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# **National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (OOHC)**

**March 2011**



**Prepared by the Child Health and Wellbeing Subcommittee of the Australian Population Health Development Principal Committee with input to Clinical Assessment Framework from the Nous Group.**



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# 1 Introduction

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.<sup>1</sup> They are also more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and are less likely to access preventative health services such as immunisation. The development of a National Clinical Assessment Framework for Children and Young People in OOHC [the Framework] is a key component of the Child Health and Wellbeing Subcommittee<sup>2</sup> (CHWS) led project aimed at '*supporting the health needs of children and young people in out of home care (OOHC)*'.

The overarching goal of the Framework is to improve responses to health needs of children and young people in OOHC and ultimately their health outcomes. Three objectives of the framework are:

- Improve the consistency of health care assessments and services for children and young people in OOHC provided by States and Territories.
- Provide advice about the role of clinicians and appropriate assessment tools.
- Guide jurisdictions to develop appropriate policies and to assist health professionals to make clinical decisions in order to detect problems early, when they are most amenable to interventions.

The Framework is one of a number of initiatives being aligned under the *National Framework for Protecting Australia's Children 2009–2020* [the National Framework]. The development of the Framework is closely related to supporting outcome four of the *National Framework* as outlined in Figure 1 below.

Additionally, another initiative arising from the *National Framework* is National Standards for OOHC which were agreed by the Community and Disability Services Ministers' Conference (CDSMC) in December 2010.

The National Standards have been designed to deliver consistency and drive improvements in the quality of care provided to children and young people.

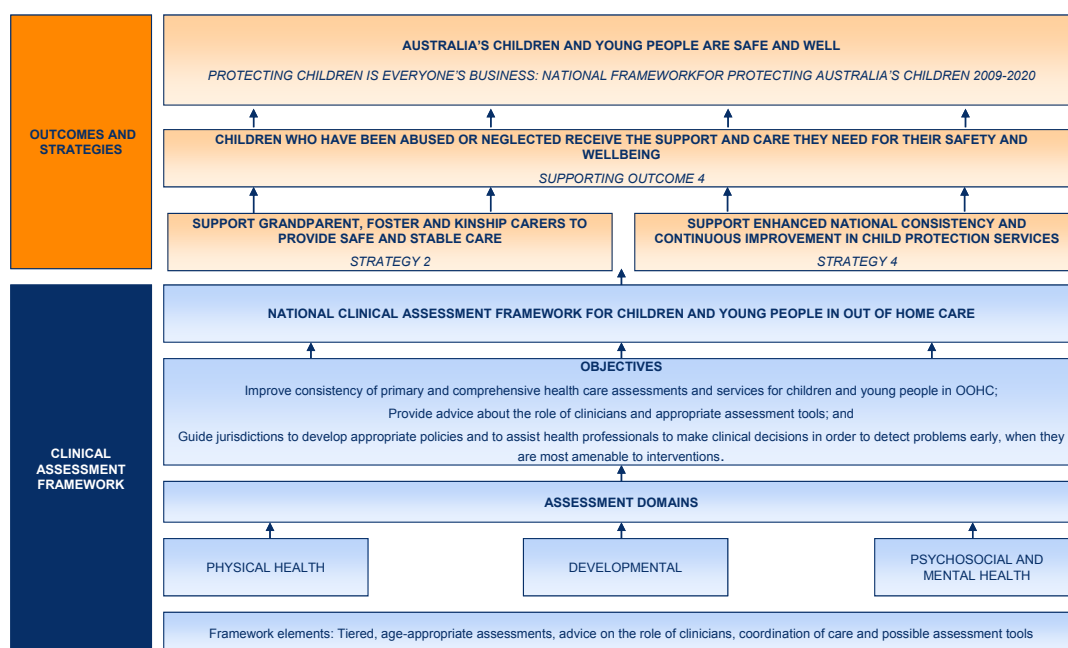
Standard No 5 states: "Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way."<sup>3</sup>

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<sup>1</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>2</sup> The CHWS reports to the Australian Population Health Development Principal Committee (APHDPC) under the auspices of the Australian Health Ministers' Advisory Council (AHMAC)

<sup>3</sup> "An outline of National Standards for out-of-home care" – Department of Families, Housing, Community Services and Indigenous Affairs & National Framework Implementation Working Group, December 2010



**Figure 1 - Relationship of the National Clinical Assessment Framework to implementation of the National Framework for Protecting Australia's Children 2009-2020**

The Framework has been developed in consultation with a range of government and non-government stakeholders with a focus on clinical, child protection and consumer issues.

## What is out-of-home care?

The Australian Institute of Health and Welfare (AIHW) has described OOHC as the provision of 'alternate accommodation for children and young people who are unable to live with their parents. It is defined as out-of-home, overnight care for children and young people under 18 years of age where the state or territory offers a financial payment.'<sup>4</sup> A more comprehensive description of OOHC is included at Appendix A.

Children or young people may enter OOHC due to substantiated child protection concerns, because their parents are incapable of providing adequate care or because alternative accommodation is needed during times of family conflict. The placement of a child or young person in OOHC often follows a successful application to a relevant court to place the child or young person on a care and protection order, although in some cases agreement is reached with families to meet the protection and care needs of the child on a voluntary basis.<sup>5</sup>

A child or young person may enter OOHC on a temporary or long term basis, which can impact the type of health assessments undertaken and the level of health care provided.

## Health status of children and young people in OOHC

Children and young people in OOHC often have high unrecognised and unmet complex health needs.<sup>6 7</sup> They tend to have poor physical health, developmental delays and

<sup>4</sup> Australian Institute of Health and Welfare (2010) Child protection Australia 2008-09. Child Welfare Series Number 47. Cat. no. CWS 35. Canberra: AIHW p4

<sup>5</sup> Australian Institute of Health and Welfare (2010) Child protection Australia 2008-09. Child Welfare Series Number 47. Cat. no. CWS 35. Canberra: AIHW p3

<sup>6</sup> Tarren-Sweeney in Bromfield, L, Higgins, D, Osborn, A, Panozzo, S, and Richardson, N, 2005, *Out of Home Care in Australia: Messages from Research* p 34.



compromised mental health; they also have a lower rate of immunisation uptake compared to their peers.<sup>8</sup> They tend to experience lack of easy access to health resources that are otherwise available to the rest of the community.<sup>9</sup>

Whilst it is true that a significant portion of children in OOHC have been the subject of abuse or neglect, multiple other reasons account for the vulnerability exhibited by these children including their greater likelihood to be socio-economically disadvantaged and their increased likelihood to have a parent with mental health or drug abuse problems. All of these factors also contribute to fragmented health care prior to placement in OOHC.<sup>10 11</sup>

Furthermore, the large number of placements experienced by some children in OOHC often leads to reduced availability of information about past medical history, maintenance of accurate information about current health status and poor continuity of healthcare.<sup>12</sup>

Early identification, referral, intervention and coordination of care have been shown to improve health and wellbeing outcomes.

It is also essential that systems are put in place to ensure that when a child or young person in OOHC is moved to a different carer, all parties involved in that child's medical, developmental and emotional care are notified and that the child's personal health record is made available to the new carers. It is also essential that all medical records are made available to any new professionals who may become involved following the move.

The Framework aims to provide better consistency of healthcare assessments and services for all children and young people in OOHC. It will assist healthcare professionals to detect problems early when they are most amenable to interventions. The Framework will also support individual state-based initiatives aimed at improving health outcomes and contribute to other initiatives aiming to collect nationally consistent data on the health and wellbeing of children in OOHC.

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<sup>7</sup> Department for Community Development (WA), Placement Services.

<sup>8</sup> Nathanson, D and Tzioumi D, (2007) Health needs of Australian Children living in out-of-home care, *Journal of Paediatric and Child Health*, 43 pp 695-9.

<sup>9</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>10</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>11</sup> Department for Community Development (Western Australia) (2004) Parental Drug and Alcohol Use as a Contributing Factor in Care and Protection Applications 2003, p 3.

<sup>12</sup> Payne H (2000) The health of children in public care. *Current opinion in psychiatry* 13: 381-388.



## 2 National Clinical Assessment Framework

The Framework outlines an approach to improving responses that address the health needs of children and young people in OOHC. Effective implementation of the Framework is likely to contribute to health outcomes for individuals in this population.

A detailed literature review and an examination of practice in a range of national and international jurisdictions were undertaken and the key learnings have been considered in the development of the Framework

The Framework has been informed by available information to identify best practice and balances the practicalities of what is possible against what is necessary to address the health needs of this vulnerable population. Consideration has been given to the need for the Framework to be able to be implemented in States and Territories and be applicable across a broad range of settings (e.g. metropolitan, rural and remote).

Overall the Framework provides guidance on:

- A structure for the provision of the necessary health assessments and pathways to clinical services that will contribute to the best quality care for children and young people
- a variety of measures that are cost efficient, evidence-based, age-appropriate and sensitive to the potential impact on children and young people in OOHC
- how assessments might complement existing universal services provided in each jurisdiction.

### Core Elements

The Framework proposes a tiered approach to age-appropriate assessments that cover the key domains of physical health, developmental and psychosocial and mental health.

It includes the following core elements:

1. A Preliminary Health Check that should be commenced as soon as possible and ideally no later than 30 days after entry to OOHC to determine areas of immediate concern.<sup>13</sup>
2. A Comprehensive Health and Developmental Assessment that should be completed within 3 months of placement.
3. Further specific assessments and management, following the Preliminary Health Check and/or the Comprehensive Health and Developmental Assessment, in accordance with the needs of the individual child or young person on a case-by-case basis.
4. Development of a Health Management Plan including a personal health record. The Health Management Plan should be integrated with other management plans (e.g. educational plans) into a single management plan for the child or young person.
5. Follow-up monitoring in accordance with the clinical needs of individuals to ensure that existing issues are being appropriately addressed and new and emerging issues are identified and addressed.
6. There will be a nominated officer/position with the role of Care Coordinator Health (CCH) This role could be provided by the statutory case officer or a health case manager and should be responsible for ensuring required health and development

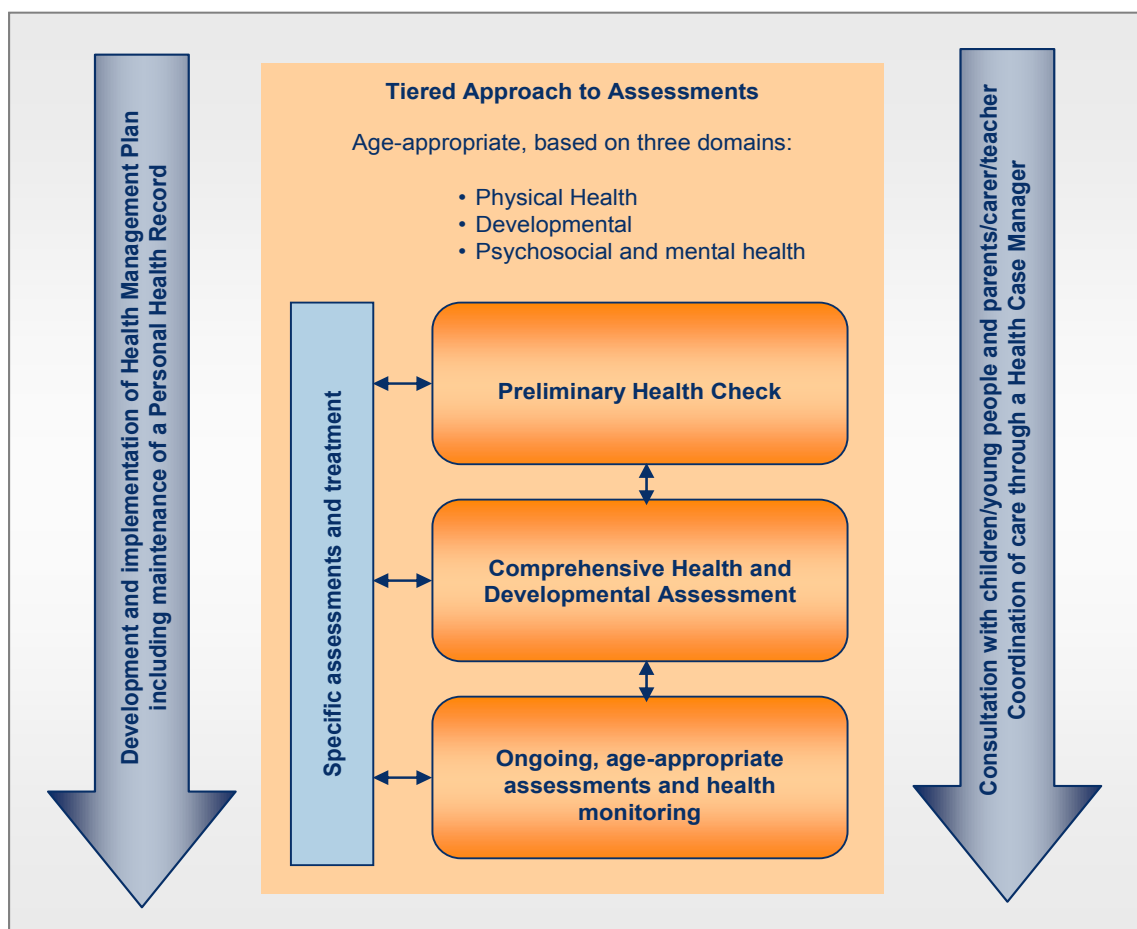
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<sup>13</sup> American Academy of Pediatrics (2000) Developmental issues of Young Children in Foster Care. *Pediatrics*, 106:1145-9



assessments occur, referrals to specialist services are made and that there is continuity of information and services following placement change<sup>14</sup>

A diagrammatic representation of the Framework is outlined in Figure 2 below.



**Figure 2 – Core elements of the National Clinical Assessment Framework**

The target group for the Framework are policy makers developing responses and clinicians and service providers managing the care of children and young people in OOHC.

### Key principles

The development of the Framework has been informed by the following key principles:

1. Children and young people in OOHC and their carers will benefit from structured processes that engage primary health care and specialist services in the identification, service provision, planning, coordination and management of their health needs.
2. The Framework should have universal application to all children and young people in OOHC whilst maintaining sensitivity to the diversity and potentially complex needs of different populations.

<sup>14</sup> Placement change includes restoration/reunification or transition to independent living.





3. Children and young people in OOHC should have their health information recorded and accessible to them, along with health providers and carers. In addition, the views of a child or young person concerning their own health and wellbeing and their desired health outcomes must be invited and taken into account. The outcomes of each assessment should be shared with the child, inform future assessments, and where appropriate, inform placement decisions.
4. Implementation in States and Territories will be informed by the relevant legislation and service system in the jurisdiction.

When States and Territories develop guidelines for the implementation of the Framework, seven additional principles are suggested. These are:

1. Initial assessments should establish **continuity of care** that is able to be maintained through subsequent interactions with the health system.
2. Practitioners should **consolidate** each individual's **health information** upon entry and continually capture and transfer health information.
3. Practitioners should have clinical and cultural competency to complete assessments. Care should be taken to avoid stereotyping or stigmatising the child or young person because of their background (e.g. ethnic, geographic or socio-economic).
4. Practitioners should have an **awareness of particular risk factors** relevant to the individual and focus on the circumstances under which the child or young person entered OOHC (e.g. family situation, history of abuse and neglect etc).
5. Practitioners should be mindful of the **diversity and potentially complex needs** of the following different populations:
  - children and young people in either home-based care (e.g. kinship or foster care); residential care (previously referred to as institutional) or custodial care
  - Aboriginal and Torres Strait Islander children and young people
  - children and young people from culturally and linguistically diverse backgrounds
  - children and young people that have a disability
  - children and young people of parents that have a disability
  - children and young people of parents that have a history of alcohol or substance abuse
  - children and young people living in rural and remote settings
  - children and young people with refugee status
  - otherwise vulnerable children and young people.
6. Children/young people and their parents/carers/teachers should be **consulted** wherever possible and **participate in decision-making processes**.
7. Practitioners should pay additional attention to **care coordination** following change of placement, re-unification or other transition from care.<sup>15</sup>

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<sup>15</sup> CREATE Foundation. (2005). Indigenous children and young people in care: Experiences of care and connections with culture. Perth, WA: Author.



## 2.1 Assessment domains

The Framework includes three key domains to ensure that the holistic health needs of individual children and young people are addressed. These are:

1. Physical health
2. Developmental
3. Psychosocial and mental health.

There is significant cross-over between and within these domains. Elements of each domain, including those outlined below, should be considered in all assessments completed under the Framework.

### 2.1.1 Elements for assessment

Within each domain there are a number of areas that could be covered in each tier of assessment and there are a range of tools that could be used.

*The following elements are proposed to guide considerations generally and should be read in conjunction with Table 1 which provides more detailed guidance on the age-appropriate focus for assessment across each domain.*

#### 1. Physical health

The elements to be considered within the Physical health domain include:

- Physical health history
- Physical examination and assessment
- Oral health assessment
- Health literacy.

Physical assessments should progress from basic screening in the Preliminary Health Check to Comprehensive Health and Developmental Assessment, as appropriate, to address the unique needs of each individual without becoming forensic in nature.

#### 2. Developmental

The elements to be considered within the Developmental domain include:

- Developmental history
- Speech, language and communication
- Motor development
- Cognitive development
- Sensory.

#### 3. Psychosocial and mental health<sup>16</sup>

The elements to be considered within the Psychosocial and mental health domain include:

- History
- Mental health

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<sup>16</sup> 'Psychosocial' generally refers to an individual's psychological development and their interaction with the social environment. In a broad sense, this relates to the individual's mental health as it does for the purposes of the Framework.



- Behavioural
- Emotional development
- Social competence
- Development of identity (including cultural and spiritual identity, particularly for Aboriginal and Torres Strait Islander children and young people).

Wherever possible, assessments should be normative and non-stigmatising with a focus on strengths rather than weaknesses.

It is important that assessments take account of the impact of developmental trauma on children, including physical and emotional abuse/neglect and being witness to acts of domestic violence. This will avoid misdiagnosis noting that children who have had these experiences can present with symptoms mimicking other conditions such as autism spectrum disorders and attention deficit/hyperactivity disorder (ADHD).

## 2.2 Age-appropriate assessments

In addition to incorporating elements of the three domains, each health assessment should be age-appropriate. For ease of reference the Framework proposes the following four broad age ranges:

1. Under 1 year
2. 1-5 years
3. 6-11 years
4. 12-18 years.

Whilst assessments will be conducted on a case-by-case basis, the proposed focus of assessment for each of the four broad age ranges is outlined in Table 1 below. When conducting assessments, a child and young person's own view of their health and wellbeing status and desired outcomes should be sought. The outcome of each assessment should be shared with the child, inform future assessments, where appropriate, inform placement decisions.

## 2.3 Tiered assessments

The Framework provides guidance to jurisdictions on an approach to organising responses to the health needs of children and young OOHC, which is based on a tiered structure spanning three phases:

1. Preliminary Health Check
2. Comprehensive Health and Developmental Assessment
3. Ongoing monitoring and assessment.

During each of these assessments, the child or young person should be consulted and, as appropriate to their age, participate in the decision-making process.

Importantly, each assessment should be informed by previous assessments and services provided in the meantime and to ensure the unique health needs of each individual are met.

The Framework recognises that completion of each level of assessment may take more than one visit to a practitioner and should therefore not be equated with a single contact.

Whilst assessments will be conducted on a case-by-case basis, the proposed focus of assessment of both the Preliminary Health Check and the Comprehensive Health and Development Assessment are outlined in Table 1 below.



### Health assessments not in scope

At the point of entry to care, children and young people may receive immediate medical assessments for specific purposes often associated with the investigative process or the immediate care of the child. At this stage of the statutory child protection process decisions about care arrangements are often not well informed and planning is subject to the outcome of the investigative process or Court Orders. The Framework is focussed to that point when the child or young person's placement in care is likely to continue.

However, while not in scope, it is important that service providers note and seek to access the information from the initial health assessments. For example, many children will have been the subject of an emergency assessment – often in a hospital environment - by a specialist under the auspices of the relevant child protection agency as part of an investigation or intake processes. This assessment may serve to determine if the child/young person requires immediate medical/dental treatment as a result of abuse or neglect and/or gather forensic evidence. Similarly, some children may require an initial health check as part of the entry to OOHC process, especially if there is a limited knowledge about the child's health. This would include children who have chronic conditions where their medications or health records could not be obtained by the caseworker, infants who may need formula feeds or nutritional supplements and children with an acute condition requiring immediate clinical assessment. Wherever possible, the Case Worker and the biological parents should be involved or consulted during this assessment.

The Framework assumes that all relevant information generated by these assessments will be made available to services providing subsequent assessments under the Framework.

### 2.3.1 Preliminary Health Check

The Preliminary Health Check aims to establish the ongoing relationship between the child, carer and the primary health care provider. This primary health care provider should provide screening and preliminary assessment of the child or young person across physical health, developmental and psychosocial and mental health domains. Importantly, this relationship will establish continuity of care and enable support of both the child and carer over time.

Assumptions have been outlined previously about the emergency assessments or initial health checks undertaken as part of the investigation/intake process, and the medical evidence identifying this population as being particularly vulnerable. Based on this, it is recommended that the Preliminary Health Check should be commenced as soon as possible and ideally no later than 30 days after entry to OOHC.

The information obtained during the Preliminary Health Check will allow the commencement of a Health Management Plan for the child or young person (see section 3 *Coordination and continuity of care*) with any immediate health, dietary, emotional difficulties, sensory deficits and/or behavioural concerns identified and where possible addressed via appropriate measures or referrals initiated.

The outcome of the Preliminary Health Check should provide guidance on the composition of the multi-disciplinary team required to complete the Comprehensive Health and Developmental Assessment outlined below. At this stage any relevant health information should be consolidated to establish the child or young person's health record (see section 3). This should include any information obtained during assessments undertaken prior to and during entry to OOHC processes.



### 2.3.2 Comprehensive Health and Developmental Assessment

The Preliminary Health Check should provide advice on the clinical specialities required and timing of the Comprehensive Health and Developmental Assessment. Another consideration would be whether practitioners likely to provide specific health assessments (see section 2.3.3) are included at this earlier stage.

The Comprehensive Health and Developmental Assessment should ideally be completed on all children and young people within 3 months of their entry to OOHC.

It is important that the Comprehensive Health and Developmental Assessment not be unnecessarily delayed. However, evidence suggests that, for some individuals, there may be difficulties in progressing comprehensive assessments in the first month of a new OOHC placement. Inaccurate results may be obtained for developmental and psychosocial assessments because, during this time, the child or young person is adapting to their new environment and may be overcoming acute trauma from abuse or neglect or trauma associated with entry to OOHC.

The Comprehensive Health and Developmental Assessment should go beyond basic screening to provide in-depth examination and assessment across each domain. It is also imperative that children and young people in OOHC receive the appropriate assessment from competent practitioners – particularly in relation to ‘Psychosocial and mental health’ elements - and their carers are provided with support.

If, during the assessments, the practitioner(s) identifies any concerns, the appropriate referral should be made – for additional assessment and treatment - and this should be documented in both the proposed Health Management Plan and included in the child/carer-held health record (see section 3). Particular attention should be paid by the Care Coordinator (Health) to ensure that appointments for specific assessments are made and attended and that the outcomes of those assessments contribute to the health record.

### 2.3.3 Ongoing monitoring and assessment

Children and young people entering OOHC are likely to have complex health needs that will require follow up assessment at regular intervals.<sup>17</sup> The frequency of follow up assessments should be a clinical decision for each individual and have both case-dependent and age-dependant considerations.

Ongoing monitoring should be aligned to the recommended timing for the general population as outlined in the jurisdictional parent-held child personal health record. This essentially provides more frequent follow up assessments for babies, toddlers and infants (‘Under 1’ and ‘1-5 years’) than for older children and young people.

Furthermore, recognising the unique health needs of this vulnerable population, additional assessments should be conducted following a change of care placement and on transition from care.

In addition to recognising the clinical health needs of the child, this approach accommodates cases where the child or young person may have reduced requirement for assessment (e.g. individuals in a stable placement where their health needs are being met and/or whose development is on-track).

Appropriate psychological assessment and/or treatment should be provided to children and young people identified to be experiencing emotional or educational difficulties during any assessment.

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<sup>17</sup> American Academy of Pediatrics (2000) Developmental issues for young people in foster care *Pediatrics*, 106:1145-49



Each individual Health Management Plan (see section 3 below) should be reviewed by a paediatrician at least once every two years.

## 2.4 Focus of Assessments

Guidance on the age-appropriate focus for tiered assessments across each domain is represented in Table 1 below.

The Framework proposes that the elements outlined in **red** form the focus of the Preliminary Health Check (see section 2.3.1). It is proposed that elements outlined in **blue** (*and italicised*) be additional foci for the Comprehensive Health and Developmental Assessment (see section 2.3.3).

Specific elements have been identified as guidance only. These provide a useful list of potential assessment areas that have been informed by practising clinicians. Table 1 should not be considered an exhaustive check-list (i.e. the absence of elements should not be read to infer that assessment/investigation of particular issues is unwarranted). The Framework defers to the clinical acumen of practitioners based on the unique health needs of each child or young person.

The Framework recognises that practitioner consideration of a number of these elements may be assisted by the use of one or more screening/assessment tools; further guidance is provided in Table 2 (see section 2.5).

**Table 1 – Focus for age-appropriate Preliminary Health Checks and Comprehensive Health and Developmental Assessments**

Age range	Focus of assessment (Domain)		
	Physical health	Developmental	Psychosocial and mental health
Under 1 year	<p>Physical health history</p> <ul style="list-style-type: none"> <li>pregnancy and birth information</li> <li>past and present health conditions (including acute and chronic)</li> <li>immunisation status</li> <li>past and present medications</li> <li>allergies</li> <li>dietary history (feeding and nutrition)</li> <li><u>safe sleep arrangements</u></li> </ul> <p>Physical examination and assessment</p> <ul style="list-style-type: none"> <li>general physical health assessment (including vital signs, growth; height, weight and head circumference and skin examination)</li> <li><u>comprehensive physical examination</u></li> </ul> <p>Oral health assessment</p> <ul style="list-style-type: none"> <li>general dental health screening</li> <li>comprehensive oral examination including teeth, gums, soft and hard palate (including details of any decayed, filled or missing teeth)</li> </ul>	<p>Developmental history</p> <ul style="list-style-type: none"> <li>birth parent and records of past placements (including history of middle-ear infections, potential Foetal Alcohol Spectrum Disorder)</li> <li>developmental milestones</li> <li><i>investigate indicators of trauma associated with past abuse and neglect</i></li> </ul> <p>Speech, language and communication</p> <ul style="list-style-type: none"> <li>development of receptive (comprehension) language</li> <li><i>play and pre-literacy skills</i></li> </ul> <p>Motor development</p> <ul style="list-style-type: none"> <li>fine and gross motor function</li> </ul> <p>Cognitive development</p> <ul style="list-style-type: none"> <li><i>problem solving skills</i></li> </ul> <p>Sensory</p> <ul style="list-style-type: none"> <li>vision and hearing screening</li> <li>hearing test and ear health assessment (including whether hearing loss is present and if so whether it is conductive, sensorineural or neural in origin)</li> <li>vision test and eye health assessment - to detect vision disorders including diminished visual acuity, amblyopia, refractive errors and strabismus</li> </ul>	<p>History</p> <ul style="list-style-type: none"> <li>birth parent and carer concerns (including behavioural)</li> <li>physical/emotional abuse</li> </ul> <p>Mental health</p> <ul style="list-style-type: none"> <li>enjoyment of life/happiness</li> <li><i>trauma related problems (including anxiety)</i></li> <li><i>depression</i></li> </ul> <p>Behavioural</p> <ul style="list-style-type: none"> <li>conduct, sleep and self regulation</li> </ul> <p>Emotional development</p> <ul style="list-style-type: none"> <li><i>engages with carer e.g. mutual gaze</i></li> <li><i>Explores confidently trusting parent's availability</i></li> <li>attachment disorders</li> <li><i>positive attachment</i></li> </ul> <p>Social Competence</p> <ul style="list-style-type: none"> <li><i>socialisation</i></li> </ul> <p>Development of identity</p> <ul style="list-style-type: none"> <li>cultural and spiritual identity essential for Aboriginal and Torres Strait Islander children as appropriate for other populations</li> </ul>
The Framework proposes that the elements outlined in <b>red</b> form the focus of the Preliminary Health Check. It is proposed that elements outlined in <b>blue</b> (and <i>italicised</i> ) be additional foci for the Comprehensive Health and Developmental Assessment.			





Age range	Focus of assessment (Domain)		
	Physical health	Developmental	Psychosocial and mental health
1-5 years	<p>Physical health history</p> <ul style="list-style-type: none"> <li>pregnancy and birth information</li> <li>past and present health conditions (including acute and chronic)</li> <li>immunisation status</li> <li>past and present medications</li> <li>allergies</li> <li>dietary history (feeding and nutrition)</li> </ul> <p>Physical examination and assessment</p> <ul style="list-style-type: none"> <li>general physical health assessment (including vital signs, growth; height, weight and head circumference and skin examination)</li> <li>comprehensive physical examination</li> </ul> <p>Oral health assessment</p> <ul style="list-style-type: none"> <li>general dental health screening</li> <li>comprehensive oral examination including teeth, gums, soft and hard palate (including details of any decayed, filled or missing teeth)</li> </ul>	<p>Developmental history</p> <ul style="list-style-type: none"> <li>birth parent and records of past placements (including history of middle-ear infections, potential Foetal Alcohol Spectrum Disorder)</li> <li>developmental milestones</li> <li>investigate indicators of trauma associated with past abuse and neglect</li> </ul> <p>Speech, language and communication</p> <ul style="list-style-type: none"> <li>speech/articulation</li> <li>expressive and receptive (comprehension) language</li> <li>play, pre-literacy and literacy skills</li> </ul> <p>Motor development</p> <ul style="list-style-type: none"> <li>fine and gross motor function</li> </ul> <p>Cognitive development</p> <ul style="list-style-type: none"> <li>problem solving skills</li> </ul> <p>Sensory</p> <ul style="list-style-type: none"> <li>vision and hearing screening</li> <li>hearing test and ear health assessment (including whether hearing loss is present and if so whether it is conductive, sensorineural or neural in origin)</li> <li>vision test and eye health assessment - to detect vision disorders including diminished visual acuity, amblyopia, refractive errors and strabismus</li> </ul>	<p>History</p> <ul style="list-style-type: none"> <li>birth parent and carer concerns (including behavioural)</li> <li>child's friendships, relationships and socialisation</li> <li>physical/emotional abuse</li> <li>exposure to violence (personal and domestic)</li> </ul> <p>Mental health</p> <ul style="list-style-type: none"> <li>enjoyment of life/happiness</li> <li>self-esteem</li> <li>trauma related problems (including anxiety)</li> <li>depression</li> </ul> <p>Behavioural</p> <ul style="list-style-type: none"> <li>conduct, sleep and self regulation</li> <li>behavioural problems and conduct disorders (defiance, inattention and hyperactivity)</li> <li>self-harm</li> </ul> <p>Emotional development</p> <ul style="list-style-type: none"> <li>explores confidently (for longer periods) trusting parent's availability on return</li> <li>aspirations</li> <li>attachment disorders</li> <li>relationship insecurity</li> </ul> <p>Social Competence</p> <ul style="list-style-type: none"> <li>socialisation</li> <li>social communication (pragmatics)</li> <li>social skills (including self-help skills)</li> </ul> <p>Development of identity</p> <ul style="list-style-type: none"> <li>cultural and spiritual identity essential for Aboriginal and Torres Strait Islander children as appropriate for other populations</li> </ul>
<p>The Framework proposes that the elements outlined in <b>red</b> form the focus of the Preliminary Health Check. It is proposed that elements outlined in <b>blue</b> (and italicised) be additional foci for the Comprehensive Health and Developmental Assessment.</p>			





Age range	Focus of assessment (Domain)		
	Physical health	Developmental	Psychosocial and mental health
6 - 11 years	<p>Physical health history</p> <ul style="list-style-type: none"> <li>pregnancy and birth information</li> <li>past and present health conditions (including acute and chronic)</li> <li>immunisation status</li> <li>past and present medications</li> <li>allergies</li> <li>dietary history (feeding and nutrition)</li> </ul> <p>Physical examination and assessment</p> <ul style="list-style-type: none"> <li>general physical health assessment (including vital signs, growth; height and weight)</li> <li>maintenance of personal hygiene</li> <li>comprehensive physical examination</li> <li>management of specific health conditions</li> </ul> <p>Oral health assessment</p> <ul style="list-style-type: none"> <li>general dental health screening</li> <li>comprehensive oral examination including teeth, gums, soft and hard palate (including details of any decayed, filled or missing teeth)</li> </ul> <p>Health literacy</p> <ul style="list-style-type: none"> <li>understanding of healthy lifestyle (including diet, exercise, sleep)</li> <li>understanding of physical/emotional changes associated with puberty (as appropriate)</li> <li>understanding of health issues, including the risks of alcohol, tobacco and other substance use and behaviours that can be a health risk (as appropriate)</li> </ul>	<p>Developmental history</p> <ul style="list-style-type: none"> <li>birth parent and records of past placements (including history of middle-ear infections, potential Foetal Alcohol Spectrum Disorder)</li> <li>developmental milestones</li> <li>educational progress</li> <li>investigate indicators of trauma associated with past abuse and neglect</li> </ul> <p>Speech, language and communication</p> <ul style="list-style-type: none"> <li>speech/articulation</li> <li>expressive and receptive (comprehension) language</li> <li>play and literacy skills</li> </ul> <p>Motor development</p> <ul style="list-style-type: none"> <li>fine and gross motor function</li> </ul> <p>Cognitive development</p> <ul style="list-style-type: none"> <li>problem solving skills</li> </ul> <p>Sensory</p> <ul style="list-style-type: none"> <li>vision and hearing screening</li> <li>hearing test and ear health assessment (including whether hearing loss is present and if so whether it is conductive, sensorineural or neural in origin)</li> <li>vision test and eye health assessment - to detect vision disorders including diminished visual acuity, amblyopia, refractive errors and strabismus</li> </ul>	<p>History</p> <ul style="list-style-type: none"> <li>birth parent and carer concerns (including behavioural)</li> <li>child's friendships, relationships and socialisation</li> <li>school performance</li> <li>physical (including sexual)/emotional abuse</li> <li>exposure to violence (personal and domestic)</li> </ul> <p>Mental health</p> <ul style="list-style-type: none"> <li>enjoyment of life/happiness</li> <li>self-esteem</li> <li>trauma related problems (including anxiety)</li> <li>depression</li> </ul> <p>Behavioural</p> <ul style="list-style-type: none"> <li>conduct, sleep and self regulation</li> <li>behavioural problems and conduct disorders (defiance, inattention and hyperactivity)</li> <li>self-harm</li> <li>sexual behaviour problems</li> </ul> <p>Emotional development</p> <ul style="list-style-type: none"> <li>aspirations</li> <li>attachment disorders</li> <li>relationship insecurity</li> </ul> <p>Social Competence</p> <ul style="list-style-type: none"> <li>socialisation (including ability to make relationships and to relate to peers)</li> <li>social communication (pragmatics)</li> <li>social skills (including self-help skills)</li> <li>awareness of basic safety issues, including road safety</li> </ul> <p>Development of identity</p> <ul style="list-style-type: none"> <li>cultural and spiritual identity essential for Aboriginal and Torres Strait Islander children as appropriate for other populations</li> </ul>
The Framework proposes that the elements outlined in <b>red</b> form the focus of the Preliminary Health Check. It is proposed that elements outlined in <b>blue</b> (and italicised) be additional foci for the Comprehensive Health and Developmental Assessment.			



Age range	Focus of assessment (Domain)		
	Physical health	Developmental	Psychosocial and mental health
12 - 18 years	<p>Physical health history</p> <ul style="list-style-type: none"> <li>pregnancy and birth information</li> <li>past and present health conditions (including acute and chronic)</li> <li>immunisation status</li> <li>past and present medications</li> <li>allergies</li> <li>dietary history (eating and nutrition)</li> </ul> <p>Physical examination and assessment</p> <ul style="list-style-type: none"> <li>general physical health assessment (including vital signs, growth; height, weight)</li> <li>dermatological health</li> <li>maintenance of personal hygiene</li> <li>comprehensive physical examination</li> <li>management of specific health conditions</li> </ul> <p>Oral health assessment</p> <ul style="list-style-type: none"> <li>general dental health screening</li> <li>comprehensive oral examination including teeth, gums, soft and hard palate (including details of any decayed, filled or missing teeth)</li> </ul> <p>Health literacy</p> <ul style="list-style-type: none"> <li>understanding of healthy lifestyle (including diet, exercise, sleep)</li> <li>understanding of physical/emotional changes associated with puberty (as appropriate)</li> <li>understanding of health issues, including the risks of alcohol, tobacco and other substance use and behaviours that can be a health risk</li> <li>understanding of issues relating to sexuality and sexual activity (inc. its role in relationships) contraception; sexually transmitted infection and particular risks of early sexual activity</li> </ul>	<p>Developmental history</p> <ul style="list-style-type: none"> <li>birth parent and records of past placements</li> <li>developmental milestones</li> <li>educational progress</li> <li>investigate indicators of trauma associated with past abuse and neglect</li> </ul> <p>Speech, language and communication</p> <ul style="list-style-type: none"> <li>speech/articulation</li> <li>expressive and receptive (comprehension) language</li> <li>literacy skills</li> <li>interpersonal skills</li> </ul> <p>Motor development</p> <ul style="list-style-type: none"> <li>fine and gross motor function</li> </ul> <p>Cognitive development</p> <ul style="list-style-type: none"> <li>problem solving skills</li> </ul> <p>Sensory</p> <ul style="list-style-type: none"> <li>vision and hearing screening</li> <li>hearing test and ear health assessment (including whether hearing loss is present and if so whether it is conductive, sensorineural or neural in origin)</li> <li>vision test and eye health assessment - to detect vision disorders including diminished visual acuity, amblyopia, refractive errors and strabismus</li> </ul>	<p>History</p> <ul style="list-style-type: none"> <li>birth parent and carer concerns (including behavioural)</li> <li>child's friendships, relationships and socialisation</li> <li>school performance</li> <li>physical (including sexual)/emotional abuse</li> <li>exposure to violence (personal and domestic)</li> </ul> <p>Mental health</p> <ul style="list-style-type: none"> <li>enjoyment of life/happiness</li> <li>self-esteem</li> <li>trauma related problems (including anxiety)</li> <li>depression</li> </ul> <p>Behavioural</p> <ul style="list-style-type: none"> <li>conduct, sleep and self regulation</li> <li>behavioural problems and conduct disorders (defiance, inattention and hyperactivity)</li> <li>self-harm</li> <li>sexual activity</li> <li>sexual behaviour problems</li> <li>independent living skills and support</li> <li>partner violence</li> </ul> <p>Emotional development</p> <ul style="list-style-type: none"> <li>aspirations</li> <li>attachment disorders</li> <li>relationship insecurity</li> <li>sexual knowledge</li> </ul> <p>Social Competence</p> <ul style="list-style-type: none"> <li>socialisation (including ability to make relationships and to relate to peers)</li> <li>social communication (pragmatics)</li> <li>social skills (including self-help skills)</li> <li>awareness of basic safety issues, including road safety</li> </ul> <p>Development of identity</p> <ul style="list-style-type: none"> <li>cultural and spiritual identity essential for Aboriginal and Torres Strait Islander children as appropriate for other populations</li> </ul>
The Framework proposes that the elements outlined in <b>red</b> form the focus of the Preliminary Health Check. It is proposed that elements outlined in <b>blue</b> (and <i>italicised</i> ) be additional foci for the Comprehensive Health and Developmental Assessment.			



## 2.5 Use of screening and assessment tools

A key objective of the Framework is to improve consistency of preliminary and comprehensive health care assessments for children and young people in OOHC, including the role of clinicians and the type of assessment tools that may be appropriate.

As outlined above, three key domains have been identified and elements within those domains have been suggested for consideration by practitioners completing each of the assessments.

The primary method of completing assessments will be via interviews with the child (as appropriate), the biological parent, carer and relevant others – eg teachers.

There is a range of screening and assessment tools that may be used by practitioners to assist assessment across the specified domains and age ranges. These tools are not designed to be used alone, but rather as part of a comprehensive approach to assessment. The Framework recognises that the skilled application of assessment tools can be useful to determine individual progress over time and may also offer significant advantages to the collection of data which might otherwise not be captured for this population (thereby hampering evidence based policy development and research).

However, the range of practitioners likely to be involved in completing assessments under the Framework limits the capacity to prescribe the use of assessment tools for the target population. Therefore the Framework does not prescribe the use of any particular tools. Rather, the Framework defers to the clinical acumen of practitioners.

There is a range of assessment tools which might be useful to practitioners in completing assessments. Only assessment tools which meet the following criteria should be considered for use:

- evidence-based and validated
- age appropriate
- normative and non-stigmatising
- cost efficient
- able to be used by appropriate clinician (or training available to support use)
- able to be administered within appropriate timeframe (if used for surveillance needs).

During consultations, stakeholders suggested that the tools most appropriate for application are the Ages and Stages Questionnaire (ASQ) and the Strengths and Difficulties Questionnaire (SDQ).

Other tools which might be considered include:

### *Developmental domain*

- Parents' Evaluation of Developmental Status (*PEDS*)
- Language Development Survey
- Child Development Inventories (CDI)
- Brigance screens
- Vision (Snellen, Sheridan Gardiner)
- Hearing.

### *Psychosocial and mental health domain*

- Achenbach Child Behaviour Check List (CBCL)



- Ages and Stages — Social and emotional (ASSE)
- CRAFFT – Screening tool for substance abuse
- HEADSS – Assessment framework for teen health risks.

The available tools and their relationship to the age groups and levels of assessment to be covered by the Framework are outlined in Table 3 below. The applicability of each tool to the four age groups and the three tiers of assessment are indicated as follows:

- ✓ Applicable
- X Not applicable



PHYSICAL HEALTH DOMAIN								
Tools	Comments	Ages				Assessment		
		Under 1 year	1-5 years	6-11 years	12-18 years	Preliminary	Comprehensive	Specific
Height and weight percentiles	Simple to administer.	✓	✓	✓	✓	✓	✓	<b>x</b>
DEVELOPMENTAL DOMAIN								
Tools	Comments	Ages				Assessment		
		Under 1 year	1-5 years	6-11 years	12-18 years	Preliminary	Comprehensive	Specific
<b>Child development</b>								
Ages and Stages Questionnaire (ASQ)	Validated tool. Parent/carer completed. Simple to administer. For children 3 months to 5 years.	✓	✓	<b>x</b>	<b>x</b>	✓	✓	✓
Parent's Evaluation of Developmental Status (PEDS)	Validated tool. Parent/carer completed. For children from birth to 8 years. Can be administered in a range of settings. Simple to administer	✓	✓	✓	<b>x</b>	✓	✓	✓
Language Development Survey	Validated tool. Parent/carer completed Simple to administer Detects language delay in children 18-35 months	<b>x</b>	✓	<b>x</b>	<b>x</b>	✓	✓	✓
Child Development Inventories (CDI)	Validated tool. Parent/carer completed. Simple to administer. For children 3 months to 6 years	<b>x</b>	✓	✓ (can be used up to 6 years)	<b>x</b>	✓	✓	✓
Brigance Screens	Validated tool. Direct measure Simple to administer. For children from birth to 7 years	✓	✓	✓	<b>x</b>	✓	✓	✓



DEVELOPMENTAL DOMAIN								
Tools	Comments	Ages				Assessment		
		Under 1 year	1-5 years	6-11 years	12-18 years	Preliminary	Comprehensive	Specific
Vision								
Snellen	Simple to use.	x	✓	✓	✓	✓	✓	✓
Sheridan Gardner	Well established test.	x	✓	✓	x	x	✓	✓
PSYCHOSOCIAL DOMAIN								
Tools	Comments	Ages				Assessment		
		Under 1 year	1-5 years	6-11 years	12-18 years	Preliminary	Comprehensive	Specific
Strengths and Difficulties Questionnaire (SDQ)	Validated tool. Simple to administer. Parent/carer report For children aged 3 to 16 years. Can be applied in different settings.	x	✓	✓	✓	✓	✓	✓
Ages and Stages – social and emotional (ASSE)	Simple to administer. Parent/carer report For children aged 3 to 66 months. Can be applied in different settings	✓	✓	x	x	✓	✓	✓
Achenbach Child Behaviour Checklist (CBCL)	Validated tool Extended questionnaire completed by Parent/Carer and scored For children 1.5 – 5 and 6-18 Youth self report	x	✓	✓	✓	✓	✓	✓
CRAFFT – screening tool for substance abuse	Self completed questionnaire/interview For Adolescents 12+	x	x	x	✓	✓	✓	✓
HEADSS – Assessment framework for teen health risks	Self completed questionnaire or interview For Adolescents 12+	x	x	x	✓	✓	✓	✓



## 2.6 Practitioner to complete assessments

The effective implementation of the Framework will require the participation of a range of practitioners working individually or in multi-disciplinary teams.

Noting that significant workforce barriers exist to the prescription of a particular health discipline to complete each of the assessments, the Framework recognises that the role of clinicians, health workers and other professionals will be determined by staff competency and availability in any given setting (e.g. metropolitan versus rural and remote areas) according to the tasks to be performed.

The following key considerations are relevant to the selection of practitioners to complete assessments:

- The practitioner should have subject specific clinical expertise, interest and cultural competency to complete assessments.
- The initial assessment should establish the primary care relationship to ensure continuity of care maintenance through subsequent interactions with the health system.

### Preliminary Health Check

The Preliminary Health Check should be completed by a primary care practitioner (e.g. GP, Nurse Practitioner, Child and Family Health Nurse or other specialty nurse or Aboriginal Health Worker) - ideally one known to the child for continuity of care - with subsequent follow-up by a GP or paediatrician, where required.

### Comprehensive Health and Developmental Assessment

The Comprehensive Health and Developmental Assessment and ongoing assessments should be established, directed and overseen by a lead clinician, involving multi-disciplinary teams according to the specific needs of the individual child or young person.

### Ongoing monitoring and assessment

Where relevant, referrals should be made for specific assessment or ongoing treatment by:

- Paediatricians
- Allied Health Professionals, including Speech Pathologists, Dietitians, Occupational Therapists, Physiotherapists, Audiologists
- Dental Health Practitioners
- Psychologists/Psychiatrists/Mental Health Nurses
- Drug and Alcohol Counsellors
- Other health professionals as appropriate.

Ideally a paediatrician should be involved in the development and implementation of a Health Management Plan (see below) and at a minimum each child or young person in OOHC should be seen by or have their Health Management Plan reviewed by a paediatrician at least once every two years.

The Framework recognises that in rural and remote settings there may be less immediate access to paediatricians and other health care professionals. Geographic isolation should not compromise effective assessment and treatment and in each case the responsible Care Coordinator (Health) should plan for and enable access to assessments and appropriate treatment services according to need.



## 3 Coordination and continuity of care

Children and young people in OOHC receive inadequate health care due, in part, to placement instability combined with limited coordination and information-sharing between service providers.<sup>18</sup>

The completion of the Comprehensive Health and Developmental Assessment will clearly define the health needs of children and young people in OOHC and identify the further treatment or interventions necessary to address these. However, for the Framework to be implemented successfully there needs to be effective communication and information sharing between all parties.

### 3.1 Coordination of care

Complementary, systematic planning and active coordination amongst the following key parties is required to ensure that children and young people in OOHC receive the specific assessments or treatments that have been identified:

- Child Protection Agency Case Worker
- Care Coordinator (Health)
- Carer
- Child or young person

Where appropriate, the school principal and teachers should also be included in the information flow.

The Framework recognises that responsibility for the care of children and young people in OOHC is achieved via a number of different models each with varying and often complex interactions between jurisdictional child protection, health and education systems.

Each jurisdiction should give consideration to the preparation of effective care pathways to outline how the implementation of the Framework could best be coordinated during a child's journey. The pathway should outline:

- the roles and responsibilities of key parties (including the child, the carer, the Health Authority and Child Protection Agency)
- the information flows associated with each step.

### 3.2 Development of a Health Management Plan

The key component to facilitate coordination and continuity of care is the development of a Health Management Plan. Under the Framework, it is recommended that each Jurisdiction work to develop for each child a Health Management Plan and for this to be a required element of the overall care plan for each child and young person in OOHC.

Upon entry into OOHC, and preferably before the Preliminary Health Check but certainly prior to the Comprehensive Health and Developmental Assessment being completed, all

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<sup>18</sup> Gluckman, Stephanie and Shaw, Terri (2009) *Improving Health Outcomes for Children in Foster Care: The Role of Electronic Record Systems* – The Children's Partnership





relevant health information should be consolidated and provided to the practitioner undertaking the assessment<sup>19</sup>. This may include information held:

- by the relevant Child Protection Agency including the child's personal history and family history if it is known
- by a school nurse
- by dental services
- by community health services
- by a GP or local hospital (e.g. Accident and Emergency Departments)
- on any child-held or parent/carer-held record
- by a paediatrician
- in the Australian Childhood Immunisation Register (or other immunisation registers)
- by child and adolescent mental health services.

This information should be supplemented with the timing and outcome of all assessments completed to date, copies of any referrals made and the timing and outcome of those specific assessments (including the results of any tests, schedules of medication or ongoing interventions).

This will essentially establish a comprehensive health record that documents the child or young person's state of health and identified health needs. This health record, together with relevant referrals and a schedule of future assessments or treatment will constitute the necessary Health Management Plan.

Initially this should be incorporated into a paper based personal health record which is completed by each practitioner and carried by the child or carer.<sup>20</sup> Eventually, it is proposed that the health record would be incorporated into an electronic health record.

This record should be updated regularly, and move with the child. Carers (and where appropriate the child or young person) should also have access to the health record to ensure effective coordination.

The Framework recognises that implementation will be dependent on jurisdictional practice and obligations under privacy legislation. Guidelines for the appropriate information collection, storage, use and disclosure of information may need to be amended. Ideally, this will allow de-identified data to be extracted to contribute to national data collections and to be used in longitudinal research projects to build the OOHC population evidence base.

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<sup>19</sup> Hill CM, (2003) Statutory Health Assessments for looked-after children: what do they achieve? *Care, Health and Development*; 29(1):3-13

<sup>20</sup> Effective examples of such records have been implemented in a number of jurisdictions – one such example is the 'Blue Book' used extensively in New South Wales.



## 4 Implementation: Barriers and Enablers

An overarching issue to be resolved if the Framework is to be implemented successfully is the role and function of the Australian Government (and its relevant Departments/Agencies) State and Territory Governments (and relevant Departments/Agencies) and the not-for-profit sector.

There were a number of high level issues raised during consultations that are relevant to the implementation of the Framework. These included:

- Facilitation of timely access to existing therapeutic resources (and identify linkages with universal services, e.g. education).
- Integration with the *National Framework* and the related documents to ensure consistency across jurisdictions.
- Funding available for effective continuity and coordination of care.
- Workforce resource requirements for effective provision of services in non-metropolitan settings and coordination in all settings.
- Support services for rural and remote communities including the use of technology such as telemedicine (eg training or Telehealth support or provision of outreach services).
- Implementation should support a renewed focus on improving consistency across jurisdictions.



## 5 Monitoring and evaluation

Monitoring the implementation of the various core elements of the Framework and evaluation of its effectiveness is essential to demonstrate progress and achievement of the Framework objectives.

It is anticipated that both monitoring and evaluation of the Framework will be accounted for through jurisdictional reporting against the *National Framework*.

### 5.1 Evaluation of the Framework

Well-designed evaluations will be an important element of the Framework. These evaluations should be conducted at both the national and jurisdictional level.

At a national level, the sum of activities across jurisdictions should be assessed to determine how effective efforts have been in pursuing the stated objectives of the Framework. For example:

- How effective was the collective response of jurisdictions in improving consistency of preliminary and comprehensive health care assessments?
- Did the implementation of the Framework lead to improvement of health outcomes for children and young people in OOHC?

At the jurisdictional level, evaluations will determine the effectiveness of the Framework in guiding jurisdictional policy development and clinical decision-making. Evaluations will be designed to address the complexities of implementing modifications to existing programs and cover a range of measures, including:

- Quantitative: awareness and use of the Framework, uptake of assessments (including the % of eligible individuals receiving assessments and % completion within specified timeframes), development of a Health Management Plan and a health record, referrals and access to specialists (ie pathway to care).
- Qualitative: nature of assessments, outcomes and remediation of problems.
- Consumer: engagement and adequacy/acceptability of the services provided.

A significant advantage of a robust approach to monitoring and evaluation will be the opportunities to gather more comprehensive data and perform short-term and longitudinal research on the OOHC population to assess the viability and sustainability of the Framework and to support future evidence-based policy and program development.



## Appendix A Glossary

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APHDPC	Australian Population Health Development Principal Committee
CBCL	Achenbach Child Behaviour Checklist
CHWS	Child Health and Wellbeing Subcommittee
COAG	Council of Australian Governments
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
OOHC	Out-of-Home Care*
'Framework'	National Clinical Assessment Framework for Children and Young People in Out-of-Home Care
'National Framework'	Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists

\*There are a number of living arrangements which constitute OOHC:

1. Residential care—where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff.
2. Family group homes—provide short-term care in departmentally-owned homes for children under care and protection orders and other children whose parents are unable to provide for their immediate welfare. Family group homes do not have salaried staff but are available rent free to approved carers, who receive board payments to reimburse them for the cost of looking after the children in their care.
3. Home-based care—where placement is in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. This is broken down into the three subcategories:
  - a. relative/kinship care—includes family members (other than parents) or a person well known to the child and/or family (based on a pre-existing relationship) who is reimbursed (or who has been offered but declined reimbursement) by the state/territory for the care of the child
  - b. foster care—where the care is authorised and carers are reimbursed (or were offered but declined reimbursement) by the state/territory and supported by an approved agency
  - c. other—home-based care which does not fall into either of the above two categories.
4. Independent living—including private board and lead tenant households.



## Appendix B Literature review

### B.1 Introduction

This overview of literature builds on the work undertaken to inform the Child Health and Wellbeing Subcommittee project – *Health care needs of children and Young people in out-of-home care*.

The objectives of the literature overview are to:

- provide an overview of the health care needs of children and young people in out-of-home care; and
- identify current models of practice both in Australia and overseas.

### B.2 Research on the health care needs of children and young people in out of home care

Published Australian data and research relating to the health and developmental status of children in out-of-home care and how the health needs of this group compare with the general child population is very limited. There have been numerous reports/studies which have highlighted the need for further Australian research and data in this area.<sup>21 22 23</sup> The shortage of research in each area means that there is a limited Australian evidence base for sound policy and practice decisions<sup>24</sup>.

The Australian Research Alliance for Children & Youth (ARACY) has, however, begun work on a small project to explore options for benchmarking social and emotional wellbeing indicators for children and young people across OECD countries. ARACY will work closely with UNICEF and experts in the field from within Australia and internationally. This project is a first critical step for achieving the ultimate aim, shared by many researchers, of achieving international comparability in order to better inform – and track the success of – policy and practice that aims to improve outcomes for Australian children and young people. ARACY has called for Expressions of Interest for papers that will address:

- What is meant by social and emotional wellbeing for children (those aged 0–12 years and 13–25)? Clarity is required on the conceptualisation and construction of social and emotional wellbeing and the theory and any sub-constructs, bearing in mind that they may change over the life of the child, particularly into adolescence. Identification of possible key national measures/indicators based on these constructs is an important component of the conceptualisation.
- What are the policy and practice implications of analysing and reporting on such data, assuming it was to become available? The challenge is not just collecting national and

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<sup>21</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of -home care. *Journal of Paediatrics and Child Health* **43** 665-669

<sup>22</sup> Royal Australasian College of Physicians (2006) Health of Children in “Out-Of-Home” Care - Paediatric Policy

<sup>23</sup> Australian Children and Young people in Care Report Card on Health (2006) Create Foundation

<sup>24</sup> Bromfield, L and Osborn, A (2007) ‘Getting the big picture’: A synopsis and critique of Australian out of-home care research. Child Abuse Prevention Issues No 26 2007 Australian Institute of Family Studies.



internationally comparable data but how it is subsequently used and interpreted in policy and practice terms.

Further work is being undertaken on improvement of the quality of child protection data at a national level.

Under the first 3-year implementation plan of the *National Framework for Protecting Australia's Children 2009-2020*, the major priority in data collection will be to enhance knowledge of children's interactions with the child protection system in order to inform future policy and service provision. Work under this priority is likely to include:

- review and improvement of data collections relating to child protection to improve national reporting
- review of existing data definitions to support unit record data collection in the child protection system
- state and territory participation in data collection and commitment to improve data sets
- developmental work on specific indicators to enable regular reporting.<sup>25</sup>

### **B.2.1 Health status of children and young people requiring out-of-home care**

The available literature widely acknowledges 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.<sup>26</sup> They are also more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and are less likely to access preventative health services such as immunisation compared with the general population.<sup>27</sup>

Assessing each child's unique health needs should be one of the highest priorities in child welfare agencies.<sup>28</sup> In doing so, a child and young person's own view of their health and wellbeing status and desired outcome must be invited and taken into account wherever possible. The outcomes of each assessment should be shared with the child, inform future assessments, and, where appropriate, inform placement decisions.

The compromised health status of children in OOHC may be a result of previous abuse and neglect and, in addition to suffering abuse and neglect, children within the child protection system have commonly been exposed to other disadvantage within their family such as:

- parental alcohol and drug abuse;
- mental health problems;
- family violence;
- poor parenting skills;

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<sup>25</sup> Australian Institute of Health and Welfare (2010) Child protection Australia 2008-09. Child Welfare Series no. 47. Cat. No. CWS. Canberra: AIHW

<sup>26</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>27</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of-home care. *Journal of Paediatrics and Child Health* **43** 665-669

<sup>28</sup> American Academy of Pediatrics (2002) Health Care of Young Children in Foster Care *Pediatrics* Vol. 109 p537



- early child bearing;
- children with health, disability and behavioural problems;
- adults with histories of being abused or neglected;
- social isolation; and
- poverty.<sup>29</sup>

**Key Learning:** Children in OOHC have significantly more health problems compared to children in the general population and therefore warrant additional medical attention.

### ***Physical and developmental health***

A study of 122 children published in 2007 demonstrated higher rates of physical, developmental and emotional health problems in children in care compared to children in the general population. Interestingly the study also found that the rates of poor health for Australian children in care were similar to that of children in care in both the United Kingdom and the United States. Specifically, the study reported that 24% of children had incomplete immunisations, 20% had failed a vision screening test, 26% failed their hearing test, 60% required a referral for a formal developmental assessment, 45% of the children aged under 5 years of age had speech delays, 20% of the older children had delayed language skills. Abnormal growth was recorded in 14% of the children and behavioural and emotional health problems were identified in 54%. The report also noted that there were a variety of additional health concerns identified that were similar to that seen in a general paediatric clinic. However, the noticeable difference was that many of the conditions had either been poorly managed or not previously recognised.<sup>30</sup>

A national survey undertaken by Meltzer and colleagues for the UK Office for National Statistics (ONS)<sup>31</sup> found that two thirds of all children entering OOHC had at least one physical health complaint and that these children are more likely than their peers to experience problems including speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems.

### ***Psychosocial health***

Children in OOHC experience high rates of developmental and mental health problems. The psychopathology is complex and is currently not well understood, however, research suggests that its origin lies in insecure attachments and the cumulative effects of childhood maltreatment.<sup>32</sup>

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<sup>29</sup>Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>30</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of -home care. *Journal of Paediatrics and Child Health* **43** 665-669

<sup>31</sup> Meltzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) The mental health of young people looked after by local authorities in England. London: The Stationery Office

<sup>32</sup> Royal Australian & New Zealand College of Psychiatrists (June 2009) Position Statement 59: Then mental health care needs of children in out-of-home care. P1





Emotional and behavioural problems are described as the greatest health need of children and young people in care.<sup>33</sup> The high prevalence of psychological and mental health problems of children in foster care has also been widely acknowledged.

The scale of mental health problems among children and young people in care has been described as 'exceptional for a non clinical population' and children in residential care have more mental health problems than those in family-type foster care or those in kinship care. Children in care may manifest complex psychopathology, characterised by attachment difficulties, relationship insecurity, problematic sexual behaviour, trauma-related anxiety, conduct problems and defiance, and inattention/hyperactivity as well as less common problems such as self injury, excessive eating and other food maintenance issues.<sup>34</sup>

Ensuring timely access to professional help for those children most in need is paramount to reducing the burden of disease in the OOHC population.<sup>35</sup>

One of the main barriers to delivery of mental health services to children and young people in OOHC is the underreporting of mental health problems by foster parents (in 43%-66% of cases). This can be used to argue that when OOHC assessments are included they should be structured ones which can be marked by the professional (such as CBCL) and that regular, focussed mental health assessments should be provided<sup>36</sup> by a mental health specialist.

One South Australian based study completed on children 6-17 years of age in OOHC between 2004 and 2006 noted the prevalence of mental health symptoms across all CBCL scales was consistently higher (six to seven times) than for children in the general community<sup>37</sup>.

In the United States, 70% of children placed for at least a year in alternative care reported moderate to severe mental health problems.<sup>38</sup> Another United States study found 84% of a foster care sample had developmental or psychological problems.<sup>39</sup>

A study of 6,177 children entering the Utah foster care system<sup>40</sup> found that 44% had one or more mental health problems (main ones being oppositional defiant disorder, attachment and adjustment disorders and mood disorders), 54% had one or more acute or chronic medical conditions. This was significantly higher than children in the general community and demonstrates not only the importance of having a particular focus on screening for

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<sup>33</sup> Nathanson, D & Tzioumi, (2007), Health needs of Australian children in out-of-home care. *Journal of Paediatrics and Child Health* **43** 665-669

<sup>34</sup> Tarren-Sweeney, M, (2008) The mental health of children in out-of-home care. *Current Opinion in Psychiatry* 21:345-349

<sup>35</sup> Royal Australian & New Zealand College of Psychiatrists (2008) The mental healthcare needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry p 38

<sup>36</sup> M, Halfon, N Zepeda A, Inkelas, (2000) Mental Health Services for Children in Foster Care Policy brief 4, UCLA Center for Healthier Children, Families and Communities

<sup>37</sup> Sawyer MG, Carbone JA, Searle AK and Robinson P. (2007) The mental health and well-being of children and adolescents in home-based foster care. *Med J Aust*; 186: 181-184

<sup>38</sup> Halfon N, Berkowitz G, Klee L. (1992) Mental health service utilization by children in foster care in California. *Pediatrics*. Jun;89(6 Pt 2):1238-1244

<sup>39</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>40</sup> Steele J, Buchi K, (2008) Medical and mental health of children entering the Utah foster care system *Pediatrics* 122; e 703-e709





mental health issues but that follow-up is performed by a professional as part of the Health management plan.

This finding is supported by the *Children in Care Study* undertaken in New South Wales which found that children in care present with exceptionally poor mental health and social competence when compared to relative normative samples.<sup>41</sup> More than half the boys and girls in the study were reported to have clinically significant mental health difficulties. They presented with complex disturbances, including multiple presentations of conduct problems and defiance, attachment disturbance, attention deficit/hyperactivity and trauma related anxiety.<sup>42</sup>

Studies have also demonstrated a strong correlation between early trauma/abuse and subsequent placement instability which further compromises health outcomes.<sup>43 44</sup>

The ONS Survey confirmed findings of earlier research<sup>45 46</sup> about the high level of mental health need amongst these children, particularly those in residential care. 45% were assessed as having a mental health disorder, rising to 72% of those in residential care. Among 5-10 year olds, 50% of boys and 33% of girls had an identifiable mental health disorder. Among 11-15 year olds, the rates were 55% for boys and 43% for girls. This compares to around 10% of the general population aged 5 to 15.

Clinically significant conduct disorders were the most common among these children (37%), while 12% had emotional health disorders (anxiety and depression) and 7% were hyperactive. Even when compared to children in a community sample from the most deprived socio-economic groups, children in OOHC still showed significantly higher rates of mental health disorders.<sup>47</sup>

Further analysis of the ONS survey carried out by Tamsin Ford et al<sup>48</sup> found that even when children in OOHC were compared to children in a community sample from the most deprived socio-economic groups, they still showed significantly higher rates of mental health disorders. The authors suggest that this is largely due to adverse factors impacting on children prior to entry into care. They also identified significantly higher rates of developmental disorders, such as autism and ADHD, which may have gone previously undiagnosed. Other studies also indicate that behaviour and mental health problems in

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<sup>41</sup> Tarren –Sweeney, M and Hazel, P. (2006) Mental Health of Children in foster and kinship care in New South Wales. *Journal of Paediatrics and Child Health*, 42, 89-97

<sup>42</sup> The Royal Australian and New Zealand College of Psychiatrists (2008) The Mental Health needs of children in out-of-home care; A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, Melbourne

<sup>43</sup> Osborn, A., & Delfabbro, P. H. (2006a). An analysis of the social background and placement history of children with multiple and complex needs in Australian out-of-home care. *Communities, Children and Families Australia*, 1, 33–42.

<sup>44</sup> Osborn, A., & Delfabbro, P. H. (2006b). National comparative study of children and young people with high support needs in Australian out-of-home care. Adelaide: University of Adelaide.

<sup>45</sup> Dimigen G., Del Priore C., Butler S. et al (1999) 'Psychiatric disorder among children at time of entering local authority care: questionnaire survey', *British Medical Journal*, 319, 675

<sup>46</sup> McCann J., James A., Wilson S. and Dunn G. (1996) 'Prevalence of psychiatric disorders in young people in the care system', *British Medical Journal* 313, 15, 29-30

<sup>47</sup> Ford T., Vostanis P., Meltzer H. and Goodman R. (2007) 'Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households', *British Journal of Psychiatry* 190, 319-325

<sup>48</sup> Ford, T. et al. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *British Journal of Psychiatry*, 190; 319-325.



children, along with a number of other factors in the child and carer, are linked to increased risk of placement breakdown.

A further source of information on the prevalence of emotional and behavioural difficulties among children in OOHC is the *Looking After Children* longitudinal study of children and young people who remained in care for at least a year<sup>49</sup>. This considered the needs of children at the point of first entry into care and identified emotional and behavioural problems from information recorded in case files by social workers and subsequently assessed by psychologists. Using these methods, it was found that 72% of children aged 5 to 15 had a mental health or behavioural problem compared to 45% in the ONS survey. Among children entering OOHC under the age of five (this age group was not included in the ONS survey), nearly one in five showed signs of emotional or behavioural problems.

**Key Learning: Children in OOHC present with health problems across three domains - physical, developmental and psychosocial.**

### **Health status of Aboriginal and Torres Strait Islander children and young people in OOHC**

Since 2003 the Kari Clinic for Aboriginal and Torres Strait Islander children in Western Sydney has collected and evaluated relevant data relating to the needs and progress of Aboriginal and Torres Strait Islander children and young people entering OOHC. In a formal report of their findings in 2007 the results showed that 53% of children had overdue immunisation status, 43% had had hearing problems, 44% had visual concerns, 61% had speech delays, 34% had fine motor problems, 66% had educational problems and 30% had global developmental delays.<sup>50</sup>

Although methodologically sound, Australian researchers to date have only identified the need for culturally specific wellbeing assessments for Aboriginal and Torres Strait Islander children, rather than directly investigating what such assessments might look like.

Studies have indicated that concepts such as attachment and bonding to assess the wellbeing of Aboriginal and Torres Strait Islander children are inconsistent with Aboriginal and Torres Strait Islander values of relatedness and childrearing practices<sup>51</sup>. Whilst others have reinforced that wellbeing indicators for Aboriginal and Torres Strait Islander children should include cultural and spiritual dimensions as well as physical, emotional and social status<sup>52</sup>.

The CREATE Foundation<sup>53</sup> has also advocated for caseworkers and carers to have training on the value of connecting Aboriginal and Torres Strait Islander children and young people to their culture.

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<sup>49</sup> Sempik J., Ward H. and Darker I. (2008) 'Emotional and behavioural difficulties of children and young people at entry to care', *Clinical Child Psychology and Psychiatry*, 13, 2, 221-233

<sup>50</sup> Kari Clinic- By Sandra Reynolds, Psychologist, KARI Aboriginal Resources Inc SNAICC News July 2008

<sup>51</sup> Yeo, S. S. (2003). Bonding and attachment of Australian Aboriginal children. *Child Abuse Review*, 12(3), 292-304.

<sup>52</sup> McMahon, A., & Reck, L. (2003). Well-being for Indigenous foster children: Alternative considerations for practice research. *Children Australia*, 28(2), 19-24

<sup>53</sup> CREATE Foundation. (2005). Indigenous children and young people in care: Experiences of care and connections with culture. Perth, WA: Author.



**Key Learning:** Aboriginal and Torres Strait Islander children and young people are over-represented in OOHC statistics and have significantly more health problems compared to other children in OOHC. Consideration should be given to the specific needs of Aboriginal and Torres Strait Islander children and young people in the development of the framework particularly in relation to building cultural connections.

### ***Impacts resulting from the rise of kinship care***

One of the primary strengths of kinship care is that children in kinship care (both Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander) can benefit from maintaining family, cultural and community connections and, as such, is the fastest growing form of OOHC in Australia<sup>54</sup>.

Research in this area has focused on grandparents providing care for grandchildren. The growing number of grandparents raising grandchildren due to parental substance abuse highlights the need for greater social, financial and service supports.<sup>55</sup>

Australian research has shown that kinship foster carers are recruited differently from non-relative foster carers, and yet assessment procedures have not been modified to account for the different circumstances<sup>56</sup>. Kinship care placements receive less (and in some instances receive no) monitoring, training and support. This is problematic, as kinship carers tend to have higher rates of poverty and disadvantage and tend to require more support than non-relative foster carers.

**Key Learning:** The Carer is an integral participant in the effective implementation of the Health management plan. Appropriate training and support should be provided to take account of individual carer's knowledge, experience and capability.

## **B.2.2 Barriers to accessing appropriate health care**

Various studies report that placement into care does not necessarily ameliorate health problems. Children in out-of-home-care are less likely to access continuous medical care, as a consequence of multiple placements, or alternating periods of placement at home and out-of-home-care. Data suggests that children in care have ongoing unmet health needs such as poor uptake of immunisations, inadequate oral health care and developmental disabilities remain prevalent as do chronic medical conditions.<sup>57</sup>

Currently across Australia, evaluation of children in care is generally performed on an as needs basis and by a range of health professionals. Assessment tends to be in response to an acute episode of ill health and relies on identification by the carer or caseworker

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<sup>54</sup> Mason, J., Falloon, J., Gibbons, L., Spence, N., & Scott, E. (2002). Understanding kinship care. Haymarket, NSW: Association of Children's Welfare Agencies and University of Western Sydney.

<sup>55</sup> Baldock, E., & Petit, C. (2006). Grandparents raising grandchildren because of alcohol and other drugs. Curtin, ACT: Canberra Mothercraft Society.

<sup>56</sup> Bromfield, L and Osborn, A (2007) 'Getting the big picture': A synopsis and critique of Australian out of-home care research. Child Abuse Prevention Issues No 26 2007 Australian Institute of Family Studies.

<sup>57</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy



rather than being undertaken as part of a health screening assessment or early intervention process. There is evidence that carers or caseworkers tend to under-report health concerns/needs and reliance on this practice identifies only about 30% of children with developmental delay and 33% with psychological problems.<sup>58 59</sup>

For children in care there are also inherent problems in either locating medical histories for some children or in recording or transferring information from one practitioner to the next. This can occur for a variety of reasons (e.g. medical histories are non-existent or records are not transferred upon change of placement) but can result in inconsistent or lack of appropriate health care for the child.<sup>60 61 62</sup>

Studies report that if there is no provision for permanent and accessible health records, and no overall coordination of a health care plan, access to services, particularly scarce developmental and mental health resources, is likely to be problematic.<sup>63</sup>

**Key Learning:** The availability of health information and continuity of care are essential elements to improve health outcomes of children in OOHC.

### ***Longer-term outcomes for children and young people in out-of-home care***

The Create Foundation *Report Card: Transitioning from Care* (March 2008) highlights specific inadequacies in the existing arrangements for children and young people transitioning from OOHC. The report identifies the need for a more coordinated approach to the provision of services to those transitioning from care.

The longer term outcomes for those leaving of out-of-home-care show that this group of children and young people experience significant health, social and educational deficits, including homelessness, disproportionate involvement in juvenile crime and prostitution, poor social supports and early parenthood.<sup>64</sup> Children who have been in care are over represented in the juvenile justice system and in prisons. A NSW inmate health survey reported that 23% of women and 21% of men had been in care before they were 16 years old.<sup>65</sup> This group of children is also at increased risk of unemployment, poverty and financial stress, drug and alcohol use/abuse, and poor physical and mental health issues.<sup>66</sup>

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<sup>58</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>59</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of -home care. *Journal of Paediatrics and Child Health* **43** 695-9

<sup>60</sup> Submission to the Special Commission of Inquiry into Child Protection Services in NSW (2008) NSW Commission for Children and Young People

<sup>61</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of -home care. *Journal of Paediatrics and Child Health* **43** 695-9

<sup>62</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>63</sup> Crawford, M, (2006), Health of Children in out-of-home care: Can we do better? *Journal of Paediatrics and Child Health* **42** 77-78

<sup>64</sup> P Mendes, B Moslehuddin (2004) Graduating from the child welfare system: a comparison of the UK and Australian leaving care debates. *International Journal of Social Welfare*,

<sup>65</sup> Royal Australasian College of Physicians (2006) Health of Children in "Out-Of-Home" Care - Paediatric Policy

<sup>66</sup> Halfon N, Berkowitz G, (1995). Health status of children in foster care: The experience of the centre for the vulnerable child. *Archive of Paediatric and Adolescent medicine*; 149: 386-392.



Research highlights that the vast majority of care leavers suffer from, or are at a greater risk of, negative outcomes in their social and psychological functioning, financial status, educational and vocational pursuits<sup>67</sup>.

Young people leaving care were found to be at great risk of experiencing negative life outcomes<sup>68</sup>, including periods of homelessness and involvement in committing offences since leaving care<sup>69</sup>. Each of these studies identify that the young people needed to develop more employment and independent living skills and more social and emotional skills before they could successfully live independently.

This is supported by further analysis of the ONS Survey results in the UK which found that unresolved mental health problems in childhood can cause ongoing problems for children, in adult life such as homelessness, poor educational outcomes and employment prospects, unsatisfactory personal relationships and even contact with the criminal justice system.<sup>70</sup>

The *UK Statutory Guidance on Promoting the Health and Well-being of Looked After Children* notes that preparing to leave care is critically important for all young people in OOHc. The Children (Leaving Care) Act 2000 requires all eligible, relevant and former relevant children to have a Pathway Plan which will focus on arrangements for the young person's successful transition to independence. The Pathway Plan will take account of the assessed health needs of the young person and set out clearly how these are to be met. Particular attention must be given to the young person's need for support in taking responsibility for his/her own health and in accessing appropriate services, including information and advice.

Care leavers consistently take a holistic view of health when asked about their views on what helps them to be healthy and what impacts adversely<sup>71</sup>. A sense of security, stability, continuity and social support were strong predictors of better outcomes for young people's long-term outcomes after leaving care<sup>72</sup>.

Research highlights the need for children to have stable and secure placements, whether that be with their natural parents or in out-of-home care. The quality of relationships with carers is also critical. Care leavers can be better supported if they are equipped with improved employment and independent living skills and more social and emotional skills while in care.<sup>73</sup>

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<sup>67</sup> Bromfield, L and Osborn, A (2007) 'Getting the big picture': A synopsis and critique of Australian out of-home care research. Child Abuse Prevention Issues No 26 2007 Australian Institute of Family Studies.

<sup>68</sup> Cashmore, J. A., & Paxman, M. (1996). Wards leaving care: A longitudinal study. Sydney: Department of Community Services.

<sup>69</sup> Maunders, D., Liddell, M., Liddell, M., & Green, S. (1999). Young people leaving care and protection. Hobart: National Youth Affairs Research Scheme.

<sup>70</sup> Ford, T. et al. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. British Journal of Psychiatry, 190; 319-325.

<sup>71</sup> Saunders L and Broad B (1997) The Health Needs of Young People Leaving Care. De Montfort University

<sup>72</sup> Cashmore, J. A., & Paxman, M. (2006). Predicting after-care outcomes: The importance of "felt" security. Child and Family Social Work, 11, 232-241.

<sup>73</sup> Cashmore, J. & Paxman, M. (1996), Wards Leaving Care: A Longitudinal Study, Department of Community Services, Sydney



**Key Learning:** Whilst the focus of the Framework is on health assessments for children and young people in OOHC, addressing the health needs of children transitioning from care is a key area for attention for an improvement in longer term outcomes to be achieved.

### **B.2.3 Current health screening and assessment practices for children and young people entering OOHC**

To understand how the health care needs of children and young people in out-of-home care may be addressed it is necessary to consider the broader processes of the overall child protection system. In this context there have been increasing concerns in recent years about the efficacy and impacts of a child protection system that is fundamentally based on statutory investigation and mandatory reporting, such as those used in Australia, the United States and Canada.<sup>74</sup> In summary, too many reports are being made to child protection authorities that do not warrant the exercise of statutory powers. As a result, much effort and cost is expended in managing reports/notifications and the children/young people who are the subject of these reports receive little in the way of support or assistance.<sup>75</sup>

As a consequence, there is an increasing international trend toward a public health model of child protection. This model of child protection is similar to that used in some Western European countries in that it is focussed on a model of prevention rather than a legalistic emphasis. The model employs a range of public health strategies that target whole populations or sub-groups within populations, and strategies are generally divided into primary, secondary and tertiary interventions.

The *National Framework for Protecting Australia's Children 2009-2020*<sup>76</sup> notes that leading researchers and practitioners – both in Australia and overseas – have suggested<sup>77 78 79</sup> that applying a public health model to care and protection will deliver better outcomes for our children and young people and their families.

“Under a public health model, priority is placed on having universal supports available for all families (for example, health and education). More intensive (secondary) prevention interventions are provided to those families that need additional assistance with a focus on early intervention. Tertiary child protection services are a last resort, and the least desirable option for families and governments.”

Brief wellbeing assessments at intake can identify children at risk of significant behavioural problems and in need of support during the early phases of placement from those with a

<sup>74</sup> Submission to the Special Commission of Inquiry into Child Protection Services in NSW (2008) NSW Commission for Children and Young People

<sup>75</sup> Report of the Special Commission of Inquiry into Child Protection Services in NSW (2008) The Hon James Wood AO QC

<sup>76</sup> Protecting Children is Everyone's Business National Framework for Protecting Australia's Children 2009-2020, Commonwealth of Australia (2009)

<sup>77</sup> Holzer, P. J. (2007). Defining the public health model for the child welfare services context. Resource Sheet no. 11. Retrieved from [www.aifs.gov.au/nch/pubs/sheets/rs11/rs11.html](http://www.aifs.gov.au/nch/pubs/sheets/rs11/rs11.html)

<sup>78</sup> O'Donnell, M., Scott, D., & Stanley, F. (2008). Child abuse and neglect - is it time for a public health approach? *Australian and New Zealand Journal of Public Health*, 32(4), 325-330.

<sup>79</sup> Scott, D. (2006). Towards a public health model of child protection in Australia. *Communities, Children and Families Australia*, 1(1), 9-16.





lowered risk<sup>80 81</sup>. Early therapeutic intervention with these children may enhance their wellbeing, provide them with greater opportunity for stability while in care and increase the likelihood of better long-term outcomes.

Studies show that when professionals use reliable and valid screening instruments, they are able to identify 70% to 80% of children with developmental delays.<sup>82</sup>

The *Submission to the Special Commission of Inquiry into Child Protection Services in NSW (March 2008)* provides extensive further detail on how the public health model could be applied to overall child protection and in addressing health care needs of children in out-of-home care.<sup>83</sup>

### B.3 Current models of practice - Australia

Although each state and territory government has in place a statutory child protection system there are variations in the systems across the jurisdictions. The different systems for each jurisdiction were comprehensively researched and documented in the *Report Card on Health 2006*.<sup>84</sup>

This section provides a brief outline of current practice in the States and Territories and is based on input provided by each jurisdiction as at November 2010.

#### Victoria

In Victoria, there is currently no state wide systematic health screening of children in out-of-home care. Children and young people should see a general practitioner and a dentist within a month of entry to out-of-home care but there is no standardised assessment guidance or the expectation of a written report.

The health needs of children are addressed through the Looking After Children (LAC) system that requires periodic review of the progress and the development of a Care and Placement Plan that addresses seven developmental domains, including health and emotional/behavioural development. New LAC Assessment and Progress records are being introduced which will allow better monitoring of outcomes along the LAC domains.

If a health or developmental issue is identified by a general practitioner or others responsible for the care of a child/young person, child protection would refer to a public hospital paediatric clinic or private paediatrician for further assessment. Children and young people requiring assessment of their emotional and behavioural wellbeing may be referred to the child protection therapeutic treatment service, Take Two, to Child and Adolescent Mental Health Services, the Australian Childhood Foundation or to private psychologists.

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<sup>80</sup> Barber, J. G., & Delfabbro, P. H. (2003b). The first four months in a new foster placement: Psychological adjustment, parental contact, and placement disruption. *Journal of Sociology and Social Welfare*, 30(2), 69–85.

<sup>81</sup> Barber, J. G., Delfabbro, P. H., & Cooper, L. (2001). The predictors of unsuccessful transition to foster care. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 42(6), 785–790.

<sup>82</sup> Squires, J. Nickel, R. E., Eisert, D. (1996). Early detection of developmental problems: Strategies for monitoring young children in the practice setting. *Journal of Developmental & Behavioral Pediatrics*, 17, 420–427.

<sup>83</sup> Submission to the Special Commission of Inquiry into Child Protection Services in NSW (2008) NSW Commission for Children and Young People

<sup>84</sup> Australian Children and Young people in Care Report Card on Health (2006) Create Foundation



Assessments are funded through a combination of Medicare, Victorian state funded health services and child protection purchase of private services.

In recognition of the absence of a standardised assessment process, the Department of Human Services piloted a model in one metropolitan region that utilised General Practitioners, paediatricians and the Take Two Intensive Therapeutic Service. Building on the learnings from that work, the department is currently working with the Department of Health to develop a model of assessment and treatment that utilises and streamlines existing health services, with a focus on early detection of health issues, assessment of all domains of child health and timely and coordinated priority pathways into mainstream localised services for ongoing care. The aim is to have an initial health check by a GP followed by a comprehensive multi modal assessment.

**Key Learning:** Establishment of Health Standards for children and young people in OOHC aim to clarify the roles and responsibilities of practitioners and contribute to improved health outcomes.

## Tasmania

In Tasmania the health needs of children in care are documented in their Case and Care Plan. This is developed upon entry into care and is updated every six months to a year, or when there is a significant event within a child's life.

In June 2010 an Operational Forum was held with Area Directors, Child Protection Managers and Child Health and Parenting Managers to discuss how the services should continue work together to meet the needs of children aged under five who were under Care and Protection Orders. The following initiatives have been trialled in some parts of Tasmania, and it was agreed that these should become the statewide policy directions for all children entering care for the first time who are under five years of age:

- a baby (under the age of 6 months) coming into care should receive a child health assessment as soon as possible; and
- a child (over 6 months of age) coming into care should receive a child health assessment within a 4 week period even if an assessment is not due
- children in care are to attend all scheduled health and development assessments
- carers should be encouraged to ensure children have regular engagement with a child and family health nurse
- all children in care are to have up to date immunisations.

It was also agreed that senior nurses from within the child health service would be invited to attend the Court Application Advisory Group (CAAG) meetings with child protection services, for all children under the age of five years.

These policy directions have been incorporated within a new draft of the *"Entering Care Policy and Practice Advice"* for Child Protection Workers.

In addition, all children entering care are required to have a baseline medical assessment with a general practitioner within four weeks of entering care. Currently this check is not monitored or co-ordinated. If a health or developmental issue is identified by a general practitioner, or others responsible for the care of child/young person, child protection would refer to a public hospital paediatric clinic or private paediatrician for further assessment.





Further referrals to other services (e.g. psychologists) would be made by the general practitioner or paediatrician as required.

Assessments are currently funded through a combination of Medicare, Tasmanian Department of Health and Human Services and the purchase of private services by child protection services.

**Key Learning:** A commitment to the ongoing provision of publicly funded services is likely to be required for the successful implementation of the Framework.

#### Western Australia

The Western Australian Government in 2008 initiated an across government project for the development and implementation of a model for *Health Care Planning for Children in Care*. The project arose in response to the findings of the Ford Review (2007) which recommended:

**R 63:** *The Departments of Health and Education be required to develop a Health Plan (covering physical, mental and dental health) and an Education Plan for each child or young person in care.*

In 2009 the Department of Health (DOH) and the Department for Child Protection (DCP) successfully piloted a collaborative health care planning pathway based on the existing DOH universal child health services provided by community health nurses for children 0-18 years of age and their families, and also state-wide dental health services for children 0-17 years of age. The pathway also acknowledged and promoted the role of General Practitioners in evaluating and responding to medical needs and in providing pathways to specialist medical services. The pilot found that the pathway:

- Improved access to existing community based universal child, school and dental health services.
- Formalised and strengthened local interagency relationships and improved use of client information shared.
- Highlighted the importance of leadership, coordination and administrative resources at state and local levels to implement and sustain the pathway.
- Recognised the added administrative tasks for both DCP and WA Health staff.

On the basis of these findings, DCP and DOH committed to a staged statewide implementation of the pathway, to be completed by July 2011. The implementation is supported by an overarching Bi-lateral Memorandum of Understanding (MOU) and operationalised at local level through Local Services Agreements.

The WA *Health Care Planning for Children in Care* pathway is comprised of the following key steps:

- 1. Medical Review upon entry into care:** Entry to care can occur for a variety of reasons. In situations of acute abuse (sexual, physical, neglect), the medical review should be provided by specialist providers such as the Princess Margaret Hospital (PMH) Child Protection Unit or other providers in rural and remote areas. For children not requiring specialist medical service upon entry into care, a general medical review is recommended within 20 working days.
- 2. Mental Health screening on entry to care:** A Strengths and Difficulties Questionnaire is completed for children aged 4 years and older within six weeks of entering care. (For



children under 4 years mental health is included as part of the Community Health Nurse Assessment)

3. **Health and Developmental Assessment:** Children new to care should be referred to the DOH community health service for a Health and Developmental Assessment. Children already in care should be referred annually as part of the review of the DCP Care Plan. Community child health nurses conduct age-appropriate assessments within 30 working days of receiving the DCP referral, and provide a summary report to the DCP within 5 working days of the assessment appointment.
4. **Dental Health Service:** Eligible children are enrolled into the School Dental Service. All children under school age receive an oral health inspection by the child health nurse and are referred to the local General Dental Clinic for full oral health assessment.
5. **Collaborative Health Care Planning:** Within 20 working days of receiving the nurse assessment report, DCP consults with the nurse to develop a 'health plan' (actions to address the health care needs of the child for the next 12 months). DCP records the 'health plan' in the health dimension of the child's overall Care Plan, and implements accordingly over the next 12 months..

A key consideration of the WA health care planning model is ensuring the maintenance of the child's health records. The *Child Health Passport* has been developed and implemented by DCP to record a child's health information and provide carers with the information they need to help meet the child's day-to-day health needs, including attendance at scheduled appointments.

Key Learning: Ongoing monitoring of the pathway during state-wide implementation is required to inform the ongoing development of the *WA Health Care Planning for Children in Care Pathway* to ensure that the proposed elements can be implemented successfully in a variety of settings given locally available resources and service models.

## South Australia

South Australia commenced a reform of the child protection system in 2004, "Keeping Them Safe," in response to the 2003 Layton Review findings. One of the key review findings was the need to improve outcomes for children and young people under guardianship of the Minister.

Subsequently, the Rapid Response Service Framework [Rapid Response] was released in 2005 with the aim of ensuring that children and young people under the guardianship of the Minister for Families and Communities have priority access to services wherever possible. Rapid Response places these children and young people firmly at its centre and focuses on providing a holistic, coordinated approach to all aspects of their lives including their health, education and wellbeing.

In recognition that their health status is significantly worse than other children, Health Standards for children and young people under guardianship of the Minister were developed to clarify the roles and responsibilities of the Health Sector in providing services to this group, and ultimately to improve their health outcomes.

The Health Standards apply to all children and young people placed on a Care and Protection order by the Youth Court.

The standards address nine key areas:



- Initial (baseline) health assessments for children and young people when they come into care
- Psychological therapeutic services
- Primary health care services – as a type of service this covers community health services, outreach, and allied health. The manner in which services are delivered will vary significantly.
- Outpatient / ambulatory services – planned appointments, usually done in hospital but can include community, outreach and visiting services.
- Emergency hospital services.
- Inpatient services – medical, surgical and elective admissions.
- Health's contribution to Guardianship of the Minister annual reviews – initiated by Families SA when they undertake an annual review of the child in care.
- Health's contribution to planning for children and young people leaving care – the process of transitioning to adult services and other youth based services.
- SA dental services.

The standards specify that a referral will be made for an initial paediatric health assessment within two months of coming into care and that the health assessment will be provided within five weeks of receiving a referral. The focus is on partnership, information exchange, support for the child or young person, priority response, continuity of care and cultural considerations.

The initial health assessment leads to ongoing referral and the development of a health care plan.

Children Youth and Women's Health Service and SA Dental Services electronically flag the guardianship status of children and young people to ensure they are registered and followed up. Compliance with the standards is measured regularly. An adolescent specific health assessment is provided for young people under guardianship in the Adelaide metropolitan region. The aim is for young people under the Guardianship of the Minister to have a 'stock take' of their health status at aged 14 years. This assessment will ensure their health needs are identified and treated prior to the transition planning phase and encourages young people to engage with health providers as they make the transition from care and beyond.

**Key Learning:** Health Standards for children and young people in OOHC aim to provide priority access to health services and health assessment at critical stages of development, addressing health inequities and contributing to improved health outcomes.

## Queensland

The process for assessing the health needs of children and young people in out of home care in Queensland is called the Child Health Passport initiative. This initiative commenced in 2006 and is led by the Department of Communities – Child Safety Services in partnership with Queensland Health and the primary care and general practice community.



The Queensland Commissioner for Children and Young People and Child Guardian has legislative responsibility for reporting and monitoring the progress of children in out of home care and this includes an audit process of Child Health Passports and Education Support Plans. The Child Health Passport process has three Phases:

- **Phase 1 – Immediate health needs.**

Identifies the immediate health needs of a child or young person when placed into out of home care including any current medical problems or medications or any allergies that are important to be communicated to the carer who has immediate care and responsibility for the child to ensure appropriate care is provided. This information is obtained by Child Safety Services. This information moves with the child if placement changes.

- **Phase 2 – Comprehensive health assessment and health plan**

Any child or young person remaining in out of home care for a period of longer than 30 days requires a comprehensive health assessment. This assessment is ideally performed after the first 30 days but within 4 months of the child entering out of home care. The Child Safety Officer with case management responsibility for the child consults with the carer to ensure the assessment is arranged and performed. The assessment can be undertaken by a range of health care providers skilled in the assessment of children and can include GPs, paediatricians, child health nurses or Aboriginal and Torres Strait Islander health workers. The clinician performing the assessment provides a summary of the child's health needs to Child Safety Services, including any significant findings and referral/s to any other specialist health services according to the assessed needs of the child or young person..

Recommended health assessment domains include:

- physical & developmental – including vision, hearing & dental screening
- nutritional assessment
- immunisation
- psychosocial and behavioural issues
- mental health

- **Phase 3 – Family health history**

This phase occurs over an extended period of time for children and young people remaining in out of home care, and where there is no plan for the reunification of the child with their biological family. This family history is provided to the young person when exiting care as some aspects of the family medical history may be relevant to the child's future and ongoing health care in later life. Relevant family history includes history of cancer or chronic medical conditions such as diabetes and heart conditions. The health history is compiled over time by the Department of Communities - Child Safety Services with the biological parent/s of the child during family meetings or information regarding family medical history and can be obtained with the consent of the parent/s from health service providers.

**Key Learning:** Establishment of a medical passport may increase the likelihood that a child or young person's health record will be maintained and passed on following a change of placement.



### **Northern Territory**

The Northern Territory's policy requires that a baseline assessment is conducted during the child's first three months in care. This is a combination of medical, dental, educational and where necessary, psychological assessments. The child's case worker is responsible for arranging any appointments, collecting copies of reports, and collating and analysing the assessment information. This provides the basis for ongoing assessment. There is no specific agency that provides health screening and assessments. Local resources are used and where necessary the Department pays for this.

### **Australian Capital Territory**

In 2006 ACT Health set up a clinic, located at the Child at Risk Health Unit, to provide nursing health and wellbeing screens for all children aged 0 –14 years entering care. This health and wellbeing screen is a baseline evaluation of the child or young person's health, not a full paediatric assessment. The Health and Wellbeing Screen provides a holistic nursing assessment, encompassing physical, dental, developmental and behavioural domains. Referrals are made to appropriate health professional as needed. The screen is available annually if there are ongoing concerns which are not being addressed.

The aims of the clinic are:

- To provide a health and wellbeing screen for children in out of home care
- To identify the unmet health needs of children in out of home care, and address as appropriate.
- To obtain an understanding of the health needs of children in out of home care in order to make recommendations for a better health care delivery model.

Referrals to the clinic are made by Care and Protection Services and/or foster care agencies when a child is taken into care.

**Key Learning:** Co-location of service providers is likely to improve information flows and therefore coordination of care.

### **New South Wales**

The NSW Government's action plan *Keep Them Safe, a Shared Approach to Child Wellbeing 2009-2014* is the NSW response to the *Report of the Special Commission of Inquiry into Child Protection Services in NSW (November 2008)* and details actions to improve the safety and wellbeing of children and young people in NSW and improve the health of children and young people in out-of-home care.

NSW Health, in collaboration with the NSW Department of Human Services – Community Services, is conducting a staged approach to the provision of comprehensive health assessments for children and young people entering out of home care. A Memorandum of Understanding supports this collaboration.

The following have been established to assist in the delivery:

- Phase 1 focuses on children and young people entering statutory out-of-home care who will remain in care for longer than 90 days to receive an initial primary health screening/consultation within 30 days of entering statutory out-of-home care and will



undergo a comprehensive assessment based on triage and findings of the initial health screening.

- A Model Pathway for Comprehensive Health Screening and Assessment developed to clarify roles and responsibilities.
- Eight Out-of-Home Care Coordinators based across the State and one Out-of-Home Care Clinical Coordinator based at The Children's Hospital, Westmead coordinate and oversee the staged implementation of the delivery of health assessments at the local level.
- Out of Area Placement Guidelines developed for OOHC Coordinators and Interagency Pathway Coordinators to align with the Pathway and further clarify roles and responsibilities when a child and/or young person who enters out of home care is in a placement outside the Community Services region that has case management responsibility.

Further work is planned to:

- Add pages to the NSW Health Personal Health Record (or 'Blue Book') to record health assessments and treatments in summary form for children in out of home care in order to allow the children and young people to keep personal health records with them.

Recognising the poor health of these children, NSW Health is proactive in providing health screening and assessments and connecting children and young people with general practitioners for ongoing health care. NSW Health aims to work in consultation with general practitioners.

These actions build on existing out-of-home care clinics/services. The aim is to continue to develop a consistent approach, methodology and framework for conducting health assessments across NSW Health for children and young people entering out-of-home care.

**Key Learning:** Appointing OOHC Coordinators and establishing a memorandum of understanding between coordinating agencies is likely to clarify roles and responsibilities and support implementation of a tiered assessment process.

## B.4 Current models of practice - Overseas

The high levels of unrecognised and unmet health needs of children in care and inequitable access to health care services has been noted in a range of studies and literature.

Consequently, specific recommendations for the health care of children in out-of-home care have been in place in both the United States and the United Kingdom for a number of years.<sup>85</sup>

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<sup>85</sup> Nathanson, D & Tzioumi, (2007), Health need of Australian children in out-of -home care. *Journal of Paediatrics and Child Health* **43** 695-9





## United Kingdom

In the United Kingdom (UK), regulations under the Children Act (1989) recommends a statutory annual health assessment (biannual if under 5 years of age). The initial health assessment includes information gathered from the child, social worker and parent/carer as well as a physical examination. The physical examination includes an assessment of hearing, vision, growth and developmental evaluation.

The UK does not have a mandatory reporting system and has a strong legally-based focus on shared inter-agency responsibility for child protection. In England, although the child protection assessment is carried out by statutory child protection workers, other services such as child health and education now use a 'common assessment framework' to identify and respond to a child and family's needs. This means that only those cases requiring a more specialised statutory child protection assessment are referred to social services.

Recently, new statutory guidance was issued to local authorities, Primary Care Trusts and Strategic Health Authorities. Each Authority must now have regard to the *Statutory Guidance on Promoting the Health and Well-being of Looked After Children* (November 2009) when exercising their functions.

The Statutory Guidance outlines the following objectives of health assessments:

- assess health risk and provide an opportunity to redress past health neglect, collate health history including peri-natal history;
- ascertain and advise on relevant family history;
- review immunisation status and missed child health screening episodes including dental and oral health;
- assess current health and mental health concerns;
- review and advise on known existing health problems and risk factors;
- ascertain outstanding appointments and places on waiting lists;
- identify unrecognised health needs;
- identify mental health, behavioural and emotional problems;
- recognise developmental or learning concerns;
- plan appropriate action and ensure recommendations are carried through;
- discuss life style issues;
- plan follow up.

The Statutory Guidance suggests that flexibility should be the key to carrying out an effective health assessment which will:

- be child focused;
- take account of the particular needs of children who are in OOHC and their families, including attention to issues of disability, race, culture and gender;
- be carried out at a time and venue convenient to the child or young person and their carers and parents;
- be sensitive to the child or young person's needs, wishes and fears;



- include information from all those involved with the care of the children, particularly the birth parents or other previous carers;
- allow sufficient time and preparation for the child to be given a clear understanding of the process and what is involved, so that they have the confidence to fully participate;
- be carried out in a place that facilitates the child or young person's participation.

**Key Learning:** Models of assessments have been designed to address the physical, developmental and overall wellbeing requirements whilst accommodating the unique needs of vulnerable populations and are being implemented in multi-cultural societies.

## Ireland

In 2003, the Government of Ireland introduced its *National Standards for Foster Care*.<sup>86</sup>

A number of elements of the Standards are relevant to the development of the Framework including:

- An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.
- The decision to use a foster care placement is based on an assessment which determines this to be in the best interests of the child.
- Child and family social workers ensure that the assessments are carried out prior to placement. They are comprehensive and, where appropriate, multidisciplinary. They consider the emotional, psychological, medical, educational and other needs of children and take account of any previous assessments of the children.
- In the case of decisions to place children in foster care in an emergency, the health board ensures completion of an initial assessment of the children within one week of placement and the completion of the comprehensive assessment within six weeks. Unplanned admissions to foster care are made in exceptional circumstances only and the reasons for them are recorded on the case file.
- Children, their families and others involved in their care are encouraged and facilitated to participate in the assessment process.
- Assessment outcomes are shared with the children in an age-appropriate manner and copies of the assessment are given to the family and foster carer/s.
- Decisions are recorded and attached to the assessment report on the case file.

**Key Learning:** The child or young person should participate actively in the assessments. The outcomes of each assessment should be shared with the child, inform the child of future assessments, and where appropriate inform placement decisions.

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<sup>86</sup> Government of Ireland (2003) National Standards for Foster Care, Department of Health and Children, Dublin





## United States

In 1988 the American Academy of Paediatrics in conjunction with the Child Welfare League made recommendations to address the health needs of children in care. These recommendations call for an initial medical review before or shortly after being placed into care. This initial physical examination focuses on the identification of acute or chronic conditions requiring immediate attention. All children are then required to receive a comprehensive health assessment within the first month, including a developmental and emotional health evaluation.

In March 2002, the American Academy of Paediatrics' Committee on Early Childhood, Adoption, and Dependant Care published its statement on Health Care of Young Children in Foster Care. This statement<sup>87</sup> reiterated the following principles:

- All children entering foster care should have an initial physical exam before or soon after placement.
- All children in foster care should receive a comprehensive physical as well as a mental health and developmental evaluation within one month of placement.
- Individual court approved social service case plans should include the results of all health assessments and incorporate the recommendations of health providers.
- The physical, developmental and mental health status of a child in foster care should be monitored more frequently than those of children living in stable homes.

The Child Abuse Research Education & Service (CARES) Institute at the University of Medicine and Dentistry of New Jersey has a comprehensive assessment program for children who are placed in foster care to provide medical and mental health assessments within 30 days of their placement. The program comprises approximately 600 children a year.

The CARES Institute prepares comprehensive reports and requests that nurses at local offices ask their staff assistants to forward the reports to the patients' primary care physicians. As part of the process, the Institute actively updates the New Jersey immunization registry, not only with vaccines previously and currently administered, but also with patient lead levels, patient alias names, etc.

Mental health providers see children from aged two, using the developmental assessment Ages & Stages Questionnaires. Developmental assessments are provided until about age 5 yrs, 6 months at which point the screening involves mental health screening. In addition to interviewing the child and accompanying adult (typically the caseworker), IQ and achievement screening measures are used, as well as measures to assess for depressive symptoms, posttraumatic stress symptoms, substance abuse, and a range of other emotional and behavioural symptoms.

**Key Learning:** Appropriate use of simple screening tools may provide a means of determining the progress of an individual's health and developmental status over time (and provide a consistent means of data collection for a given population).

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<sup>87</sup> American Academy of Paediatrics, Committee on Early Childhood, Adoption and Dependent Care, (2002)



Another example of a program designed to assess children entering placement is the Children's Crisis Care Center (CCCC) in Texas<sup>88</sup>. The CCCC is a collaborative partnership in Harris County. Partners in the program include Harris County Children's Protective Services (CPS), Texas Department of Protective and Regulatory Services, Baylor College of Medicine: Child Trauma Programs, and Harris County's Mental Health and Mental Retardation Association. The program provides a proactive, up-front, multi-disciplinary assessment of children referred by the child welfare agency. The assessment is performed by a special unit which is completely separate from both the intake/investigation unit and the family maintenance/reunification unit.

A percentage of children and young people entering the CPS system were found to have significant problems across multiple domains. 23% of children were unable to be completely tested due to unresponsiveness, opposition, and/or high emotional distress. Of the remaining children, 62% were found to have at least one developmental delay and over 79% were found to have more than one caution and/or at least one delay on the Denver II scale (a measure that may under-identify some developmental problems). Of those children with delays at their initial screening, 76% had delays in language skills. In other areas, delays were significant with gross motor development being the least effected (only 18%). Within this sample, 60% of children assessed had delays or a clinical presentation that warranted further evaluation or enrollment in specialised early childhood intervention services. Findings further suggest that the longer a child had been in a neglectful or abusive setting, the more pervasive and severe the problems were.

As a group, pilot children and adolescents (6-18yrs) removed from their families by CPS demonstrated many problems. Two of the most striking findings are related to being raised in chaotic and threatening environments. Mild post-traumatic stress (PTSD) symptoms were reported by 86% of this group, with 22% reporting very severe PTSD symptoms. As a group, these children were more proficient at processing non-verbal than verbal information. Academic problems and other neuropsychiatric problems were more common in these children than in the general paediatric population. Findings from an examination of data from the Core Assessments suggest that early assessment of children and adolescents as they enter the CPS system is vital in identifying areas for concentrated treatment and services.

Two types of assessments are provided by the CCCC. A family assessment, which consists of a semi-structured clinical interview and the administration of standardised measures of family, child, and parent functioning which are completed within 72 hours of placement. Within the next 10 to 14 days, a multi-dimensional developmental (for children under age 6) or psychological (for children age 6 or above) screening is completed. The assessment results are reported to the social worker and the court within 20 days of placement. Information from the assessments is used to make recommendations regarding treatment and placement. Program evaluations indicate that assessed children experience fewer placement disruptions, a shorter average time between the initial placement and long-term placement, a higher percentage of relative placements, and higher rates of reunification.

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<sup>88</sup> Doran, Lee. and Berliner, Lucy (2001) Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review Washington State Institute for Public Policy Document No. 01-02-3902



**Key Learning:** Models of tiered, multi-domain health assessments have been successfully implemented in other countries. Evaluation of these programs have demonstrated improvements including reduction in placement disruptions and increased restoration.

In April 2008, Texas rolled out a Department of Health and Human Services-funded online Health Passport system. More than 30,000 foster children have electronic records that update most information automatically and follow the child when they move to a new home. At the time of rollout, the system was pre-populated with insurance claims and medical data for these children.<sup>89</sup>

An ERS can be a powerful tool to more effectively collect, store, share, and analyse health information and can improve the health of children in foster care and more efficiently use funding allocated to meet their needs.<sup>90</sup>

**Key Learning:** An electronic record system can improve the collection, storage and access to health information and contribute to better health outcomes.

## Europe

In most of Western Europe the assessment of, and response to, children at risk is largely undertaken by non-statutory services.<sup>91</sup>

Quality4Children – formed via the cooperation of three organisations, FICE (Fédération Internationale des Communautés Educatives), IFCO (International Foster Care Organisation) and SOS Children's Villages – have developed a quality standard which seeks to improve the situation of children without parental care and support their development. While the Standards have no formal status within the European Union, they have been designed to be directly applied by practitioners.

The key principles outlined in the standards that are relevant to the development of the Framework are outlined below.

- *The child is empowered to participate in the decision-making process:* All parties involved listen to and respect the child. The child is adequately informed about his/her situation, encouraged to express his/her views and to participate in this process according to his/her level of understanding.
- *The out-of-home care process is guided by an individual care plan:* An individual care plan is created during the decision-making process to be further developed and implemented during the entire out-of-home care process. This plan is intended to guide the overall development of the child. Generally, the care plan defines the developmental status of the child, sets objectives and measures and clarifies the

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<sup>89</sup> Michels Patrick (2008) Electronic Health Records Document Foster Children's Medical Histories. *Texas Technology* July 22, 2008)

<sup>90</sup> Gluckman, Stephanie and Shaw, Terri (2009) *Improving Health Outcomes for Children in Foster Care: The Role of Electronic Record Systems* – The Children's Partnership [Executive Summary]

<sup>91</sup> Submission to the Special Commission of Inquiry into Child Protection Services in NSW (2008) NSW Commission for Children and Young People



resources needed to support the overall development of the child. Every relevant decision during the out-of-home care process is guided by this plan.

- *Children with special needs receive appropriate care:* Caregivers are continuously and specifically trained and supported to meet the special needs of the children in their care.
- *The leaving-care process is thoroughly planned and implemented:* The leaving-care process is a crucial stage in out-of-home child care and is thoroughly planned and implemented. It is primarily based on the child's/young adult's individual care plan. The child/young adult is recognised as an expert regarding the quality of his/her care. His/her feedback is essential for further developing the quality of the care system and the respective care model.
- *Follow-up, continuous support and opportunity for contact are ensured:* After the child/young adult has left out-of-home care, he/she has the opportunity to receive assistance and support. The care organisation strives to ensure that he/she does not perceive the leaving-care process as a major new disruption. If the young adult has reached the age of majority, the care organisation should continue offering support and opportunity to maintain contact.

**Key Learning:** An individual Health management plan is crucial for the coordination of care and to assist overall decision making. It is also important that the child or young person is recognised to be an expert regarding the quality of his/her care throughout the process.



## **Appendix C**

### **Capacity of existing Medicare items to meet the primary health care needs of children and young people in out of home care.**

#### **Purpose**

Appendix C provides an analysis of the capacity of existing Medicare items to meet the primary health care needs of children in out-of-home care (OOHC), including the health assessments outlined in the National Clinical Assessment Framework for Children in Out-of-Home care.

#### **Background**

In October 2008, the Australian Health Minister's Advisory Council (AHMAC) agreed that the CHWS of the Australian Population Health Development Principal Committee (APHDPC) would oversee and report to AHMAC on the following work in relation to children and young people entering and in, out of home care:

- a) identify and document the clinical health needs of children and young people in out of home care (review of literature);
- b) analyse the capacity of existing MBS items to meet the primary healthcare needs of children and young people in out of home care; and
- c) consider and advise on a standard national clinical assessment framework to be used with children and young people entering out of home care.

#### **Appropriate Medicare items for each stage of the assessment framework**

The National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (OOHC Framework) is based on a tiered approach to age-appropriate assessments covering the key domains of physical health, developmental and psychosocial and mental health.

A large number of Medicare items are appropriate for various aspects of the care of children and young people in out-of-home care.

This guide to Medicare items is based on the tiered assessment structure, with items grouped according to the three phases of the framework:

- Preliminary health check
- Comprehensive health and development assessment
- Ongoing monitoring and assessment

In this document, because of the large number of Medicare items available, a separate component for the development of a Health Management Plan has been included within the Comprehensive Health and Development Assessment section.

The framework recognises that completion of each level of assessment may take more than one visit to a practitioner and should therefore not be equated to a single contact.

Throughout the document, management or treatment items have been included alongside assessment items.

As the list of items is for guidance only, practitioners are advised to check full eligibility criteria at MBS online (<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>). There may be other Medicare items that are suitable at each stage of the assessment and care of children in out-of-home care.

## **PRELIMINARY HEALTH CHECK**

*A Preliminary Health Check should be commenced as soon as possible and no later than 30 days after entry to OOHC to determine areas of immediate need.*

### **Items for all children**

#### **GPs**

- MBS General Attendance Items 23 (Level B), 36 (Level C) and 44 (Level D) in consulting rooms, provided by a general practitioner.
- MBS General Attendance Items 24 (Level B), 37 (Level C) and 47 (Level D) at a place other than consulting rooms or a residential aged care facility, provided by a general practitioner.

#### ***Other Medical Practitioners (not vocationally registered)***

- MBS Consultation Items 53 (Standard), 54 (Long) and 57 (Prolonged) in consulting rooms, provided by another medical practitioner.
- MBS Consultation Items 59 (Standard), 60 (Long) and 65 (Prolonged) provided as a home visit or consultation at an institution (including a hospital), by another medical practitioner.

#### ***Consultant Medical Practitioners (including paediatricians)***

- MBS Item 110 for referred initial consultation in consulting rooms or hospital – in a single course of treatment.
- MBS Item 122 for referred consultation provided as a home visit – in a single course of treatment.

#### ***Consultant Psychiatrists***

- MBS Items 296, 297 and 299 for referred initial consultation.

### **Items for specific population groups**

These items may be available if the child meet one of the following criteria:

- Aboriginal and/or Torres Strait Islander;
- Aged at least 3 and less than 5 years;
- Has an intellectual disability; and
- Refugee or humanitarian entrant, and who has been in Australia for less than 12 months.

Check full eligibility criteria and note that some items can be billed annually while others can be billed once only per child.

#### **GPs**

- MBS time-based health assessment item 701 (Brief, less than thirty minutes) for a child:
  - aged at least 3 years and less than 5 years, who has received or is receiving their four year old immunisation who is about to commence school (available once only for each eligible child who has not already received an MBS Item 10986 service);
  - with an intellectual disability (available annually); and
  - who is a refugee or humanitarian entrant, and who has been in Australia for less than 12 months (available once only for each eligible child).
- MBS item 715, the health assessment for Aboriginal and Torres Strait Islander people, for Aboriginal and Torres Strait Islander children aged 0-14 years of age inclusive (available annually).

#### **Practice nurses or Aboriginal Health Workers**

- MBS Health Assessment Item 10986 Healthy Kids Check provided by a practice nurse or registered Aboriginal health worker (available once only for each eligible child who has not already received a Healthy Kids Check service under MBS Items 701, 703, 705 or 707).



## COMPREHENSIVE HEALTH AND DEVELOPMENTAL ASSESSMENT

*A Comprehensive Health and Developmental Assessment should be completed within 3 months of a child's placement.*

### **Items for all children**

#### **GPs**

- MBS General Attendance Items 36 (Level C) and 44 (Level D) in consulting rooms, provided by a general practitioner.
- MBS General Attendance Items 37 (Level C) and 47 (Level D) at a place other than consulting rooms or a residential Aged-Care facility, provided by a general practitioner.

#### ***Other Medical Practitioners (not vocationally registered)***

- MBS Consultation Items 54 (Long) and 57 (Prolonged) in consulting rooms, provided by another medical practitioner.
- MBS Consultation Items 60 (Long) and 65 (Prolonged) provided as a home visit or consultation at an institution (including a hospital), by another medical practitioner.

#### ***Consultant Medical Practitioners (including paediatricians)***

- MBS Items 110 and 122 for referred initial consultation— in a single course of treatment.
- MBS Items 116 and 128 for subsequent attendance – in a single course of treatment
- MBS Items 119 and 131 for minor subsequent consultation – where limited or no physical examination required.

#### ***Consultant Psychiatrists***

- MBS Item 291 for referred attendance of at least 45 minutes for provision of an assessment and development of a management plan.
- MBS Items 293 for professional attendance of at least 45 minutes for review of management plan provided under item 291.
- MBS items 296, 297 and 299 for referred initial consultation on a new patient.

#### ***Specialist Medical Practitioners***

- MBS Item 104 for referred initial consultation.
- MBS Item 105 for subsequent attendance.
- MBS Item 106 for initial specialist ophthalmologist attendance – in a single course of treatment provided for refractive testing for the issue of a prescription for spectacles or contact lenses.
- MBS Item 109 for initial ophthalmologist paediatric attendance – in a single course of treatment provided to a child aged 8 years or under or to a child aged 14 years or under with developmental delay.



### **Health assessment items for specific population groups**

These items may be available if the child meets one of the following criteria:

- Aboriginal and/or Torres Strait Islander;
- Aged at least 3 and less than 5 years;
- A Child with an intellectual disability;
- Refugee or humanitarian entrant, and who has been in Australia for less than twelve months

#### **GPs**

- MBS item 715, the health assessment for Aboriginal and Torres Strait Islander people, for Aboriginal and Torres Strait Islander children aged 0-14 years of age inclusive (available annually).
- MBS time-based health assessment items 703 (Standard), 705 (Long) or 707 (Prolonged) for a child:
  - aged at least 3 years and less than 5 years, who has received or is receiving their 4 year old immunisation who is about to commence school (available once only for each eligible child who has not already received an MBS Item 10986 service);
  - with an intellectual disability (available annually); and
  - who is a refugee or humanitarian entrant, and who has been in Australia for less than 12 months (available once only for each eligible child).

## **COMPREHENSIVE HEALTH AND DEVELOPMENTAL ASSESSMENT :**

### **DEVELOPMENT OF A HEALTH MANAGEMENT PLAN**

*Development of a Health Management Plan including a personal health record is recommended. The Health Management Plan should be integrated with other management plans (e.g. educational plans) into a single management plan for the child or young person.*

#### **Items for all children**

##### **GPs**

- MBS General Attendance Items 36 (Level C) and 44 (Level D) in consulting rooms, provided by a general practitioner.
- MBS General Attendance Items 37 (Level C) and 47 (Level D) at a place other than consulting rooms or a residential Aged-Care facility, provided by a general practitioner.

##### ***Other Medical Practitioners (not vocationally registered)***

- MBS Consultation Items 54 (Long) and 57 (Prolonged) in consulting rooms, provided by another medical practitioner.
- MBS Consultation Items 60 (Long) and 65 (Prolonged) provided as a home visit or consultation at an institution (including a hospital), by another medical practitioner.

##### ***Consultant Medical Practitioners (including paediatricians)***

- MBS Items 110 and 122 for referred initial consultation– in a single course of treatment.
- MBS Items 116 and 128 for subsequent attendance – in a single course of treatment
- MBS Items 119 and 131 for minor subsequent consultation – where limited or no physical examination required.

##### ***Consultant Psychiatrists***

- MBS Item 291 for referred attendance of at least 45 minutes for provision of an assessment and development of a management plan.
- MBS Items 293 for professional attendance of at least 45 minutes for review of management plan provided under item 291.
- MBS items 296, 297 and 299 for referred initial consultation on a new patient.

#### **Items for Aboriginal and Torres Strait Islander children:**

- MBS item 715, the health assessment for Aboriginal and Torres Strait Islander people, for Aboriginal and Torres Strait Islander children aged 0-14 years of age inclusive (available annually).

### **Items for children with mental health condition**

#### ***General Practitioners***

- MBS Item 2702 and 2710 Preparation of a GP Mental Health Treatment Plan.

#### ***Consultant psychiatrists***

- MBS Item 291 (Long) referred Patient Assessment and Management by Consultant Psychiatrists.
- MBS Item 296, 297 and 299 initial consultation in rooms, in hospital or at home, provided by Consultant Psychiatrist.
- MBS Items 300 - 319 for subsequent consultation in consulting rooms, provided by Consultant Psychiatrist.
- MBS Items 320 - 328 for consultation in hospital provided by Consultant Psychiatrist.
- MBS Item 330 - 338 for referred consultation at home, provided by Consultant Psychiatrist.

### **Items for children with autism or other pervasive developmental disorder**

#### **Assessment**

- MBS Items 135 and 289 Consultant physicians (paediatrician or psychiatrists) - for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder on referral from a GP.
- MBS Item 82000, 82005 and 82010 - Allied health items for psychologists, speech pathologists and occupational therapists to assist consultant physicians with the assessment and diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder.

The allied health professionals must be referred by a consultant physician for up to four services in any combination for children aged less than 15 years.

### **Items for children with asthma**

#### **Items for the completion of the asthma cycle of care:**

- MBS Items 2546, 2552 and 2558 Consultation at consulting rooms.
- MBS Items 2547, 2553, 2559 and Consultation at a place other than consulting rooms.

### **Items for children with diabetes mellitus**

- MBS Items 2517, 2521 and 2525 Consultation at consulting rooms.
- MBS Items 2518, 2522 and 2526 Consultation at a place other than consulting rooms.

**Items for children with a chronic (or terminal) medical condition with or without complex care needs**

- MBS Item 721 Preparation of a GP Management Plan.
- MBS Item 723 Coordination of Team Care Arrangements.

**Items for children with complex and at least two morbidities, including paediatricians**

***Consultant physician***

- MBS Items 132 for referred attendance of at least 45 minutes for an initial assessment and development of a treatment and management plan of significant complexity.
- MBS Items 133 for professional attendance of at least 20 minutes for subsequent visits and review of the treatment and management plan.

**Items for children with binocular or accommodative dysfunction**

***Optometrist***

- MBS Item 10943 for a patient ages 3 – 14 years (inclusive) to confirm diagnosis of, or establish a treatment regime for a significant binocular or accommodative dysfunction, including ocular motility, vergences or fusional reserves.

## **ONGOING MONITORING, ASSESSMENT AND CARE**

*Follow-up monitoring should occur in accordance with the clinical needs of individuals to ensure that existing issues are being appropriately addressed and new and emerging issues are identified and addressed.*

### **Items for all children**

#### **GPs**

- MBS General Attendance Items 36 (Level C) and 44 (Level D) in consulting rooms, provided by a general practitioner.
- MBS General Attendance Items 37 (Level C) and 47 (Level D) at a place other than consulting rooms or a residential aged care facility, provided by a general practitioner.

#### ***Other Medical Practitioners (not vocationally registered)***

- MBS Consultation Items 54 (Long) and 57 (Prolonged) in consulting rooms, provided by other medical practitioner.
- MBS Consultation Items 60 (Long) and 65 (Prolonged) provided as a home visit or consultation at an institution (including a hospital), by other medical practitioner.

#### ***Consultant Medical Practitioners (including paediatricians)***

- MBS Items 110 and 122 for referred initial consultation– in a single course of treatment.
- MBS Items 116 and 128 for subsequent attendance – in a single course of treatment
- MBS Items 119 and 131 for minor subsequent consultation – where limited or no physical examination required.

#### ***Consultant Psychiatrists***

- MBS Items 300 –319 for subsequent consultation in consulting rooms.
- MBS Items 320 – 328 for consultation in hospital provided by Consultant Psychiatrist
- MBS Items 330 – 338 for referred consultation at home, provided by Consultant Psychiatrist.



### **Items for children with a mental health condition**

#### **GPs**

- MBS Item 2702 and 2710 Preparation of a GP Mental Health Treatment Plan.
- MBS Item 2712 Review of a GP Mental Health Care Plan
- MBS Item 2713 GP Mental Health Care Consultation (20+ minute consultation).

#### **Consultant Psychiatrist**

- MBS Item 291 Patient Assessment and Management by a Consultant Psychiatrist.
- MBS Item 293 Review of Referred Patient Assessment and Management consultation by a Consultant Psychiatrist.
- MBS Item 296, 297 and 299 Initial consultation in rooms, in hospital or at home, provided by Consultant Psychiatrist.
- MBS Items 855, 857 and 858 to organise and coordinate a community case conference of at least two other formal care providers of different discipline.
- MBS Items 861, 864 and 866 to organise and coordinate a discharge case conference of at least two other formal care providers of different discipline.

#### **Other Health Professionals**

Medicare rebates are available for up to 12 individual (18 in exceptional circumstances) and 12 group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by a GP under mental health treatment plan or under a psychiatrist assessment and management plan or by a psychiatrist or paediatrician.

- MBS Items 80000 and 80010 Psychological therapy service provided by a clinical psychologist, in rooms.
- MBS Items 80005 and 80015 Psychological therapy service provided by a clinical psychologist, out of rooms.
- MBS Item 80020 Psychological therapy group session provided by a clinical psychologist.
- MBS Items 80100 and 80110 Focussed psychological strategies provided by a general psychologist in rooms.
- MBS Items 80105 and 80115 Focussed psychological strategies provided by a general psychologist out of rooms.
- MBS Item 80120 Focussed psychological strategies group session provided by a general psychologist.
- MBS Items 80125 and 80135 Focussed psychological strategies provided by an occupational therapist, in rooms.
- MBS Items 80130 and 80140 Focussed psychological strategies provided by an occupational therapist, out of rooms.
- MBS Items 80145 Focussed psychological strategies group session provided by an occupational therapist.
- MBS Items 80150 and 80160 Focussed psychological strategies provided by a social worker, in rooms.
- MBS Items 80155 and 80165 Focussed psychological strategies provided by a social worker, out of rooms.
- MBS Item 80170 Focussed psychological strategies group session provided by a social worker.



### **Items for Aboriginal and Torres Strait Islander children**

#### **Assessment**

##### **GPs**

- MBS item 715, the health assessment for Aboriginal and Torres Strait Islander people, for Aboriginal and Torres Strait Islander children aged 0-14 years of age inclusive (available annually).

##### **Other health professionals**

- MBS Item 10987 follow up service provided by a practice nurse or registered Aboriginal health worker for an Aboriginal and Torres Strait Islander who has received a health assessment (maximum of 10 services in a calendar year).

#### **Management**

##### **Other health professionals**

- MBS Item 81300 follow-up Aboriginal and Torres Strait Islander health service provided by an Aboriginal health worker for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81305 follow-up diabetes education health service provided by a diabetes educator for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81310 follow-up audiology health service provided by an audiologist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81315 follow-up exercise physiology health service provided by an exercise physiologist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81320 follow-up dietetics health service provided by a dietitian for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81325 follow-up mental health service provided by a mental health worker for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81330 follow-up occupational therapy health service provided by an occupational therapist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81335 follow-up physiotherapy health service provided by a physiotherapist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81340 follow-up podiatry health service provided by a podiatrist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81345 follow-up chiropractic health service provided by a chiropractor for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81350 follow-up osteopathy health service provided by an osteopath for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81355 follow-up psychology health service provided by a psychologist for Aboriginal and Torres Strait Islanders who have had a health assessment.
- MBS Item 81360 follow-up speech pathology health service provided by a speech pathologist for Aboriginal and Torres Strait Islanders who have had a health assessment.

*Note: A total of 5 services may be provided in a calendar year using MBS items 8133-81360. A single service or mix of service types may be provided within this 5 service limit. Patients must have had a health check from their GP before they are eligible to be referred for items 81300-81360*





## **Items for children with a chronic or terminal medical condition with or without complex care needs**

### **GP**

- MBS item 721 Preparation of a GP Management Plan
- MBS Item 723 Coordination of Team Care Arrangements.
- MBS Item 729 Contribution to a multidisciplinary care plan being prepared by another health or care provider.
- MBS Item 732 Review of a GP Management Plan and/or Coordination of a Review of Team Care Arrangements.

### ***Consultant physicians***

- MBS Items 820, 822 and 823 to organise and coordinate a community case conference of at least three other formal care providers of different discipline.
- MBS Items 825, 826 and 828 to participate a community case conference of at least two other formal care providers of different discipline.
- MBS Items 830, 832 and 834 to organise and coordinate a discharge case conference of at least three other formal care providers of different discipline.
- MBS Items 835, 837 and 838 to organise and coordinate a discharge case conference of at least two other formal care providers of different discipline.

### ***Other health professionals***

- MBS Item 10950 Aboriginal or Torres Strait Islander health service provided by an Aboriginal health worker to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10951 diabetes education health service provided by a diabetes educator to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10952 audiology health service provided by an audiologist to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10953 exercise physiology health service provided by an exercise physiologist to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10954 dietetics health service provided by a dietitian to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10956 mental health service provided by a mental health worker to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10958 occupational therapy health service provided by an occupational therapist to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10960 physiotherapy health service provided by a physiotherapist to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10962 podiatry health service provided by a podiatrist to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10964 chiropractic health service provided by a chiropractor to a person who has a chronic condition and complex care needs being managed under both a GP Management Plan and Team Care Arrangements.
- MBS Item 10966 osteopathy health service provided by an osteopath to a person who has



**Items for children with autism or other pervasive developmental disorder**

**Assessment**

- MBS Items 135 and 289 Consultant physicians (paediatrician or psychiatrists) - for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder on referral from a GP.
- MBS Item 82000, 82005 and 82010 - Allied health items for psychologists, speech pathologists and occupational therapists to assist consultant physicians with the assessment and diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder.

The allied health professionals must be referred by a consultant physician for up to four services in any combination for children aged less than 15 years.

**Management**

- MBS Item 82015 Psychology health service provided to a child aged under 15 years with a pervasive developmental disorder.
- MBS Item 82020 Speech pathology health service provided to a child aged under 15 years with a pervasive developmental disorder.

MBS Item 82025 Occupational health service provided to a child aged under 15 years with a pervasive developmental disorder.