approval from the Health Executive for the HMP to be used as the transferrable, portable medical record for children and young people in statutory OOHC as an interim measure until the development of an effective electronic health record. The Health Management Plan is designed to be a comprehensive, portable record of the health assessments undertaken while the child/young person is in statutory OOHC. In addition to the copy retained by the child/young person, a copy of the Health Management Plan is provided to the child/young persons case worker, the carer and other health professionals involved in the care in order to support communication regarding the ongoing care needs and review schedule.

NSW Health and FaCS-CS are continuing to work closely on the development of tracking health records for children and young people under the Pathway to ensure it is transferable and accessible to those that require it.

Children and young people who are not eligible for the Model Pathway, but who are assessed as being in need of care and protection or in OoHC will have a case plan developed. As part of the process for assessing the child or young person and developing their case plan, caseworkers gather a variety of information about the child's strengths, challenges, and where available obtains copies of relevant assessment and progress reports; medical and dental records; behaviour management plan; school and education assessment reports. This information is recorded in the child's file and FACS-CS Key information Data System (KiDS).

All children and young people in NSW receive a Personal Health Record - Blue Book which is presented to each child by NSW Health and provides a Personal Health Record (PHR), for health professionals and patterns to detail their child's health, growth and development.

Carers in NSW receive the child's Personal Health Record for children placed with them, and provide updates on the child's health, dental and developmental progress. If the child's Personal Health Record is not available, the carer is able to receive a new one from their local child health centre or hospital. The Personal Health Record then moves with the child or young person if they return home or move to another placement.

Effectiveness of current methods

HMPs provide a comprehensive and transportable record of the health assessments and referred interventions that a child or young person receives whilst in statutory OOHC. It does not capture or record all of the child's health interventions since birth.

FACS-CS Client Information System (KIDS) is an electronic record for children and young people in the child protection system, including their relevant medical history. However, only information that is available to Community Services is recorded in the KiDS system, which is not always comprehensive due to difficulties in accessing information about a child or young person's medical history. Recording information in KiDS involves manual data entry and because of this the extent and quality of the information recorded can vary.

The Personal Health Record - Blue Book which is provided to all children in NSW is also an effective method for tracking children's health histories, provided it is maintained and follows the child wherever he or she is placed. For children and young people in the child protection system, prior to their entry into the child protection system, many children may have had irregular contact with health services, or their health details may be incomplete, making it difficult to piece together a clear and reliable history. This can lead to delays in finding and dealing with health and developmental issues.

Continuity of Care

- To ensure continuity of care, health records must follow the child or young person.
- Continuity of care is provided by ensuring that the child or young person's HMP follows them, wherever they are placed, and by ensuring that the child or young person's HMP is communicated to the child and all relevant professionals and carers involved in the child's life. If a child leaves care the HMP is provided to birth parents, adoptive parent or guardian.
- A similar approach is adopted for a child's Personal Health Record which is available for all children in NSW and should accompany the child wherever he or she is placed.

Role of technology

Technology has the potential to provide a more streamlined, efficient and accurate mechanism for recording and tracking medical histories of children and young people in the child protection system. The advantage of centralised, electronic health records is their accessibility. Such records can be updated from a variety of different sources and locations, provided the person has access to the system. This means that professionals can update one single record for the child, rather than duplicating records within agencies. A centralised single health record also ensures consistent health recorded for children regardless of whether they are in OOHC. NSW Health is working towards solutions for the provision of effective, centralised electronic health records to improve the accessibility of health related information for this vulnerable population.

Barriers and enablers to implementing effective tracking of health records

Reported barriers and challenges

- Lack of centralised electronic health records. There is currently no mechanism to centrally and electronically track a child's medical history. This means that child's records are maintained in a piecemeal approach between FACS, Non-government OOHC service providers, NSW Health and public and private health service providers. These multiple records are updated by relevant professionals and where possible, information is shared to maintain comprehensive medical records and health histories for children in the child protection system. However, this approach is prone to information gaps in health histories.
- Accuracy records within the KIDS system - KIDS allows for electronic documentation of a child or young person's medical history as it is known to FACS-CS. The system is only accessible by FACS-CS staff, which means health professionals cannot input information directly into the system. Although caseworkers liaise with relevant family members, carers and health professionals regarding the child or young person's health status and history and can also obtain copies of relevant health records, this approach is time consuming for frontline caseworkers and is also prone to information gaps. This system also relies on manual data entry by caseworkers and casework practice around record keeping does vary.
- The absence of a centralised electronic health record system within NSW creates barriers to accessing information. If a child has resided in more than one LHD, FACS-CS caseworkers must request information about the child from a variety of LHDs.
- NGO OOHC providers lack access to Community Services records around the medical histories of children and young people in the OOHC system. A summary of information around a child or young person's medical history and health needs is shared with the child's NGO OOHC provider at the point of transfer and includes their HRF, HMP and their current case plan.
- If children exit the child protection system, their health histories captured in their KiDS record, their case plan or their HMP are no longer updated. A copy of the child's Personal Health Record – Blue Book is provide to the child's permanent carer, but not all children in the child protection system have their original Personal Health Record.

Reported enablers

- The HMP for a child/young person on the Model Pathway provides a comprehensive and transferable record of health assessments undertaken whilst in care and contributes to providing integrated case planning and service delivery to this group.
- Good casework practice around obtaining and recording information about a child or young person's health history.
- Under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998, prescribed bodies have the ability to request information which will assist to make any decision, assessment or to plan, initiate or conduct any investigation or to provide services relating to the safety welfare and wellbeing of a child or young person. This enables a significant amount of information exchange across agencies regarding the health histories of children and young people in the child protection system

Other related matters

Funding of health assessments and interventions

NSW Health has undertaken a significant amount of advocacy with the Commonwealth to discuss the need for a dedicated MBS item for the NSW Model Pathway. The Child Health and Wellbeing Sub-committee was not successful in attaining a dedicated MBS item for the OOHC Health Pathway however the Commonwealth described the current MBS items which could be used.

Wherever possible, health services for children and young people in the child protection system are accessed through the public health system. If public health services are not available, costs associated with accessing 'fee for service' health services are paid for by FACS-CS, provided the health treatment is part of an approved case plan for the child or young person.

Recording and reporting of information on client health needs and outcomes

Quarterly reporting by FACS-CS and NSW Health will be governed by the joint data strategy that is currently being developed.

Coordination between departments and agencies

The Model Pathway outlines the role of NSW Health, FaCS-CS and OOHC service providers as well as other government agencies and carers in delivering health assessments and interventions for children and young people on the Model Pathway. The journey of the child is central to the Pathway.

The OOHC Pathway Working Group includes representatives from NSW Health and FACS-CS at a head office level and meets bi- monthly.

Memorandum of Understanding between NSW Health and FaCS-CS on Health Screening, Assessment Intervention and Review for Children and Young People in Out-of-home-care provides the roles and responsibilities of each agency in facilitating access to health assessment and intervention for children and young people in OOHC. Specialist coordinator positions provide a key coordination role for the Model Pathway.

Practitioner collaboration

Strong collaboration between frontline practitioners in NSW Health, FACS-CS and Non-Government OOHC agencies has enabled effective implementation of the Model Pathway. Collaboration between practitioners was facilitated though Local OOHC Health Coordinators appointed by NSW Health and Interagency Pathway Coordinators appointed by FACS. These positions supported the development of local service delivery models and promote best practice in the provision of health assessments to children and young people entering statutory OOHC. These positions were responsible for planning, implementing, monitoring and reporting on the process of providing health assessments for children and young persons entering OOHC within their region or LHD. The Interagency Pathway Coordinators and OOHC Health Coordinators also liaised regularly with frontline staff and also conducted joint training sessions to NGOs.

Strong relationships at the local level have been established through between FACS-CS and NSW Health professionals and facilitate communication and enabled effective implementation of the OOHC Health pathway.

Close collaboration with carers has also been important for effective implementation of the Model Pathway. Under the pathway caseworkers frequently liaise with carers and health practitioners to organise assessments and interventions and share information about the outcome of these assessments or interventions.

Workforce and training issues

Workforce issues that impact on the provision of health assessments and interventions for children and young people in the child protection system include:

- Difficulty in recruiting and retaining staff in rural and remote areas, which was experienced by both FACS and NSW Health. For example, rural LHDs experienced difficulty in recruiting an OOHC Health Coordinator which impacted on the implementation of the Model Pathway. Lack of available medical professionals within a local area can impact on timely assessment and health interventions.
- Medical practitioners who understand the health needs and vulnerabilities of children and young people in the child protection system as opposed to children in the general population are important. Practitioners conducting health assessments should be aware of the impact of trauma on attachment issues, relationship insecurity, disordered sexual behaviours, anxiety due to past trauma, behavioural issues such as inattention/hyperactivity, conduct problems and defiance, and other less common problems such as self-injury, excessive eating and other food
- NSW Government Keep Them Safe funding for this program has been secured until June 2014. Central funding of FACS IPC positions ceased in June 2013. Funding for NSW Health OoHC Health Coordinator positions ceases in June 2014. FACS districts have developed transition plans for embedding the work of the IPC into local practice. The impact of this change has not yet been assessed.
- Effective training about the Model Pathway and the roles and responsibilities of professionals has assisted with the implementation of the Model Pathway. Training in the Model Pathway has recently been provided to the NGO OOHC agencies across NSW.
- Community Services is currently in consultation with the Learning and Development Branch around implementing ongoing training of NGO OOHC agencies and entry level caseworkers in the OOHC Health pathway
- Support and education of carers is equally important in providing effective health assessments and interventions for children in the child protection system. Carers are responsible for meeting the day-to-day health and medical needs of children in their care. Ongoing communication, training and support should be provided to carers to assist with their responsibilities.

B.3 Northern Territory

Contributors: Northern Territory Government, Office of Children and Families

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

The Northern Territory Care and Protection of Children Act 2007 (the Act) provides the legislative framework to address the health needs of children in out of home care. Under the Act, a care plan must be prepared and implemented as soon as practicable and includes identification of the child's needs and measures to address these. The Act stipulates that care plans must be reviewed initially at 2 months and then six months thereafter. The Act also stipulates other circumstances when the care plan must be reviewed and includes when there is a change to a child's placement arrangement and when a young person is leaving care.

Policy

National Policy Framework

National Framework for Protecting Australia's Children 2009-2020.

National Standards for OOHC. Standard 5. 'Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way'.

It is a Department of Children and Families (DCF) policy requirement that all children subject to child protection intervention have a case plan. The need for a health assessment is on a case by case basis.

DCF has existing policy for health assessments and interventions for children in out of home care. When a child enters care a baseline assessment is completed during the first three months. It covers medical, dental, educational and where necessary, psychological assessment. It is used to identify any significant needs as well as provide a baseline of information for future assessments.

Health assessments

Jurisdictional approach to providing health assessments to children and young people

DCF uses the health systems currently in place in the Northern Territory. This includes services provided by the Department of Health in urban and remote areas; GP clinics; Aboriginal health services, hospitals; health services in remote communities. The recent formation of DCF led hospital-based Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs provides a collaborative assessment and response to children with complex needs, including those in out of home care.

All children in the care of the CEO are required to have a care plan that addresses their needs. The care plan tool has domains that cover all of the child's health and wellbeing and requires that these are addressed and regularly reviewed. Health assessments for children who are the subject of a child protection investigation are on a case by case basis.

Outcomes of assessment

There are no current reporting measures in place.

Possible pathways to health assessments

When a child enters care information is gathered from the child's family and health professionals to inform an Essential Information Record and a Baseline Assessment. The Essential Information Record and Baseline Assessment assists DCF to ensure that the child is provided with an appropriate level of care. The information gathered assists in determining whether there has been previous or recent health assessments of the child and informs what is required to complete a baseline assessment. If a child already has a GP this may be the most appropriate person to conduct the assessment or to provide existing information. If the child is Aboriginal it may be more appropriate that the health assessment is undertaken by an Aboriginal health service.

Health service system pathways exist for children and young people assessed as vulnerable and/or at risk. DCF led hospital-based Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs provide a collaborative assessment and response to children with complex needs, including those in out of home care. The key government agencies that participate are Health, Police, Education and SAF'T the peak Aboriginal organisation in the NT.

There are also Community Safety and Wellbeing Teams in a number of remote communities across the NT. These are community and interagency forums where community and locally based agencies collaborate in planning prevention, early intervention, and safety coordination responses to communities and families with complex child safety and wellbeing needs. The local health agency is a core member of the team.

Screening and assessment tools utilised

The Baseline Assessment tool supports the policy requirement for a baseline assessment to be conducted within 3 months of a child entering care. DCF also have templates for care plans which cover all the domains that relate to child health and wellbeing.

Health Services use the range of tools that are available to health professionals

Barriers and enablers to health assessment

The ability to obtain a complete paediatric assessment or to obtain follow up services once an assessment has been completed is a barrier particularly in remote areas. Remote areas often only have visiting specialists which impacts on the availability and coordination of appointments. At times there is a lack of services and there are the associated costs of seeking assessment in urban areas.

The ability to provide health services to young people who abscond and who DCF are unable to engage with.

Enablers include the ability of staff in regions to develop working relationships with local health staff. DCF has mechanisms in place to promote cross agency collaboration. For example, the DCF led hospital-based Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs and the Child Safety and Wellbeing Teams in some remote communities.

Health interventions

Range of health interventions available

Health assessments are available through services provided by the Department of Health; GP clinics; Aboriginal health services, hospitals; health services in remote communities. If a child already has a GP this may be the most appropriate person to conduct the assessment or to provide existing information. If the child is Aboriginal it may be more appropriate that the health assessment is undertaken by an Aboriginal health service.

Effectiveness of referral pathways from health assessment to interventions

Remoteness and recruitment issues can make it difficult to obtain follow up services one an assessment is completed.

Barriers and enablers to the provision of health assessments

The ability to obtain a complete paediatric assessment or to obtain follow up services once an assessment has been completed is a barrier. Remote areas often only have visiting specialists which impacts on the availability and coordination of appointments. At times there is a lack of services and there are the associated costs of seeking assessment in Darwin.

Enablers include the ability of staff in regions to develop working relationships with local health staff. OCF has mechanisms in place to promote cross agency collaboration. For example, the OCF led hospital-based Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs and the Child Safety and Wellbeing Teams in some remote communities.

Medical history

Current approach to recording and tracking medical histories

In DCF client information is managed and maintained in two ways: hard file kept in Service Centre and electronic record in the Community Care Information System (CCIS). Together they provide a complete and integrated record. Original copies of reports; assessments etc are not able to be stored in CCIS. However in a CCIS Progress Note a cross reference is made to documents placed on the hard file. In addition to DCF records, the NT has had a shared electronic health record system since 2005.

Other related matters

Funding of health assessments and interventions

There are some Medicare Benefits Schedule assessments available to children and offer opportunities to address the health needs of children in the child protection system or in out of home care.

For children in care DCF meets the cost of initial remedial dental work when a child initially enters care and the costs of dental services not available in the public health system, e.g. dental treatment of children requiring a general anaesthetic or specialist orthodontic work. The foster and kinship care allowance covers basic dental care.

For children in care DCF meets the cost of: immediate acute medical treatment that could impact on the commencement of a placement and initial health and dental assessments that need to be arranged by the child's case manager; all ongoing chronic or repeat prescriptions or over the counter medications; ongoing treatment of chronic medical conditions through a registered health provider; specialist medical and health services where the child or young

person is not able to access the service in the public health system, or access the service in the public system in an appropriate time-frame. This includes speech therapy, occupational therapy and physiotherapy. The foster and kinship care allowance covers basic medical care. DCF pays for the gap payment and medical treatments after carer has funded 3 medical visits in one year. Where a carer has placed a child in care under their private health cover DCF will pay the gap for a specific medical or dental service or course of treatment if pre-approved by DCF.

For children in care DCF also pays for spectacles, standard corrective and specialist corrective and contact lenses and solutions.

DCF also pays for medical transport costs.

Recording and reporting of information on client health needs and outcomes

DCF has two integrated systems for record keeping, hard files maintained at Service Centres and the Community Care Information System. Currently there is no form of data reporting.

Coordination between departments and agencies

DCF led hospital-based Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs provides a collaborative assessment and response to children with complex needs, including those in out of home care. The key government agencies that participate are Health, Police, Education and SAF'T the peak Aboriginal organisation in the NT.

Practitioner collaboration

Caseworkers develop working relationships with local health services. There are also Community Safety and Wellbeing Teams in six remote communities across the NT. These are community and interagency forums where community and locally based agencies collaborate in planning prevention, early intervention, and safety coordination responses to communities and families with complex child safety and wellbeing needs. The local health agency is a core member of the team.

Workforce and training issues

There is a continuous need to ensure effective mechanisms are in place for child protection and health professionals to work together for children in the child protection system and out of home care.

B.4 Queensland

Contributors: Queensland Government Department of Communities, Child Safety and Disability Services

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

The Charter of rights for a child in care, schedule 1 of the Child Protection Act 1999 (the Act), recognises that the state has responsibility for a child in need of protection who is in the custody or guardianship of the chief executive. The Charter establishes that a child in care

has the right to have access to dental, medical and therapeutic services, necessary to meet the child's needs. Section 74 of the Act states that as far as reasonably practicable, the chief executive must ensure the charter of rights for a child in care in schedule 1 is complied with in relation to the child.

Statement of standards in section 122 of the Act, states that the chief executive must take reasonable steps to ensure a child is cared for in a way that meets standards of care. A child will receive dental, medical and therapeutic services necessary to meet his or her needs and if a child has a disability, the child will receive care and help appropriate to the child's special needs.

Policy

The child health passport (CHP) process was implemented in Queensland in 2007 with extensive guidance to staff provided through procedural guidelines and practice resource. The procedures and resource were revised in 2009 and 2010.

Research that has informed policy and practice

The initial program guidelines were developed as a joint project between the Department of Health and the Department of Child Safety, now Department of Communities, Child Safety and Disability Services (DCCSDS), and based on the "Health of children in out of home care" Paediatric Policy of the Royal Australasian College of Physicians that was initially drafted in 2005.

The program was initially piloted in a number of sites that included a rural and remote Indigenous community incorporating the Royal Flying Doctor Service, a child advocacy clinic at a large metropolitan hospital, two regional hospitals and a community child health program. Results confirmed that almost all children assessed during the pilot had multiple health issues that included medical, physical, emotional, developmental and behavioural concerns.

Health assessments

Jurisdictional approach to providing health assessments to children and young people

A health appraisal or health assessment is required for children and young people in the child protection system. A health appraisal is appropriate if a child has seen a health professional within the last 12 months and the health professional has enough information about the child to provide a comprehensive report in relation to the child's day to day health needs, health status and any medical follow up or treatment that may be required. A health assessment is required when the child has not seen a health professional in the last 12 months or if the health professional is unable to provide a comprehensive report about the child's health status without seeing the child. The child's health assessment may be conducted by a range of health care professionals, including:

- general practitioners and general practice nurses
- Indigenous health services
- Royal Flying Doctor Service and outreach paediatric clinics
- paediatricians
- child health nurses.

Where a child is already being seen by a paediatrician or other health professional, it may be more appropriate that they undertake the assessment. If a child has a regular general practitioner (GP) and has been seen recently, a health appraisal will determine whether or not they need a full health assessment. A child may not require a full assessment if their health professional is regularly reviewing and monitoring their health. If a child has a regular GP but has not been seen recently, it may be preferable that this GP completes the assessment to ensure continuity of care.

If the child is Aboriginal or Torres Strait Islander, it may be more appropriate that the health assessment process is undertaken by an Aboriginal Medical Service, Indigenous health service or a culturally sensitive general practitioner. The same considerations apply when referring a child from any cultural background for a health assessment.

The child's case plan is also likely to influence which health professional is engaged to conduct a health assessment. For example, when a young person is transitioning from care, considerations may include:

- linking them to a health professional that could manage their health care needs after they exit care
- whether the proposed health service bulk bills so that lack of finances does not prevent the young person accessing their doctor, following their transition from care
- if the young person is living independently, engaging them with a health service that is close to public transport.
- The overall goal of the case plan will also be a consideration informing the decision about the most appropriate health professional to conduct a health assessment. For example:
- when the goal is reunification, it may be appropriate to use the parents' health care provider or a health service located close to the parents' residence
- when the goal is long-term out-of-home care, it may be appropriate to use the carers' usual general practitioner.

Deciding the most appropriate health professional to undertake the health assessment ultimately requires professional judgment by the case worker, having regard to the above-mentioned considerations and the views of the child, parents and the carers.

Disability Services can prioritise assessments and make recommendations for specialist services for children in out-of-home care. Specialist disability assessments are also provided by the Evolve Behaviour Support Services within DCCSDS for children and young people with a disability at risk of entering statutory care; in care; or returning home to birth families from care.

A child health passport process must begin 30 days and no later than 60 days, after a child enters OoHC. The process is commenced when Child Safety staff make a request in writing for a health and dental professional to complete an appraisal or undertake an assessment of a child's health and dental needs, or when confirmation of a medical appointment has been received. A child health passport is required for a child in out-of-home care subject to:

- child protection care agreement that has been extended beyond 30 days
- court assessment agreement that has been extended beyond 30 days

- an interim child protection order granting custody to the chief executive
- a child protection order granting custody or guardianship to the chief executive.

Outcomes of assessment

As at 30 June 2012, 5,004 children in Queensland required a child health passport. Of these, 4,714 or (94.2 per cent) had a child health passport commenced or recommenced. It is not possible to provide data regarding the nature and outcomes of individual children's health assessments.

Possible pathways to health assessments

When a child is to be placed in OoHC, information from parents and where necessary, relatives or other health professionals, will be gathered about the child's immediate health needs, including details of the child's general practitioner, health specialist and any outstanding appointments, and the child's essential medical history. This essential health information obtained from the child's parent, carer or other sources will inform whether a health assessment or health appraisal is required.

Where a health professional may have enough information to provide a comprehensive report about the child's health needs, a health appraisal will be arranged. The information they provide is the health summary and forms the basis of the child health passport. Where a health assessment is required, the child's general practitioner (GP) should complete the health assessment where possible. Where the child has not seen a GP, the child's age, Indigenous status and current living arrangements will assist in deciding the most appropriate professional to conduct the health assessment. As much as possible, the child, parents and the carer will be involved in the health assessment.

Screening and assessment tools utilised

The health professional undertaking the health assessment is able to use any available tool to inform the health assessment. The standard health assessment process usually undertaken by a health professional for children in the general community is acceptable. Examinations and assessments include an assessment of the child's general physical health including their height and weight; visual and hearing screens and an appraisal of the child's developmental milestones.

Tools available to health professionals include the 'Well Child Health Check' or Healthy Kids Check for children who are four years old and the 'Age Appropriate Assessment' tool which entail an assessment of a child's physical health, general well-being and development, with the purpose of initiating medical interventions as appropriate. For mental health screenings, health professionals also have a choice of tools and these might include the 'Strengths and Difficulties Questionnaire', 'Ages and Stages Questionnaire' and the 'Kessels 10' tool.

The health assessment may be referred to in various ways including baseline health assessment, child health check, health screen, universal child health check or Well Child Health Check. Despite the differing terminology used by health professionals, the assessed domains are consistent.

Barriers and enables to health assessment

The issuing of individual Medicare and health care cards assists children in out-of-home care to access available health assessments and interventions. All children subject to child protection orders that grant custody or guardianship to the chief executive are eligible for their own Medicare and health care cards, following the provision of suitable identification documents. An individual Medicare card can be issued for a child while continuing to be listed on their parent's card. This allows parents and carers can be involved in meeting the day to day health care needs of a child in out-of-home care.

All children in out-of-home care are entitled to a Health care card in their own name. The card remains with the child even if they change placement and it is automatically renewed every six months, as long as the child remains eligible. Health care cards for children in out-of-home care are exempt from income and asset testing.

In circumstances where a child's birth has not been registered, a birth certificate will not be issued until the child is subject to a child protection order. This can cause delays in the issuing of a Medicare care or a health care card.

A promotional strategy within the DCCSDS was undertaken in 2010 with a focus on the health and wellbeing needs of children and young people in out-of-home care. The strategy aimed to ensure that that initial assessments or appraisals were completed and the child health passport process was commenced. The resource 'A guide for General Practitioners completing health assessments and appraisals for children in out-of-home care' was developed and distributed to general practitioners in Queensland to better inform them of the health needs of children and young people in out-of-home care and of the child health passport process.

Health interventions

Range of health interventions available

Children and young people in the child protection system in Queensland are able to access the full range of health interventions available to children and young people in the general population.

In addition, a child or young person in out of home care under an interim or finalised children protection order granting custody or guardianship to the chief executive of DCCSDS who presents with severe and complex psychological and/or behavioural problems may be eligible for a service from the Evolve Interagency Services (Evolve) program. Evolve comprises teams of both mental health professionals from HHS (Evolve Therapeutic Services) and psychologists, speech and language pathologists and occupational therapists from Disability Services (Evolve Behaviour Support Services).

These teams work in collaboration with school guidance officers and the case worker with case responsibility to provide therapeutic and behaviour support for children in out-of home care who have severe and complex behavioural and psychological issues. Evolve allows an intensity of service provision consistent with the level of need of the child and their support network to:

- reduce frequency and intensity of challenging behaviour
- form secure attachments and positive peer relationships
- increase placement stability

- increase participation in educational programs and improve educational outcomes
- increase participation in community activities to facilitate their wellbeing
- enhance communication with the key people involved with their care
- promote greater understanding of their behaviour and the best way to respond to their needs
- build capacity of their support.

Effectiveness of referral pathways from health assessment to interventions

It is acknowledged that Aboriginal and Torres Strait Islander people experience lower levels of access to specialist health services than the general population. Specialist health services will generally be located in larger regional or metropolitan centres. Aboriginal and Torres Strait Islander health programs and rural health services may be available in some regional or remote areas. However, children in remote areas, including children in out-of-home care may also experience barriers to specialist services due to factors such as proximity, availability and cultural appropriateness of health services, or transport availability.

Medical history

Current approach to recording and tracking medical histories

The child health passport contains the information the carer requires to meet the day-to-day health needs of the child. A health care file is created for filing all original documents relating to the child's health on the health care file and copies of the originals are filed in the child health passport folder. Relevant information filed includes:

- a child information form
- details of the child’s Medicare care card and health care card
- health appraisal or health summary letter
- letters regarding consent processes for medical decisions
- information relating to the specific health needs of the child, including a diagnosed disability or any other health related information that would assist the carer to meet the child's health needs
- information about any prescribed medications
- information about any medical alerts

All medical alerts for the child, including adverse drug reaction, sensitivity/allergies of significance, significant mental health alerts, prescribed psychotropic medications and infections of significance, require an alert to be placed on the child health passport folder. In addition, where an alert relates to a life threatening medical condition, the medical condition is recorded as a 'serious health condition' alert on the child's person record in the department’s electronic client record system, Integrated Client Management System (ICMS).

Details of a child’s immunisation history, child health passport, health cards, any medical conditions or disabilities are recorded under the health tab on a child's person record in ICMS.

Information relating to a child’s health needs and recorded in ICMS can be accessed by Child Safety staff across Queensland immediately the information is entered in ICMS.

When or if a child commences a new out-of home care placement, the new carer is provided with the child's paper based health passport and informed about any medical alerts for the child including any life threatening condition. Medicare is also advised of the child's new address.

When a child commences a respite placement, the respite carer is advised of the child's health needs, including all medical alerts and any appointments or treatment required during the placement period. Depending on the length or frequency of the respite placement, the primary carer may provide the respite carer with the child health passport, for the duration of the respite placement.

When a child returns to the care of parents, the parents are provided with the child health passport and the parents advised about relevant medical information and any follow up appointments. Medicare is also advised of the child's new address.

When a young person transitions from care to independence, they are provided with the child health passport.

Barriers and enablers to implementing effective tracking of health records

The child health passport folder is prepared and provided to the carer at the commencement of the child's first placement. This process is initiated by the child's case worker and prioritised in conjunction with other tasks at the commencement of a child's placement. Clear guidelines and administrative support for case workers for the creation of health care files and child health passports assists in establishing a consistent recording process.

Other related matters

Funding of health assessments and interventions

A number of Medicare items may cover an assessment of the health needs of a child in out-of-home care. For an Aboriginal or Torres Strait Islander child, the health professional has the discretion to bulk bill the cost of a health assessment and may use either of the enhanced primary care items for Indigenous children when billing for the assessment. For a non-Indigenous child, there is no single Medicare item number for a health assessment and full payment may be necessary.

Carers pay the costs associated with charges incurred with a health professional for the initial health assessment and claim through Medicare. Child Safety reimburses the carer for the 'gap fee' associated with the health assessment.

When a child is referred to other health providers for follow up, the carer pays for one appointment only and Child Safety meets the cost of the other appointments. Examples of these costs may include: diagnostic tests, extraordinary pharmaceutical costs, specialised meal supplements, mobility aids, optical equipment, specialist mental and dental health treatment, or where a young person is living independently and requires general medical assessment and treatment.

In relation to dental assessments and treatment, school age children can be assessed through the Child and Adolescent Oral Health Service, at no cost. Children younger than four years of age and those who have completed Year 10 of secondary school are also eligible for publicly funded oral health care if they hold a current concession card such as a Health

Care Card. Additionally, the Teen Dental Plan provides annual vouchers that cover the initial costs of a dental examination.

Recording and reporting of information on client health needs and outcomes

Data regarding health assessments, interventions and histories is recorded in ICMS on the health tab and in the case note of a child's record.

Two key indicators are reported on: children who require a child health passport and of these, how many have a child health passport. Number of children who require a child health passport is calculated by using data regarding the placement type of the child and the type of intervention for the child. Using the start date of the intervention and start date of the continuous time in out-of-home care, if the child has been subject to both (simultaneously) for 60 days or more, they meet the criteria for requiring a child health passport.

None of these sections recorded under the health tab of the child's person record in ICMS including health cards, immunisations, disabilities and medical conditions, are currently used in corporate reporting Detailed information regarding health assessments, interventions and histories is not recorded in these sections but is recorded in the case notes of a child's record. These are free text fields and not readily usable for reporting.

While the reporting of health needs and client outcomes would be considered beneficial, at this stage, limitations of how detailed data is recorded for the health needs and outcomes of a child is recorded, means that significant changes to ICMS would be required before reporting on these aspects could be considered.

Coordination between departments and agencies

Coordination is limited between departments and across agencies in meeting the health needs of children at a case level where case management is the responsibility of a Child Safety Officer.

At a systems level, the original development of the child health passport process was facilitated by the appointment of a Child Safety Director in Department of Health who led the coordination, communication and strategic planning within Department of Health on the initiative. Implementation of the process was also assisted by a Child Safety Director within Disability Services.

Initial health assessments of children may also be facilitated by the involvement of local networks such as the Suspected Child Abuse and Neglect (SCAN) teams. SCAN teams include Department of Health, Child Safety, Queensland Police and Department of Education, Training and Employment. When concerns are first received about a child and where the child requires a medical assessment, referral to and involvement of the SCAN team can ensure their health needs are comprehensively assessed.

The Evolve program, as a specific program response, takes an active role in coordinating the mental health therapeutic and/or positive behavioural support services for children in care who are accessing the program including children with a disability.

The aim of the program is to provide intensive support to the child and their key stakeholders to reduce the frequency and intensity of challenging behaviours, increase placement

stability, improve their emotional and mental health wellbeing and develop and enhance skills to participate in school and the community.

Practitioner collaboration

The Evolve mental health therapeutic and positive behavioural support planning and intervention is developed and implemented in collaboration with the Evolve stakeholders. Evolve is a collaborative partnership across the DCCSDS, Department of Health (DH), Hospital and Health Services (HHS) and the Department of Education, Training and Employment.

Evolve provides a service consistent with the child's or young person's level of need. The Evolve plan is informed by the Child Safety case plan and vice versa to ensure a consistent and collaborative response.

The Evolve mental health therapeutic component of the program delivered through the Hospital and Health Services (HHS) comprises of mental health professionals such as psychiatrists, psychologists, nurses and social workers in addition to Indigenous health officers, multi-cultural officers, and professional development coordinators. The Evolve behaviour support component of the program delivered through Disability Services compromises psychologists, speech and language pathologists and occupational therapists.

In circumstances where a child requires additional health care assessments or interventions that cannot be met through the multi-disciplinary teams within the Evolve program, the Evolve clinician works with the child's case worker to refer to appropriate health services. Evolve staff have the capacity to work with other health practitioners to ensure a collaborative holistic response to the child or young person's needs.

For the Evolve program, identified issues or blockages are addressed at a local or regional level and are not tracked at a central level. Service agreements are negotiated between the Evolve program and 19 HHS across the state.

Workforce and training issues

There remain barriers to the provision of the full spectrum of medical services, including mental health, disability and other specialist services, in a culturally appropriate way, especially in rural and remote localities. Strategies, including workforce and training factors, could improve access to and responsiveness of the mainstream health system to the health needs of Aboriginal and Torres Strait Islander children in care, and children from culturally and linguistically diverse backgrounds.

As a specific program response, Evolve staff within HHS and Disability Services, adhere to practice intervention framework and professional development consistent with their professional domain and their respective agency to ensure health assessments and interventions are in line with best practice and current research. Staff within the Evolve program developed expertise in treatment and management of children and young people with extreme and complex behaviours and in the fields of trauma, attachment and positive behaviour support. Evolve staff have provided training across government, non-government and private sectors to support professional development within the sector, develop knowledge and skill across children and young people's support networks, and provide direct support to carers to enhance outcomes for children and young people.

Evolve delivers training to key stakeholders including: Child Safety staff; education staff; Department of Health and Hospital and Health Services staff; foster and kinship carers; and youth workers and residential care staff. In addition, information and training is supplied to the broader community, including psychiatrists, medical students, social workers, Queensland Police and court staff.

Training was provided to carers and professionals increasing the capacity and skill to support children and young people with complex and extreme needs. In addition, staff across HHS and Disability Services Evolve teams provided training and coaching of carers, teachers, family and other key stakeholders in strategies to manage the specific needs of children and young people accessing the Evolve program. Training was also provided to Therapeutic Residential Care Services as part of the establishment of these services.

The primary focus areas for training conducted includes: trauma and attachment; mental health diagnoses; mental illness and clinical presentations; issues around sexualised behaviour; managing self-harm and aggression.

B.5 South Australia

Contributors: Government of South Australia, Department for Education and Child Development; Government of South Australia, SA Health – Women's and Children's Health Network.

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

SA Children's Protection Act 1993 Section 51(1)(e)

Policy

Health Standards for Children and Young People under the guardianship of the Minister were developed under Rapid Response: Whole of Government Services for children and young people under guardianship of the Minister.

Research that has informed policy and practice

An unpublished literature review was conducted during the initial development of the Health Standards.

Health assessments

Jurisdictional approaches to providing health assessments to children and young people

The approach is being reviewed in line with implementation of the National Clinical Assessment Framework. The existing approach is for an initial (comprehensive) health assessment to be conducted within around three months of a child entering out-of-home care (referral made by Families SA within 2 months, appointment scheduled by SA Health within 5 weeks)

All children placed in out-of-home care under a care and protection order are eligible and required to have a health assessment. See page 4 of the current Health Standards for further detail on specific orders, if required.

Outcomes of assessment

Implementation of health assessments in line with the National Clinical Assessment Framework has not commenced in SA. The existing initial health assessment is comparable with the comprehensive health assessment in the National Clinical Assessment Framework. This question relates to measure 5.1 of the National Standards for OoHC, scheduled for national reporting in 2014.

The nature of the initial health assessment and intended outcomes is outlined on page 22 of the Health Standards. SA is not able to provide data on outcomes.

Possible pathways to health assessments

Children are referred by their Families SA case manager for the initial health assessment. There is some variation in the process depending on the location and individual circumstances of the child. Some children may be referred to a GP on entry into care and the GP will then provide referral to a paediatrician working in a public health setting to complete the (comprehensive) initial health assessment – This is the pathway that SA is intending to implement with the revised Health Standards in line with the National Clinical Assessment Framework. Other children may have already seen a paediatrician as part of the investigative process preceding their entry into care and this information may inform the initial health assessment.

Screening and assessment tools utilised

At the moment there is no standard assessment for children entering out-of-home care in South Australia. The National Clinical Assessment Framework does not prescribe the use of any particular screening and assessment tools. We would like all children in out of home care to have a formal developmental assessment, such as a Griffith, as it is well recognized that they are at risk of developmental delay, learning and behavioural difficulties.

Barriers and enables to health assessment

Ensuring that children receive the same level of service regardless of where they receive the assessment. Access to GP and specialist services in rural and remote areas is very constrained. Having GP's and paediatricians who are able to undertake assessment that is informed by an understanding of trauma and its impact on children (a dedicated MBS item would provide support towards addressing these barriers).

Situations where there may be change of placement/carer or change of worker following entry into care – results in greater difficulty providing the full picture of a child's health needs and tracking progress of referrals. A Health plan which follows the child would enable improved responses to assessments. Many children receive multiple assessments during different periods of engagement with the child protection system, which can result in duplication.

Families SA C3MS case management system provides the existing infrastructure to record health assessments and outcomes. There are some challenges in implementing consistent recording to ensure quality of data. It works well where we have a coordinating role to ensure the initial assessment includes all relevant health history.

Health interventions

Range of health interventions available

Initial (comprehensive) health assessment comprise: psychological therapeutic services, primary health care services, outpatient services, emergency services, inpatient services, dental services. Children are eligible for priority service in all SA Health settings as part of Health Standards under Rapid Response.

Effectiveness of referral pathways from health assessment to interventions

SA considers that the most effective referral pathways are where SA Health takes the lead responsibility for making referrals to required health interventions in consultation with Families SA. In practice this may vary in response to the barriers/enablers listed above and location that the service occurs.

Barriers and enables to implementing referrals

As mentioned above, changes of placement/carer/case worker can all present challenges to keeping track of required health interventions and ensuring that referrals are followed through in a timely way. Health assessments and interventions in rural and remote areas may be provided on a sessional/visiting basis, which impacts on timely access. The multiplicity and incompatibility of IT systems, within and between health services and child protection services present another barrier to timely intervention.

Medical histories

Current approach to recording and tracking medical histories

Families SA case workers can record referrals and attach assessment outcomes in the C3MS case management system. Different IT systems across health settings do not provide for one repository for health assessments and interventions. Children under guardianship are flagged on SA Health IT systems to indicate priority service is required under Rapid Response.

Recording on C3MS means that Families SA has capacity to track medical histories of children in care over time. The effectiveness of this is only limited by the ability of case workers to place information in the relevant location in C3MS. This also means that the case worker is required to communicate relevant information to health practitioners and carers who do not have access to C3MS.

Barriers and enablers to implementing effective tracking of health records

Some health events are not documented and provided to Families SA for recording, e.g. carer arranges an unplanned appointment with a GP for a child in care. Storage of information on C3MS does not allow for access by health professionals operating from different services – at present exchange of information is dependent on Families SA. Consistent recording of health information by case workers is another issue impacting on effective tracking of health records.

Other related matters

Funding of health assessments and interventions

Existing MBS items are used where a referral is made from a GP. These MBS items are not effective in ensuring consistent level of assessment. Existing MBS items do not provide support or incentive to GPs to undertake initial assessments based on the specific needs of children and young people in care.

Recording and reporting of information on client health needs and outcomes

Recorded by Families SA case workers on C3MS. Quality of data is dependent on consistency of recording practice by case workers.

Coordination between departments and agencies

Coordination occurs at level of Across Government Steering Committee. One SA Health location has directed resourcing to a coordinating role working in conjunction with local Families SA offices. In other locations the Families SA case worker is required to coordinate health assessments and interventions.

Practitioner collaboration and workforce and training issues

Practitioners collaborate as required by the circumstances of the individual child. Families SA or SA Health may take a lead role depending on location.

B.6 Tasmania

Contributors: Tasmanian Government Department of Health and Human Services, Children and Youth Services

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

The Children, Young Persons and Their Families Act 1997 enables the Department to:

- have a child professionally examined, tested or assessed if they are under the custody of the Secretary or under an assessment order. This does not require the consent of the child's guardian; Section 29
- make arrangements (including admission to hospital) for the medical or dental examination or treatment of the child or for such other professional examination or treatment as may be necessary or desirable; Section 69(1)(e)
- make provision for the physical, intellectual, psychological and emotional development of the child; (Section 69(2)(c)

Policy

The Tasmanian Child Protection Practice Manual provides explicit direction on the health assessments and interventions for children and young people in the child protection system. Relevant advice outlined in the Manual includes:

- Considerations of good practice in the identification and management of health needs for children and young people in OoHC
- Direction on a range of health and wellbeing considerations that need to be incorporated in the Case and Care Plan
- Specific consideration in identifying and managing Aboriginal health issues

The Practice Manual states that children should have a full medical check within one month of the child entering care.

Research that has informed policy and practice

During 2011-13, the Community Paediatric Registrar at the Royal Hobart Hospital undertook a project looking into the health of 4-6yo children in out-of-home care compared to Tasmanian peers. The children were the first cohort to be seen in the out-of-home care health screening clinic at the Royal Hobart Hospital. The results have not yet been published.

Provision of health assessments

Jurisdictional approach to providing health assessments

In Southern Tasmania there is a paediatrician led out-of-home care clinic that provides comprehensive health screening, as well as assessment of developmental, mental health, and behavioural issues. This clinic, operating out of the Royal Hobart Hospital, and with an out-clinic at Bridgewater, commenced in 2011 and has seen all children currently in care in the South, as well as all new entrants to out-of-home care in the South since 2012. The clinic is part of the HEARTS program (Health, Education, Activities, Records, Tracking and Supports) which commenced in 2011 and is "A Multidisciplinary Community Based Intervention Project to Improve the Emotional Health and Wellbeing of Children in Out of Home Care".

- All children entering care in Southern Tasmania are seen by a GP and referred to the out-of-home care clinic at the Royal Hobart Hospital if they are 0-14yo. Older children are referred to a youth health service (Headspace, Pulse).
- In Northern Tasmania a Paediatrician led out-of-home care clinic is in the planning stages, based on the experience from the South. At present children are seen by a GP on an as needs basis and referred to local paediatricians as required.
- Out-of-home care guidelines state that all children should also be seen by Oral Health Tasmania for dental review, and by the Child Health and Parenting Service (CHAPS) if under the age of four.
- An immunisation report is generated for each child with an overdue immunisation status, as determined from the Australian Childhood Immunisation Register, on a quarterly basis. This report is provided to the child's caseworker and guardian so that a catch up program can be organised through the child's GP.
- A DHHS Children and Youth Services data warehouse project (KIDS Data Warehouse) has integrated a number of internal and external agency data sources thus enabling the production of an 'Individual Profile Report' for each child in out-of-home care. The IPR currently contains CHAPS attendances, school absences and suspensions, oral health DMFT scores, emergency presentations, hospital admissions, as well as all out-of-home care involvements.
- The Child Protection Practice manual states that all children are required to have a medical assessment within one month of entering out-of-home care.
- Children in out-of-home care in the South aged 0-14 are provided with health assessments via the HEARTS health assessment and screening program. Children aged 14-17 are encouraged to access Youth Health Services.

- Similar comprehensive screening and assessment services are not yet available to children in out-of-home care in the North and North West, however assessments with general practitioners and medical specialists are conducted as required.

Outcomes of assessment

Data on child health assessments conducted by the Southern HEARTS clinic is not yet available. A data linkage project is currently under way that will enable child health assessments for children in care to be reported.

The pilot screening clinic saw 129 children. It has continued to provide screening for children in care. However data from the screening clinic is not yet available.

Data is not available at present as without appropriate systems the reporting burden is too great for the clinicians involved in providing the assessments. A data linkage project is under way which will make assessment outcomes data available for reporting. The nature of the assessments is summarised below.

For Southern Tasmania only:

- Children and young people aged 0-14 years: The out-of-home care clinic is a paediatrician run clinic that assesses:
- Health: history, including antenatal and birth history, and thorough examination;
- Psychological wellbeing and behaviour: the Strength and Difficulties Questionnaire is used for >4yo for psychological health, and the Ages and Stages questionnaire for 0-4 year olds;
- Development: using the Brigance Developmental Screening tool, and further assessment using the Griffiths Mental Developmental Scales as needed; and
- Visual Acuity.

Following the assessment, relevant referrals are made, and in some cases, treatments are provided by this clinic. In addition, a letter reporting assessment outcomes is generated as a PDF document for inclusion as a case note in the Child Protection Information System (CPIS), and forwarding to the child's GP. This clinic retains the responsibility for follow-up of these children. They are seen at least annually whilst in out-of-home care.

- Young people aged 15 years or more: Young people are referred to one of two youth health services (Pulse or Headspace) in the Hobart region. These services offer a GP clinic, sexual health, and psychology services. If input from a paediatrician is required the GP can refer to the out-of-home care clinic. Information is returned to child protection services about what services the young person is accessing, and when, but not the details of the assessments. Those young people living outside Hobart are seen by their local GP on an as needs basis. Copies of reports from all health contacts are requested for entry into CPIS.

Screening and assessment tools utilised

Mental health and behaviour, for children >4yo, is assessed by the RHH paediatrician clinic using the Strength and Difficulties Questionnaire (SDQ). The SDQ is a brief screening measure that is employed for the purpose of identifying behavioural and emotional problems in 4-17 year old children. There are SDQs for parent/carers, and teachers, and self-reporting for ≥12yo.

Children 0-4yo have their mental health screened using the Ages and Stages Social and Emotional Questionnaire. This screening tool is completed by carers and helps identify children who may be at risk of developing social or emotional difficulties. It is a prompt for further evaluation.

- The Ages and Stages questionnaire can be used at intervals 6, 12, 18, 24, 30, 36, 48, and 60 months. Each questionnaire contains 22-36 questions addressing seven behavioural areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Anyone who spends time with the child on a regular basis, such as parents, caregivers, foster parents, grandparents, aunts and uncles, is qualified to answer questionnaire items.
- Development is screened at the Out-of-Home Care Clinic using the Brigance Developmental Screening tool. It is designed for children from birth to the end of year one (seven years, six months). It tests language, motor and academic areas of development, and is a prompt for further investigation.

Barriers and enablers to health assessment

Enablers which have improved the provision of health assessments include:

- The establishment of a Community / Child Protection Paediatrician. The position description states that "This is a state-wide paediatric position with responsibility for the coordination and delivery of a state-wide clinical service for children and young people when physical, sexual abuse and/or neglect is suspected. The role has responsibility for the coordination and delivery of a clinical service for children and young people who are clients of Child Protection services or in Out of Home Care."
- This position provides expert clinical advice with regard to child protection clients and promotes multi-disciplinary collaboration between paediatric services, general medical services and child protection services.
- A Child Protection Liaison Officer has been established at the Royal Hobart Hospital to improve the interface between Child Protection Services and the Royal Hobart Hospital.
- The Child Protection Model of Care (December 2011) provides a recommendation to 'give consideration to extending the role of both the Community Paediatrician and the Child Protection hospital liaison officer to the North and North West'. However this recommendation has not been implemented at this time.
- The HEARTS multiagency collaboration project which focuses on improving health, education and wellbeing outcomes for children under State guardianship in Southern Tasmania.
- An outreach clinic in Bridgewater to help improve access in that area to the out-of-home care clinic.
- A potential future enabler will be the use of electronic health records to manage the health needs of children and young people.
- Barriers, or issues, which have hindered the provision of health assessments and interventions include:
- The resources available to the Child Protection Paediatrician to conduct health screening for children in the child protection system are restricted and services are currently only provided in the South, despite this being a state-wide position.

- Insufficient resources to implement state-wide processes for ongoing medical assessments and interventions.
- Financial costs and logistical difficulties faced by carers in accessing medical services for children and young people, particularly in the North West.
- Financial costs associated with engaging private practitioners to conduct medical assessments.
- Foster carers with numerous children often find it difficult to organise alternative care to take one child to an appointment.
- Under resourced specialist intervention services for developmental trauma and mental health support.
- Under resourced learning and behavioural support for children with developmental trauma in the education system that do not fulfil the existing requirements for educational support.

Health interventions for children and young people

Range of health interventions available

A range of intervention services are available throughout the State for support of family and child health. Access to these services is provided by a community based access and assessment service known as Gateway Services which is led by a single lead community services agency in each area of the State. This service provides a single visible point of entry, as well as consultation with Child Protection Services, information and advice, and data collection to support reporting. An integrated model of care is delivered via a range of support services, some of which are:

- Early Years Parenting and Support – targeted intensive family support for vulnerable families with children aged 0-5 years;
- Child and Family Centres – community centres which aim to meet the health and wellbeing needs of local children aged 0-5, as well as provide support and education for parents;
- Child Health and Parenting Services – universal health checks for children and specialised support for first time parents;
- Integrated Family Support Services - works to improve the safety, wellbeing and health of children from birth to 18 years and their families;
- Targeted Youth Support Services – intensive and sustained therapeutic casework for young people experiencing any of a wide range of barriers to health and wellbeing; and
- Disability Services.

Most intervention services are located in the four main centres of Burnie, Devonport, Hobart, and Launceston, however some centres have limited capacity, and some services are available only in Launceston or Hobart. In addition to standard medical specialists the available service providers include:

- Early Childhood Intervention Services (Department of Education);
- Oral Health Services Tasmania (DHHS);
- State-wide Mental Health Services (DHHS), including:
- Mental Health Services; and

- Alcohol and Drug Services.
- GP Mental Health Plan, Headspace; and
- Family Violence Counselling and Support Services (DHHS), including the Children and Young Persons Program (CHYPP).

Effectiveness of referral pathways from health assessment to interventions

Medical assessments, referrals and follow-ups are managed by the out-of-home care clinic in Southern Tasmania. Medical care is well resourced. However specialist ear, nose and throat services in the public sector have very long waiting lists, in some instances greater than 12 months. Specialist paediatric surgical services are easily accessed.

Psychological intervention and support services are insufficient for the identified needs arising from the out-of-home care clinic in Southern Tasmania. The Child and Adolescent Mental Health Services have limited capacity for trauma based counselling, or support with difficult behaviours. The Australian Childhood Foundation offer trauma based services for children in out-of-home care, however waiting lists often greater than six months, and only the most severely affected children are able to be seen. Domestic violence counselling for children is accessible through CHYPP however waiting lists are also greater than six months. Private psychologists are able to be accessed through GP mental health plans however there are few with child and adolescent expertise, especially in the area of developmental trauma.

Community based developmental services, for early intervention under the age of 5 years, are well resourced and access is usually within six months for specialist occupational therapy, speech therapy and physiotherapy in Hobart. Early Childhood Intervention Services (ECIS) access is possible in major centres.

Medical histories

Current approach to recording and tracking medical histories

A data exchange process for children under guardianship and custody orders has been established between Children and Youth Services and Hospitals. Hospital involvements for children under orders are stored in the KIDS Data Warehouse and presented in a visual timeline. A similar process for oral health data is currently being established.

A spread sheet has been used by the OOHC clinic to record clients' health details. Hospital and oral health medical histories are only exchanged for the public health system which is a limitation of this method. Another limitation is multiple disparate systems, each containing only part of a child's medical history. This could be improved if clients had a central electronic health record.

Barriers and enablers to implementing effective tracking of health records

- Optimising the available resource for development of information gathering, analysis, and sharing systems and tools.
- Establishing protocols for, and allocation of resource to, the implementation of data linkage projects across agencies.

Other related matters

Funding of health assessments and interventions

Initial health assessments are carried out by the Child Health and Parenting Service (CHAPS) nurses and general practitioners, who bill to MBS. The HEARTS program in the South of the State, which implements a more comprehensive out-of-home care assessment program (Royal Hobart Hospital and Bridgewater), is funded by the Royal Hobart Hospital. Standard out-patient clinic appointments are used and billing is as per the MBS schedule.

Interventions, such as hospital admissions and emergency presentations, are funded by RHH operations. Access to mental health services is based on MBS funding.

Recording and reporting of information on client health needs and outcomes

Health assessments, interventions and histories are recorded in a range of disparate information systems and in various formats. Only a small subset of the information is available to Child Protection and currently only for children under guardianship and custody orders. There is currently no reporting on the health needs and outcomes of children in the child protection system.

Coordination between departments and agencies

When a child enters Child Protection Service (CPS) care, the Child Protection Worker (CPW) requests that the child's carer obtain an indefinite referral to the Out of Home Care (OoHC) Clinic at RHH from their GP. The GP is requested to provide information about the child's health needs, and any health concerns which require further assessment. Information is also requested from the child's school and carer through completion of the Strengths and Difficulties Questionnaires (SDQs) which should be completed prior to the appointment.

Once the GP referral is received by RHH, Paediatric Outpatient clinic RHH will schedule an appointment, and forward this to CPS via the generic Child Protection Liaison Officer (CPLO) mailbox.

The CPLO forwards details of the appointment to the child's CPW, who must advise the child's carer and ensure that they can attend. The CPW should assist the child/carer to attend the appointment if required, i.e. by providing transport.

The child then attends the health screening appointment at RHH accompanied by their carer, CPW and/or birth parents (if appropriate). The Community Paediatrician completes the health assessment, and arranges follow up as required. The Community Paediatrician prepares a health assessment report, which is forwarded to CPS via the CPLO following the appointment. A copy of the health assessment is stored on the child's file, and is shared with the CPW and carer.

Communication between CPS and RHH is managed by the CPLO, which minimises the potential for communication breakdown due to the child's worker or placement changing. Children's addresses at RHH are marked as c/o CPS, which ensures that any appointment letters for the child are sent to CPS and can be forwarded to the child's current placement and address.

Children's health assessments are reviewed on an annual basis, or sooner if required.

Practitioner collaboration

There has been a high level of collaboration between the Community Paediatrician and CPWs in the development and ongoing management of the OoHC clinic. In the initial phases

of the clinic, the Community Paediatrician met with individual CPWs to arrange appointments for children on their caseload. This allowed CPWs to discuss the child's individual needs, and allowed discussion of particularly complex emotional or behavioural difficulties. It also assisted in identifying which children had a treating Paediatrician, and therefore did not require further health assessment.

The Community Paediatrician has developed working relationships with community health service providers such as St Giles and Early Childhood Intervention Service (ECIS), and makes referrals directly to these and other services where there are specific needs. Oral Health Services has also collaborated with CPS in sharing information about children's engagement with their service, so that all children have access to dental care.

The Community Paediatrician has been willing to consult with CPWs regarding children and young people with complex medical or emotional and behavioural needs. This has included attending multi-agency Care Team meetings, or meeting individually with CPWs and the CPLO. CPWs have identified that having access to specialist health professionals assists them to meet children's health needs, and access health services for children and young people.

Workforce and training issues

An understanding by health professionals, carers and caseworkers of the effects of trauma on health, development, and mental wellbeing is considered important in understanding how best to respond to children n care. Ongoing dissemination of health referral pathway information to caseworkers, carers and GP's is important to ensure effective access to services.

The Community Paediatrician and paediatric trainees are undertaking a training course and certification program in the Neuro-sequential Model of Therapeutics (NMT) by the Child Trauma Academy (U.S.A). This will enable these health professionals to provide specific assessments for developmental trauma using the Neuro-sequential Model of Therapeutics' clinical practice tool, and to guide interventions.

Regular training sessions for caseworkers and foster carers in southern Tasmania are provided in Hobart on the health needs of children, developmental issues, health referral pathways, and other health related areas. General practitioners in Southern Tasmania have had educational material on the specific health needs of children in care and appropriate referral pathways provided via newsletters and education days.

B.7 Victoria

Contributors: Victorian Government Department of Human Services; Victorian Government Department of Health

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

The Children, Youth and Families Act 2005 (CYFA) provides the legislative context for children and young people in the child protection system, including the out-of-home care system.

Section 10(1) of the CYFA states that “the best interests of the child must always be paramount” and Section 10 (3)(n) specifies that this includes giving consideration to the desirability of the child being supported to gain access to appropriate health services.

All foster care and residential care in Victoria (apart from 3 small Departmental facilities) is provided by funded out-of-home care service providers. Approximately half of the kinship care placements arranged or maintained as a result of child protection involvement are also supported by funded kinship service providers. Sections 58 -61 of the CYFA provides for performance standards to be published in the Government Gazette which must be complied with by community services who are registered to provide services funded by the department.

Policy

The Department of Human Services has one fully integrated set of standards (The Department of Human Services Standards) which apply to a broad range of services funded by the department (including disability services, housing services, and children, youth and families services). Community services are required to participate in an ongoing accreditation and independent review under these standards in order to be registered.

For registration purposes, service providers must demonstrate that they meet the requirements of the standards including meeting any specific program requirements relevant to each service type for which they are funded. The out of home care program has specific program requirements for residential care and home based care

The program requirements for residential care services in Victoria 2012 specify that:

- CSOs (community service organisations) will support the requirement that children and young people entering care for the first time (or for the first time during the current period of involvement) will undergo a comprehensive health assessment as soon as possible or within three months of admission to the placement and thereafter on at least an annual basis or as often as required in their treatment plan
- CSOs will promote the health needs of children and young people in residential care. This includes medical, dental, auditory, mental health and specialist needs.
- Residential carers will attend to each child and young person’s health care needs as they arise. Specific details of any ongoing treatment required in any of the health care areas will be outlined in each child and young person’s placement plan.
- Residential carers will maintain records detailing the child and young person’s health care assessments and treatment plans, including records of any immunisations the child or young person has received.
- The program requirements for home based care in Victoria 2012 specify that
- CSOs will promote a child’s medical health needs being met. Health needs include general medical, dental, optical, auditory, mental health, disability and specialist needs.
- Children entering home based care for the first time (or for the first time during the current period of involvement) will have their medical health needs (including general

medical, dental, optical, auditory) identified by a medical practitioner as soon as possible or within one month of entering care

- If a child is entering the placement from another placement, CSOs will confirm the last date on which the child received a health assessment(including general medical, dental, optical and auditory examinations) and will arrange many assessment that may be required.
- CSOs will ensure children's medical health needs are monitored annually or more frequently if their health status requires, as detailed in their care plan. CSOs will maintain up-to-date records derailing the child's medical health needs and health assessments, including records of any health treatments, ongoing and prescribed medication administration, and any specialist assessments and immunisations received. These records will be passed onto the child, their family or the relevant CSO when a child changes placement or at the conclusion of a placement.

Research that has informed policy and practice

The Department of Health facilitated an expert advisory group to review available literature and develop a clinical pathway for providing comprehensive health assessments and treatment for children in OoHC. This clinical advisory group report was produced in May 2012 and is an unpublished report.

The Department of Human Services has contracted the Australian Institute of Family Studies to undertake "Beyond 18; the Longitudinal Study of Children Leaving Care to better understand young people's experience during their transition from out-of-home care and after they have left care. The purpose of the study is to inform government policy in supporting more effective transitions for young people from out-of-home care. In particular, it will aim to improve young people's move towards interdependent relationships and eventual independence by providing insights into the critical success factors associated with transition from out-of-home care, and proposing ways to enhance out-of-home care and improve the transition and post-transition phases from care.

The study will be conducted with young people born between July 1996 and June 1997 (i.e. young people who are scheduled to transition out of the system during 2014 as they're turning 18 years of age). The study will also provide in-depth analysis on the effects of out-of-home care on Aboriginal young people and other young people experiencing specific vulnerabilities, such as those living with disabilities, alcohol and drug dependencies and mental health issues.

Provision of health assessments

Jurisdictional approach to providing health assessments

The approach applicable for all children and young people in out-of home care is to require funded out-of-home care service providers to comply with the program requirements detailed above as per their service agreement with the department and as required to meet independent review requirements for accreditation purposes associated with maintaining their status as registered community services.

In addition, the 2011-12 Victorian State budget provided funding of $12.8 million over four years for the Health and Education Assessments Initiative for children in out-of-home care. This initiative provides additional resources to enhance and facilitate more effective

implementation of health and education assessments for children in out-of-home care. There are two different enhanced approaches currently being tested in two separate but concurrent projects:

- Pathway to Good Health approach to comprehensive healthcare for vulnerable babies, children and young people in OoHC. Currently being implemented in the North and West metropolitan areas of Melbourne involving children in all types of OoHC.
- The state-wide health and education assessments project for young people in residential care.

The Pathway to Good Health is a partnership project between the Department of Health and Department of Human Services. This pathway aims to utilise mainstream health providers to provide coordinated and holistic health care for children and young people in all types of out-of-home care including foster care, kinship care and residential care. This project is implementing the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care that was released in March 2011. The project commenced in November 2012 and is being rolled out in the former North and West metropolitan region of Melbourne. Further roll out across the state is subject to the findings of the evaluation of this initial roll out. The key components of the Pathway are:

- initial health check within 14 days entry to care – undertaken by selected GP's in the local area
- optometry, dental check and audiology (on referral from GP) within 14 – 30 days after entry to care – undertaken by private bulk billing providers in the local area
- referral by GP to specialised Multi-disciplinary teams (MDT) at designated Pathway to Good Health clinics from four sites in the project area: Royal Children's Hospital (RCH) Centre for Adolescent Health, RCH Centre for Community Child Health, Djerriwarrh Community Health and Dianella Community Health – specifically funded for this purpose to provide priority access to appointments.
- screening tools completed by the GP, the child's carers, teachers and the child themselves (depending on the child's age) in preparation for the comprehensive assessment process undertaken by the MDT.
- comprehensive assessment undertaken at the MDT clinics with core clinicians comprising paediatrician, mental health and speech pathologist (under 5yrs). Assessment required within 60 – 90 days of entry to care
- development of a health management plan by the MDT that is provided to the referring GP and those responsible for the child's care to incorporate into the overall care planning for the child. Plan to be provided within one month of assessment
- reatment provided based on recommendations made in the plan and where possible provided via publically funded services but if not available in a timely way then brokerage funds are provided by DHS to access private health services. Ensuring that treatment is provided to the child under the recommended plan is the responsibility of the responsible case manager or carer of the child as part of the child's case planning process
- review within one year by the MDT

The Project co-ordinator and her manager from the Department of Health have engaged key stakeholders and provide information and education about the project, in conjunction with two Department of Human Services based coordinators. This has included selection and support of participating GPs and the four MDTs and provision of ongoing education/ information sessions at all levels within Child Protection, Community Service Organisations, GPs, Medicare Locals and Multi-Disciplinary Teams. All children participating in this initiative, including those in foster care and kinship care, have access to the brokerage provided as part of the statewide initiative for children in residential care (described below).

The health component of the statewide health and education assessments project is targeted specifically for young people in residential care as a highly vulnerable group within the overall out-of-home care population with more complex health (and education) related needs. The first assessments and associated follow up treatment undertaken through this initiative occurred in December 2012.

This project has engaged eight departmental positions to coordinate the initial roll out of this initiative. The departmental coordinators are also expected to facilitate an equivalent educational assessment component of the project. The coordinators in the North and West metropolitan areas also support the Pathway to Good Health project.

This initiative provides health assessment related brokerage funding based an average of $1500 per child per year (based on average residential care occupancy rates in the respective Divisions). The departmental coordinators manage the use of brokerage to fund necessary follow up treatments arising from health assessments and any necessary assessments provided by private practitioners where equivalent publicly funded assessments are unable to be accessed in a timely way.

The key health related components of this initiative are:

- Initial health check or health review by a GP within one month of the young person entering the current residential placement (unless a recent health check or review makes this inappropriate)
- "catch up" initial health checks or health reviews by a GP as soon as possible of all young people currently in residential care who have not had an initial health check or health review within the previous 12 months
- Optometry testing, dental care, audiology examinations, immunisations, mental health assessment and treatment, drug and alcohol assessment and treatment, speech therapy, sexual health care, as required in conjunction with the GP examination and arranged by the out-of-home care service provider
- Specialist assessments and treatments on referral from GP including paediatric assessment and paediatric follow up care, mental health assessment and treatment, and drug and alcohol assessment and treatment, speech therapy, sexual health care, and immunisation – which in combination and based on the individual child's health needs comprise a comprehensive assessment process

This initiative builds on current practice of accessing local GP's and does not prescribe any screening tools or assessment formats. There is no recruitment of specific GP's to undertake this work as in the Pathway to Good Health approach.

The Department of Human Services also funds a statewide mental health service specifically for children involved with child protection (and predominantly those in out-of-home care) called Take Two. Take Two is auspiced by Berry Street Victoria, on a behalf a consortium which includes Austin Health, La Trobe University School of Health Sciences and Mindful - the Victorian Child Psychiatry Training Department.

As outlined in the Program requirements related to departmental standards and referenced above, children and young people in OoHC are required to have health assessments.

- CSOs funded to provide foster care and/or kinship care placement support are required to ensure that all children in foster care and supported kinship care entering home based care for the first time (or for the first time during the current period of involvement) have their medical health needs (including general medical, dental, optical, auditory) identified by a medical practitioner as soon as possible or within one month of entering care, and for their medical needs to be monitored annually (as described above in program requirements in the policy framework section)
- CSOs funded to provide residential care and lead tenant care are required to ensure that all children entering residential care and lead tenant care undergo a comprehensive a health assessment as soon as possible or within three months of admission to the placement and thereafter on at least an annual basis as often as required in their treatment plan (as described above in program requirements in the policy framework section)

Eligibility

Since November 2012, all children in the North and West metropolitan areas of Melbourne who enter foster care, kinship care, or residential care for the first time are eligible for Pathway to Good Health coordinated health assessments and follow up care – with the initial health check from a participating GP to be arranged within two weeks where possible or at least within the first month (as described above).

Since November 2012, all young people in residential care in all areas of Victoria are eligible for health assessments and associated treatments facilitated through the statewide Health and Education Assessments Initiative with the initial health check or a health review by a GP to be arranged within one month for new entries to residential care and as soon as practicable for those in care before the initiative commenced.

Outcomes of assessment

Monitoring of children required to have health assessments is undertaken via the independent evaluation process associated with registration of community services providing out-of-home care. CSOs do not currently submit data to the department regarding the number of children who receive health assessments and there is no established statewide data base with this specific information.

Implementation monitoring data is being collected specifically for children eligible for the Victorian health assessment initiatives. It is still too early in the implementation phase to provide significant data about the outcomes the health assessment projects.

However, departmental project coordinators advise that there have been noteworthy early outcomes for many children, especially due to the enhanced focus on initial health checks or health reviews, dental care, optometry assessments, and auditory assessments for all

children in residential care as well as those entering foster care and kinship care in the North and West metropolitan areas of Melbourne. This has resulted in some previously undetected medical conditions being identified and treated, immunisations being brought up to date , better dental care, glasses being prescribed and obtained for children not previously identified as having sight problems, speech therapy being arranged, dieticians being consulted, and a range of other specialist interventions being provided. The additional brokerage component that has been made available to participants eligible for the two enhanced projects has enabled some assessments and treatments including surgery to be provided through the private health system (thereby avoiding lengthy delays) for medical conditions that were directly impacting on the child's health and development.

The initial feedback from the initial GP check and multi-disciplinary assessment process in the Pathway to Good Health project has been very positive both from the health professionals involved and the care providers for the children and young people. Written health management plans that summarise the medical conditions and treatment recommendations for the child and young are received by both the referring GP and the child's case manager and this enables the building of a medical history for the child as well as assisting in their ongoing care planning. At this stage in the implementation phase it is not clear how the treatment recommendations are being followed but the Pathway to Good Health approach requires an annual review of the plan by either the multidisciplinary team or the treating GP.

Screening and assessment tools utilised

Victoria uses the Looking After Children (LAC) approach to care management which includes an Assessment and Progress Record and an Essential Information Record. These records document the available health information (along with information about other areas of the child's life including emotional and behavioural development, education, family and social relationships, identity etc) that is needed for good care and that a good parent would generally know about their own children, The health related information in these records provides the basic foundation for collating the important information that care teams generally need to be pass on to health professionals undertaking formal health assessments.

Assessments undertaken through the Pathway to Good Health project use specific health assessment screening and comprehensive health related assessment tools.

In the Pathway to Good Health at the stage prior to accessing the MDT – validated screening tools are sent to the nominated carer or case manager for completion and return prior to the assessment taking place. These screening tools are scored and results form part of the child's medical record. The screening tools that are being used:

- < 3 years ASQ & ASQ –SE
- 3 – 5.5 years SDQ ASQ ASQ-SE
- 5.5 – 6 years SDQ CBCCL (1.5 – 5 yrs)
- 6 – 10 years SDQ CBCL (6 – 18yrs) CBCL Teacher Report
- 11 -18 years SDQ SDQ (self-report) CBCL (6 – 18 yrs) CBCL Teacher Report CBCL self-report

The Clinical Advisory group associated with the Pathway to Good Health project has also developed guidance for the GPs and the MDT for the whole comprehensive assessment process based on the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care released in March 2011.

All of the tools used were considered by the expert group that developed the model of care, as in a paediatric context the completion of these validated tools are widely used as means of highlighting issues of concern at a paediatric consultation. In the Pathway program it is envisaged that when the child has a review appointment at the MDT within 12 months that the same tools will be used again and the results compared.

Barriers and enables to the provision of health assessments

Reported barriers include:

- coordination of multiple service response elements across child protection, OoHC service providers and public and private health providers.
- access to and compilation of health records and health information including parental and other family medical history especially when children have moved several times
- difficulties associated with changes to placements, critical incidents and life crises especially for those in residential care which is provided for the most complex needs, and in relation to scheduling and keeping of medical appointments
- difficulties associated with the impact of trauma and adverse life experiences that led to them being in OoHC that result in some young people being unwilling to participate in assessment processes and participate in treatment (in particular dental care)
- the need to support young people with complex needs to most effectively participate in their assessments and the subsequent follow up work
- training of CSO and child protection staff to improve and promote understanding of the importance of good health for children in the out of home care system to build awareness and embed health assessments and ongoing management as part of standard care for these children
- training of residential workers in relation to how best to prepare and support young people to effectively participate in their assessments and subsequent follow up work
- training of health professionals in relation to the needs and management of this vulnerable target group
- access to appropriate specialist health professionals in rural areas
- insufficiency of current Medicare funded items to adequately recompense GPs and others in the public system for the extra time, skill and effort involved in assessing and managing the health needs of this vulnerable target group.

Reported enablers include:

- A strong desire by both the child welfare sector workers and health professionals to achieve the best health outcomes for these children
- The appointment of eight project coordinators in each of the previous regional areas of the Department of Human Services for the initial roll out of the statewide residential care initiative
- The appointment of one project co-ordinator for the Pathway to Good health project from the Department of Health to engage key health stakeholders and provide information and education about the project.- in conjunction with two Department of Human Services based coordinators
- The willingness by a wide ranging group of health professionals in North and West metropolitan area who have agreed to participate in the Pathway to Good Health including GP's, paediatricians, mental health and allied health to undertake this work based on MBS funding and top up for specialist clinics
- The availability of brokerage to provide access to the private health sector when needed and top cover the cost of follow up care including glasses, specialist treatment etc

- The development by the Pathway to Good Health project of information sheets and guidance for children and young people, parents, child welfare sector workers and health professionals
- The development by the Pathway to Good Health project of a web based electronic record that will assist all specialist clinics in maintaining records, producing consistent health management plans and linking to any developments with the Personally Controlled electronic Health Record (PCeHR) and with existing GP medical record systems

Health interventions for children and young people

Range of health interventions available

The full range of health interventions is available. There is no prescribed limit on health interventions provided in accordance with the recommended follow up from assessments. The additional brokerage provided through the two enhanced projects has significantly increased the flexibility and capacity for those eligible for these projects.

Effectiveness of referral pathways from health assessment to interventions

It is still early in implementation of the two referral pathways currently being piloted through the two projects above.

Medical history

Current approach to recording and tracking medical histories

As described above, the program requirements state that community services providing out-of-home care must maintain records detailing the child and young person's health care assessments and treatment plans, including records of any immunisations the child or young person has received and pass these on when the child leaves their care. These records also form a permanent part of the child's statutory case file.

The Pathway to Good Health project is testing an enhanced electronic record for recording and building medical histories when children access a multi-disciplinary clinic. This includes the commissioning of a web based electronic record that will assist all specialist clinics in maintaining records, producing consistent health management plans and data collection on health issues. This record has the capacity to link with the Personally Controlled electronic Health Record (PCeHR) and can be uploaded into existing GP medical record systems. It is anticipated that this electronic record will be operational in the Pathway to Good Health clinics by the end of 2013.

As described above, the barriers to undertaking health assessments and treatment of children in out-of-home care include the difficulties associated with access to and compilation of health records and health information including parental and other family medical history particularly when children have moved several times

Barriers and enablers to implementing effective tracking of health records

Reported enablers

- Effective care teams working collaboratively with health professionals to share the information and follow up in the way that good parents generally do when caring for their own children

- The effective use of the Looking After Children processes and tools for day-to-day care management by care teams as a foundation for good health care
- The use of the portable hand held Heath Diary in the Pathway to Good Health. This diary records basic health contacts and major health alerts as well as documenting the child's case manager and placement history. The diary belongs to the child and will move with them regardless of any change of placement.

Reported barriers

- The complexity of the client information that is recorded by multiple professionals for multiple processes in a secure way.
- The accessibility and security of paper based health information kept by child protection and out-of-home care service providers.
- The inherent difficulties in sharing information across multiple service elements and systems used by child protection, out-of-home care service providers and public and private health providers.
- The complexity of coordinating health information about the child when they are in out-of-home care as could be expected when most children are in their parents' care.

Other related matters

Funding of health assessments and interventions

The full range of health interventions is available. The Medicare funded and public health system is used to the greatest extent possible. Funding for additional health related costs are met on a needs basis from client expenses for children in out-of home care. Children participating in the two projects outlined above have access to specific brokerage funds as described above and the additional brokerage provided through the two enhanced projects has significantly increased this capacity for those eligible for these projects. Victoria considers that a specific MBS item would provide a consistent approach to these assessments.

Recording and reporting of information on client health needs and outcomes

This information forms part of the child's statutory case file. Child protection practitioners workers place the health information they receive on the child's electronic CRIS file (although documents too large to scan may be placed on a related paper file). Depending on the nature of the information it may be incorporated within a pre-existing data category (eg Medicare number, professionals' details) or attached to a case note. The Looking After Children records include three key tools which compile health related information: the Essential Information record, the 6 age related Assessment and Progress Records and the Care and Placement Plan (0-14 years) and the 15+ Care and Transition Plan (15 years and older). These records are expected to be kept up to date by the care team and it is the responsibility of the CSO to ensure they are completed and kept on the child's file.

Victoria does not undertake formal reporting on health needs and outcomes of children in out-of-home care.

Coordination between departments and agencies

Collaboration across departments and agencies is part of day-to-day policy development. There is a statewide cross-departmental Health and Education Assessment Initiatives Group overseeing the two projects.

Practitioner collaboration

Collaboration between child protection practitioners, out-of-home care practitioners and health practitioners is part of day-to-day practice. Care teams comprising the key people involved in the day to day care of the child (their carers, CSO based practitioners, child protection practitioners and birth parents wherever possible) are expected to work closely with health professionals including mental health professionals to promote the child's health and wellbeing.

Workforce and training issues

The Department of Health has an online training program for health professionals regarding children at risk http://vulnerablechildren.e3learning.com.au . As part of the Pathway to Good Health a health forum was conducted for all participating health providers and DHS managers to provide education regarding the health needs and the impact of trauma and how it might present in a consultation. The Pathway to Good Health also works closely with Medicare Locals to support education and training for GP's and other health professionals. As part of this health network, the Department of Health in conjunction with General Practice Victoria and Medicare locals will be developing short webinars to provide ongoing education about the health needs and the support needed for this vulnerable group.

B.8 Western Australia

Contributors: Western Australian Government Department for Child Protection and Family Support; Western Australian Government Department of Health

Legislation and policy relevant to action on health assessments and interventions for children and young people in child protection

Legislation

Legislative Authority: Children and Community Services Act 2004 – relevant sections such as 39, 89 and 90.

Policy

Standards: Better Care, Better Services – Standards for Children and Young People in Protection and Care

The Department's Care Planning Policy requires all children in the care of the Chief Executive Officer (CEO) to have a care plan or provisional care plan that focus on identifying and meeting the needs of the child while in care; this includes their health needs.

Research that has informed policy and practice

In response to the 2007 Ford Review Report Recommendations and in accordance with the Western Australian Rapid Response Framework, the Department and the Department of Health (DoH) formalised a joint pathway (Health Care Planning for Children in Care pathway) so that children in care have regular health checks (i.e. dental, physical,

developmental and mental) and health plans developed and documented in their provisional care plan or care plan.

The 2008 DoH Issues Paper - Health Care Planning for Children in Care: Ford Report Implementation - provided the foundations and rationale for a pilot project to be undertaken. Through research (including what other child protection jurisdictions had in place) and consultation with stakeholders, the Department and DoH proposed a community health nurse-led framework, based on existing DoH state-wide child and school health services. The pilot took place over a six month period during 2009 in four districts.

The final evaluation report of the pilot (April 2010) recommended state-wide implementation of the pathway. Results from the evaluation were used to inform state-wide implementation which was completed in May 2011.

Policy and practice guidelines have also been informed by:

- Ford Review Recommendations
- National Standards for Out-of-Home Care (2011)
- National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (2011)

Provision of health assessments

Jurisdictional approach to providing health assessments

As part of the care planning process, all children in care of the CEO of the Department must have a health assessment to assist in developing and implementing the 'health' dimension of each child's care plan. The health plan should be developed in consultation with the community health nurse or relevant health professional and recorded in the child's care plan. The term 'health plan' refers to a documented action plan, within the care plan, that aims to improve the physical and developmental outcomes for a child in care.

When a child first comes into the CEO's care, including provisional protection and care, the child protection worker must arrange for a medical examination of the child with a general practitioner (GP) or other health professional. The examination must occur within 20 working days, unless an examination has already occurred (for example, where a child has been examined at the Princess Margaret Hospital Child Protection Unit).

Each child in care is referred to a community health nurse, general practitioner or other health professional once they have been in care for 30 days or more, for an age-appropriate health developmental assessment as part of the care plan development and annual review process.

Children who come into care aged 4 years and older must have a Strengths and Difficulties Questionnaire (SDQ) completed once they have been in care for six months.

All children in care aged 4 years and older must have a SDQ completed each year by someone known to the child – this may be done before the care plan review or at one of the quarterly care visits during the year.

Children in care who are of school age must be enrolled in the School Dental Service program to ensure they receive dental care.

All children (0-17 years) who are in the care of the CEO of the Department must have a health assessment. The assessment may be provided by various health professionals. This includes: community health nurses, general practitioners, paediatricians, Aboriginal Medical Services staff.

Outcomes of assessment

As at June 2013 care planning compliance (including health care planning) was 80%.

Possible pathways to health assessments

The Health Care Planning Pathway caters for children and young people both new to care or already in care. The pathway is under review to include other health professionals outside of the DoH.

Screening and assessment tools utilised

Screening and assessment types/tools used in the pathway include:

- Medical examination for children who come into the care of the CEO - When a child comes into the CEO's care, they must have a general medical examination as soon as practicable but within 20 working days, unless an examination has already occurred. This assessment is usually conducted using the Department for Child Protection and Family Support template: GP Medical Examination Form (Form 513) – see attached.
- Ages and Stages Questionnaire (ASQ) - is used for by the child health nurse for children under school age (0-4years). Where the nurse considers there may be mental or emotional development issues; the nurse may use the Ages and Stages Questionnaire - Social and Emotional (ASQSE) to assess the child and to recommend appropriate services for referral if required. Where the nurse assesses that there are mental health concerns, the child protection worker should consult the district psychologist to discuss the child's mental health needs and services to which the child should be referred.
- Strengths and Difficulties Questionnaire (SDQ) - The SDQ is a one page mental health screening tool used for children aged 4 years and above. The Department uses the relevant age appropriate SDQ form from the 'youth in mind' website.
- Dental health - An oral health inspection is undertaken by a nurse as part of the health assessment for those children in care who are under school age. If a dental check is recommended, the nurse will complete a Lift the Lip Referral form and provide this to the child protection worker. The child protection worker will make an appointment at the local public dental clinic for a dental check and/or treatment as required. All children in care who are of school age are enrolled in the School Dental Service (SDS) program and will be seen by the SDS for an examination and treatment as required. A child protection worker will arrange an appointment at the local public dental clinic for those children who are unable to access this service.
- The health and development assessment - A child who is new to care will be referred for a health and development assessment once they have been in care for 30 days, and after the general medical examination has occurred. Children already in care are referred for a health and development assessment two to three months before the child's care plan is due for review, and then annually. If a child cannot be seen via a community health nurse, for example, the child is not engaged in school or the

Department of Health does not provide a service at a particular school, then a GP medical examination may be arranged instead to inform the health dimension of the child's care plan. Similarly, if a child is already being seen by other health professionals, those assessments will inform the health plan for the child. If the assessment is conducted by a community health nurse, they will complete and return a Health Assessment and Improvement Plan and any referral documents to the child protection worker within five working days of the assessment. The plan includes any significant findings, recommended referrals or follow-up, and actions they suggest be taken. This process is under review to better identify the roles of other health professionals in providing assessments for children in care that are outside of the Department of Health.

- Assessment of young people in detention or on remand - A young person is reviewed by a nurse when admitted to the centre, and any urgent health needs are addressed. If they require a doctor's review, an appointment will be made for the next available clinic. A physical assessment of all young people is carried out by a GP within 28 days of admission.

Rapid Response framework - Under the Rapid Response framework, the DoH has agreed that based on clinical assessment of need, a child in care will receive a priority response.

The effectiveness of the Health Care Planning pathway is yet to be fully determined due to its relatively recent implementation.

A staff survey was carried out by the Department in April 2013 to review the health care planning processes and establish what is working well and what changes may be needed. The data is currently being analysed. The DoH conducted a similar survey in June 2013 which will also assist in refining the pathway processes.

Barriers and enablers to health assessment

Reported barriers:

- Structural differences between the two agencies complicate the communication, referral and information exchange pathway e.g. child placement changes, engagement with new services, reporting.
- Differing expectations of ability to provide services between the two agencies.
- Different understanding of each agency's business and language - ongoing discussion around these issues will assist in resolution.
- Capacity/gaps in services and ability to respond to referrals in a timely way, particularly in relation to meeting the needs of remote/rural communities.
- Surveys conducted by both agencies will shed more light on barriers and enablers.

Health interventions

Range of health interventions available

The complete range of DoH services is available for all children in care state-wide from primary (including universal community health services) to specialised (including child development services,) to tertiary and acute services.

Private health services are used when: particular assessment or treatment services are not available within the Department; existing DoH services are unable to provide the service within the referral timeframe; or impartiality of the Department is, or could be, important for legal or therapeutic reasons. In these instances the Department will engage private health services/practitioners i.e. approved psychologists, social work practitioners, speech therapists.

Interagency work with local main stream public health services includes Community Health Nurse Services, Princess Margaret Hospital (PMH), School Dental Service, School Psych Services, etc. Specialised public health services include PMH Refugee Clinic, Child and Adolescent Mental Health Unit.

Department Psychologists and education officers are also available.

Effectiveness of referral pathways from health assessment to interventions

Positive and effective working relationships support a clear, ongoing commitment by both agencies to build on the significant progress achieved to date in implementing, evaluating and improving the health care planning pathway. Clear planning and accountability supports comprehensive assessment and intervention in meeting the health needs of children in care.

Barriers and enablers to implementing referrals

The Department and DoH are currently developing a system that will allow for secure exchange of health reports.

Capacity/gaps in services and ability to respond to referrals in a timely way, in particular the wait times for the diverse range of clinicians required to meet the complex needs of children affected by trauma.

Limited services and availability of clinicians is particularly problematic in remote/rural communities in WA.

Medical histories

Current approach to recording and tracking medical histories

Child Health Passport – The Department has produced the Child Health Passport (Passport) which records a child's health information/history. The Passport is used to provide carers and health professionals with information they need to help meet the child's day-to-day health needs. The Passport contains the following information:

- child’s details including any medical alerts and the emergency contact
- health background and any medical conditions
- health professionals and their contact details
- health and dental appointments
- medications - past and present
- immunisation records.

Health Care Planning Tracking Sheet

Filing of health reports - Child protection workers place all reports and other relevant documentation from assessments and examinations in the Child History Folder (hardcopy

file), after scanning and saving a copy to the electronic file - Child History File. When a child leaves the CEO's care at 18 years of age, they must be provided with their Child History Folder containing all relevant original documentation. If a child leaves the CEO's care prior to 18 years of age, the decision to release information contained in the Child History Folder will be made on an assessment of the child's situation; for example, level of maturity and ability to manage/keep information. The Department may choose to provide copies of the contents of the folder to the parent and/or guardian.

The care plan document - The health plan is documented in the child's care plan, which lists recommended actions to maintain or improve the child's health status over the next 12 months, such as referrals, preventative measures and a timeframe for follow-up. The care plan is distributed to the child, carer/s, parent/s, and any other person considered to have a direct and significant interest in the wellbeing of the child.

All children who access the DoH health service have a confidential health record. The Child Development Information System currently under development will provide a metro wide data base for all children accessing community child health service and a central booking system. The Commonwealth eHealth system will have an impact on tracking medical histories but the impact of this is not known at this time.

The Child Health Passport is seen as an effective way to keep health records for everyday use by carers and health professionals, however this is a paper based record and could be lost.

The ability to exchange health records efficiently and confidentially is seen as an important means to maintaining and tracking children's medical records. Further work is being undertaken by both agencies to enable this process via each department's IT system.

Formal evaluation currently being undertaken will inform changes to recording and tracking as required.

Barriers and enablers to implementing effective tracking of health records

The Department has piloted a learning program specifically for new child protection workers on managing and supporting children in care. This new program will help to promote awareness of the importance of planning for children in care, including health care planning. The program provides information on the health care planning processes including record keeping.

Work is being carried out by both agencies to allow for more efficient exchange of health records.

Other related matters

Funding of health assessments and interventions

The public health system is used wherever possible. Health and development assessments provided by community health nurses are funded by the DoH. Where a public health service is not available, health assessment and intervention for a child in care is funded by the Department. Current MBS item numbers are used.

Coordination between departments and agencies

The Department and DoH have regular joint working group meetings to review progress.

Practitioner collaboration

In general, collaboration between practitioners (i.e. child protection workers and health practitioners) is progressing. Information from the evaluation currently being undertaken will identify areas for further development.

Workforce and training issues

The survey evaluations being undertaken by the Department and DoH inform what needs to be considered. Further training and a review of case practice guidance may be required.

Attachment C Summary of outcomes of the Expert Reference Group meeting – Sydney July 2013

Review of Health Assessments and Interventions for Children and Young People in the Child Protection System

1. Opening The Chair welcomed participants and noted apologies.

2. Purpose The terms of reference of the Expert Reference Group (ERG) were noted including the emphasis on provision of advice to the project on:

- Best practice
- What is currently working well
- Gaps and barriers in current service delivery
- Opportunities that can inform effective service delivery and improved.

3. Background

The project on health assessments and interventions for children and young people in the child protection system (the initiative), in consultation with key stakeholders, was required to:

- Describe current jurisdictional practice
- Examine strengths and best practice
- Identify gaps, barriers and opportunities
- Develop options to progress the initiative

4. Best Practice models /

6. Strengths of current practice

The following best practice models and particular strengths of current practice in individual jurisdictions were discussed.

- Established service coordination roles enable relationships, referrals and information sharing between health services and child protection case workers (such as in Victoria and NSW)
- Clear policy frameworks to underpin agreed clinical standards, roles and responsibilities, and issues of priority access to health services (such as through 'rapid response' in SA and WA)
- Engagement, information sharing and training of GPs and primary care practitioners in the needs of children and young people in the child protection system
- Clear and established pathways from preliminary health assessment to comprehensive and multidisciplinary assessment
- Competency based training regimes for health professionals (currently in operation in the UK)
- Coordination and collaboration with the educational and schools platform.

5. Key features of current Australian approaches

ACIL Allen Consulting presented on preliminary assessment of jurisdictional consultation feedback and areas for possible discussion.

7. Gaps in current practice

Members raised the following key concerns and gaps in current practice drawing from the individual experiences of jurisdictions.

- Concern over current and future skill set of General Practitioners, paediatricians and practice nurses to work with children and young people who have experienced trauma, abuse and neglect
- Deficiencies in interagency collaboration and communication
- Need for shared understanding, coordination and accountability at senior government levels.
- Differing focus and emphasis among health professionals and child protection staff, on the health and developmental needs of children and young people
- Poor understanding at a policy design level of the on the ground issues associated with collecting health histories and coordinating health assessments for this population group, including amount of administrative and follow up work required to make referrals and ensure treatment (intervention) outcomes
- A lack of consistency and shared understanding around appropriate roles and responsibilities
- A risk-averse approach to issues of privacy and information sharing
- Variable use and take up of current MBS items to enable health assessments and interventions for this population group
- Absence of a dedicated MBS item for General Practice (major concern) and for specialist assessment (less of a concern)
- Need to ensure that approaches to health assessment and intervention for Aboriginal and Torres Strait Islander children and young people are culturally appropriate
- Need for support for foster carers to ensure best outcomes for the child (for example, payment of Medicare gap).

8. Opportunities for improved national action

Members identified areas for improved national action centred on the following themes.

- Achieving coordination at all levels
- Obtaining recognition of health priority in the health and child protection systems
- Ensuring General Practice, specialist health professionals and nurse minimum competencies
- Access to treatment services (including multidisciplinary teams)
- Support for foster carers and community sector agencies
- Effective maintenance and sharing of health records
- Development of data and evidence base
- Approaches for Aboriginal and Torres Strait Islander children and young people in the Child Protection system
- Dedicated MBS item for primary care (and to a lesser extent) comprehensive assessments

- Role of Medicare Locals.

Under some themes, multiple opportunities for improved national action were identified. All identified themes and opportunities were considered by members to be of critical importance. Notwithstanding, members identified three themes and their respective opportunities for priority action. The identified themes and opportunities are detailed in Table 3.

9. Summary

See Table 3 below

10. Next steps and close

It was agreed that the key outcomes of the meeting would be provided to members for their validation.

The Chair thanked members for their participation

Table C1 ERG identified areas of focus and opportunities for improved national action

Health records

Effective health records system seen as an enabler to support continuity of health information and overcome difficulties of multiple sources of information and storage of records. Opportunities consistent with Second Action Plan and build on jurisdictional developments in areas of legislation and information storage.

- Legislative provision to enable information sharing across health services and child protection agencies
- Potential of using the OoHC cohort as a trial population of the national e-health records initiative
- Linking of e-health record and the parent held child health record.

Priority: High

Medicare Locals

Potential to focus on the OoHC population and improve local collaboration between the primary health care sector and child protection agencies. Medicare Locals seen as a key point of reference to improving access to health practitioners, skills development and prioritising of children and young people in the child protection system.

- Exploration of potential of Medicare Locals as a platform to drive education, awareness, and training requirements (see also link to skills base and development of national competencies) This could be pursued at national, state and regional levels

Priority: High

Coordination

To better represent the intent of the NCAF, greater specification is required around the coordinating role to facilitate conduct of assessments and the importance of commitment to funding these roles across jurisdictions. Based on the experiences of a number of jurisdictions about what works well, heeding the concerns of some about funding uncertainty for existing coordinator roles and recognising the need to increase the profile of coordinators in all sectors (health, education and community services), strengthened coordination effort across relevant government agencies was critical to effective implementation.

- Shared ownership and accountability for OoHC population across Child Protection, Health and Education at both a policy and practice level (needs to reflect resourcing and administrative requirements of this type of interagency work)
- Coordinator positions to be identified in each of the sectors; community services, health and education.

Priority: High

Data and evidence

An agreed minimum dataset was essential to track progress on health assessments and their contribution to improved health outcomes for children and young people in child protection. The National Standards for Out-of-Home Care includes a requirement to measure the number and proportion of children receiving an initial health check within a specified period after entering out-of-home care. Reporting will commence in 2014 based on 2012-13 administrative data for at least four jurisdictions with definitions to be developed. Under the Second Action Plan tracking outcomes will be explored using available data sets.

- Agreed minimum data set capturing outcomes of health assessments (rather than just outputs), collated as part of AIHW child protection data collection and reporting.

Health priority

Build on jurisdictional developments (such as South Australia's Rapid Response arrangements, Queensland's Evolve program providing targeted therapeutic and behavioural support services and Victoria's approach to priority mental health services) to establish priority access to health assessment and intervention for children and young people in child protection consistent with the need for early intervention, such as on entry to out-of-home care.

Development of policy (or legislative frameworks) that prioritise OoHC population access to health services and treatment

- Improve shared ownership and education, awareness and skills base across health and child protection agencies.

Aboriginal and Torres Strait Islander OoHC population

The rate of growth of Indigenous children on care and protection orders continues to rise. This is affecting out-of-home care in all jurisdictions and warranted consideration of appropriate approaches to health assessment and interventions specific to the needs of Indigenous children and young people.

- Investigation and development of trauma / Indigenous healing informed approaches to health and wellbeing in consultation with Aboriginal health services providers.

General Practice and specialist health professional skills base

Ensure quality of health assessments and interventions by building health practitioner competencies related to the needs of children and young people in child protection. (Link to similar work in the UK on safeguarding children and the roles and competencies of health care staff (Royal College of Paediatrics and Child Health Intercollegiate document).) This will involve supporting the primary care provider to complete the preliminary health check under the Framework, and the specialist paediatrician and other specialists in a multi-disciplinary team, to undertake the comprehensive health and development assessment. National competencies would enable specialist training and maintain a child centred focus among General Practitioners. Could also link to accessing new dedicated MBS items (see MBS item focus area).

- Development of a set of National Competencies for General Practitioners, Paediatricians, Child Psychiatrists, and Community and Practice Nurses.

Access to treatment services

Apply innovative approaches to addressing the supply of health practitioners required for effective health assessments and interventions for children and young people in child protection in rural and remote areas.

- Potential of models of telehealth and specialist outreach to be explored for rural and remote clients
- Use of the allied health platform to support access including through child health training.

Support for foster carers and agencies

- Recognition of the importance of foster carer (and agency) capability to successful health treatments for OoHC population.
- Provision of practical assistance to foster carers to enable reparative and holistic approaches to addressing health needs of OoHC population
- Consideration also of the growing role of statutory kinship carers.

MBS Item

While there is support for a dedicated MBS item, there are opportunities to build on the existing range of items to reinforce the clinical knowledge and skills appropriate to effective service outcomes.

- Investigate specific MBS items that could be enhanced to reflect an appropriate level of clinical knowledge and skills including building on the Aboriginal and Torres Strait Islander peoples health checks
- Investigate application of a new MBS item relevant to young people leaving care.