NSW Children's Guardian's

comments on the

National Clinical Framework for Children and Young People in Out-of-Home Care

INTRODUCTION

The Children's Guardian is pleased to make a submission in response to the Child Health and Wellbeing Subcommittee discussion paper "*Development of a National Clinical Assessment Framework for Children and Young People in Out-of-home Care*".

The Children's Guardian supports this initiative to improve and monitor the health and wellbeing of children and young people in out-of-home care and the co-ordination of this initiative across jurisdictions in line with the *National Framework for Protecting Australia's Children 2009-2020.*

This submission is divided into two parts. Part one provides an overview of the Children's Guardian's functions with particular reference to the regulation of out-of-home care in NSW. Part two considers the consultation questions raised in the discussion paper.

Legislative provisions in NSW cover a number of situations in which children and young people may find themselves in out-of-home care. This submission is confined to statutory out-of-home care, that is court ordered out-of-home care that is provided for a period of more than 14 days pursuant to s135A of the Children and Young Persons (Care and Protection) Act 1998,

PART ONE

THE NSW CHILDREN'S GUARDIAN AND THE REGULATION OF OUT-OF-HOME CARE IN NSW

THE NSW CHILDREN'S GUARDIAN – OVERVIEW

The Children's Guardian provides independent oversight of, and quality assurance for, the New South Wales statutory out-of-home care (OOHC) system.

Since its inception the Children's Guardian's jurisdiction has grown to include the regulation of children's employment in prescribed industries, domestic and inter-country adoption service providers and more recently, as a result of the Special Commission of Inquiry into Child Protection Services in NSW, the regulation of voluntary out-of-home care.

Notwithstanding the above, the Children's Guardian's principal functions continue to relate to children and young people in OOHC and the accreditation and monitoring of designated agencies that provide or arrange OOHC.

The Children's Guardian is also responsible for developing the NSW OOHC Standards and a series of Statutory Guidelines, with the approval of the Minister for Community Services. Organisations are required to meet the criteria set within the NSW OOHC Standards and show compliance with our Statutory Guidelines[1] in order to become an accredited service provider of OOHC.

CASE FILE AUDIT PROGRAM

The Children's Guardian is also responsible for monitoring the responsibilities of designated agencies. The Case File Audit Program was initiated by the Children's Guardian in 2004 to monitor the extent to which case management and casework practice of designated agencies is compliant with legislative provisions, Statutory Guidelines and the NSW Out-of-Home Care Standards.

The Case File Audit program focuses on documentation held on case files as the best available indicator of case management and casework practice.

In 2006, the Children's Guardian identified health, education and connectedness as major areas of risk and as priority areas for future Case File Audits.

2008/09 CASE FILE AUDIT PROGRAM – HEALTH FOCUS

As the literature review points out in the discussion paper, there is considerable evidence both in Australia and overseas to indicate that children and young people in OOHC have a higher prevalence of acute and chronic health problems, developmental disabilities and mental health problems than other children and young people.

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[1] Guidelines for Designated Agencies for Developing a Behaviour Management Policy; Guidelines for Designated Agencies on the Review of Placements of Children and Young Persons in Out-of-Home Care; Guidelines for the Disclosure of Placement Information to parents and other significant people. Available at www.kidsguardian.nsw.gov.au

Previous Case File Audits had included some health related items such as the development of the child and immunisation details.[2] The 2008/09 and 2009/10 Case File Audits were extended to include a broader range of health related items (physical, emotional and mental health) which could realistically be expected to be documented on case files.

The Case File Audit selected a statistically valid sample across the sector where the 2008/09 Audit included 2124 files of children and young people (926 in Community Services and 1198 in non-government agencies/Aging Disability and Home Care), while the 2009/10 Audit will include 1358 files in Community Services.

In developing the Case File Audit, the Children's Guardian established an advisory group comprised of representatives of specialist out-of-home care clinics at children's hospitals in Randwick, Westmead and Newcastle, and the KARI clinic. In addition, recommendations by the following organisations were considered:

- the Royal Australasian College of Physicians;
- the Royal Australian and New Zealand College of Psychiatrists;
- the National Health and Medical Research Council;
- CREATE Foundation Ltd; and
- Community Services.

The Case File Audit report examines the practice of agencies in relation to:

- obtaining and recording health related information;
- assessment of health status and needs;
- planning and monitoring; and
- providing information to parents.

At the time of the Case File Audit, there was no standardised practice requirement for some areas examined. For example, the completion of initial health assessments, annual health assessments and health plans were not routinely required. In examining practice in these areas, the Children's Guardian hoped to identify opportunities for improvement in practice.

The Case File Audit results provide a baseline for measuring future improvement in practice related to health. The Children's Guardian hopes to continue to collaborate with NSW Health in supporting health outcomes for children and young people in OOHC and intends to conduct a follow-up health audit no sooner than 3 years from the completion of the current audit Phase 2, to allow for implementation of the current reforms under *Keep Them Safe,* the NSW Government response to the recent Special Commission of Inquiry into Child Protection Services in NSW.

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[2] See Children's Guardian's Report on Case File Audit 2007/08 available at www.kidsguardian.gov.nsw.au

COLLABORATION WITH OTHERS TO PROMOTE THE WELLBEING OF CHILDREN AND YOUNG PEOPLE IN OOHC

The Children's Guardian, within its budget constraints, initiates or supports the work of other agencies or individuals that has the potential to benefit the OOHC population.

1. The Children's Guardian has been invited to join the NSW Health Out of Home Care Advisory Group, in an on-going partnership with NSW Health and Community Services to plan for implementation of the recommendations of *Keep Them Safe*. The Children's Guardian has provided the Advisory Group with Case File Audit data to assist in identifying improvements that need to be made to support health assessment and on-going health management of children and young people in OOHC. The Case File Audit data has been provided by sub-groups including age, Indigenous status and placement type. It is also proposed to interrogate the data further to determine results by placement location.

2. The Children's Guardian approached the Royal Australian and New Zealand College of Psychiatry to develop practice guidelines for psychiatrists and mental health professionals working with children and young people in OOHC.

   The Children's Guardian took this action in response to recent Australian research that found that a high proportion of children and young people in OOHC have exceptionally poor mental health, resembling "clinic-referred" children and young people in terms of the scope and severity of their problems.[3]

   The expert working committee responsible for developing the guidelines was chaired by Dr Phil Brock of the College's Faculty of Child and Adolescent Psychiatry. A full report and position statement was subsequently published by the College in 2008 and 2009 respectively.[4]

3. The Children's Guardian has supported a pilot project undertaken by the Department of Child, Adolescent and Family Psychiatry at Redbank House, Alternative Care Clinic to look at the training and support needs of foster carers caring for children and young people in OOHC with complex behavioral needs.

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[3] In particular, see: Sawyer, Carbone, Searle, Robinson. *The mental health and well-being of children and adolescents in home-based foster care*. Medical Journal of Australia, Vol 186(4), Feb 2007. Tarren-Sweeny and Hazell. *The mental health of children in foster and kinship care in new South Wales, Australia*. Journal of Paediatrics and Child Health, 42 (2006): 91-99.

[4] See Royal Australian and New Zealand College of Psychiatrists. (2008) The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry and Royal Australian and New Zealand College of Psychiatrists Position Statement 59: The mental health needs of children in out-of-home care (June 2009)

PART TWO

NATIONAL CLINICAL ASSESSMENT FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME CARE

Consultation question 1
Should the Framework identify specific measures that are appropriate for these diverse groups or should all measures identified be appropriate to all population groups?

The discussion paper correctly identifies the different population groups that will benefit from the Framework and the Children's Guardian agrees that its design and implementation should be broad enough to be responsive to the needs of these different populations. To do otherwise could arguably run the risk of having a complex set of guidelines that clinicians would find difficult to adopt.[5] That said, given the diversity, the Children's Guardian strongly supports the need for the guidelines to be enhanced with reference to evidence based practice (from the fields of medical and social science) to ensure clinicians are conversant with the issues that face these different groups and are in a better position to understand and collaborate with their interagency partners.[6]

Notwithstanding the above comments, the Children's Guardian is also of the view that specific measures should be in place to address the inequalities in health outcomes for Aboriginal and Torres Strait Islander children and young people in OOHC and Aboriginal health workers should be involved in the health assessments and health planning for Aboriginal children wherever possible.

Studies and national performance indicators relating to the health and wellbeing of Aboriginal and Torres Strait Islander children and young people consistently point to poor health outcomes.[7]

As pointed out by the Australian Research Alliance for Children and Youth:[8]

> In Australia, Indigenous children do not fare as well as non-Indigenous children, and fare substantially less well than the best comparators internationally. This disparity holds true for nearly every indicator and every measure for which data were available.

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[5] See for example, Grilli and Lomas (1994) as cited by Davis, D. A., and A, Taylor-Vaisey. (1997). *Translating guidelines into practice. A systemic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines.* Canadian Medical Association, 15 August 1997; 157 (4) p408-416

[6] Gori, R., and Grimshaw, J. (2003). *From best evidence to best practice: effective implementation of change in patients' care*. Research into Practice. The Lancet Vol. 362, October 11, 2003, 1225-1230

[7] Steering Committee for the Review of Government Service Provision. (2009). *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra. Australian Institute of Health and Welfare 2008. Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: Detailed analyses. Cat. no. IHW 22. Canberra: AIHW.

[8] Australian Research Alliance for Children and Youth (2008) *Wellbeing of Young Australians: Technical Report*

Whilst there has been little research into the health status of Aboriginal and Torres Strait Islander children and young people in OOHC, what information we do have suggests that this population is at significant risk of poor health outcomes.[9]

The Children's Guardian's Case File Audit can also throw some light on this issue. For example, our 2008/09 Audit found that where initial health assessments were undertaken[10] compared to their non Aboriginal and Torres Strait Islander peers, Aboriginal and Torres Strait Islander children and young people in OOHC were less likely to have initial health assessments that contained; a medical history of the child or their family, a visual and dental check, a behavioural and developmental assessment or screening for pathological conditions. Hearing checks were the only aspect of the physical health check that went against this trend although it should be pointed out that apart from screening for pathological conditions in the non Aboriginal and Torres Strait Islander group, neither population groups obtained compliance thresholds above 80% on any of the abovementioned categories.

[9] Reynolds, S. (2008). The KARI Clinic Identifying and Responding to the needs of Indigenous Children and Young People in Out-of-Home Care (OOHC). *SNAICC News*. July 2008.

[10] There was evidence of an initial health assessment in only one quarter of all cases, with Aboriginal and Torres Strait Islander children and young people being more likely to have had these assessments (24%-28%)

Consultation question 2
Are the key domains for assessments the right areas to focus on? Should mental health be a domain in its own right or continue to be combined with psychosocial health?

The key domains addressed in the discussion paper combined with the focus provided within each domain in the age appropriate assessment table (pages 13-14) address the areas that need to be covered to enable a comprehensive and holistic clinical assessment of the health needs of children and young people in OOHC.

The question as to whether mental health should have its own assessment domain is possibly a matter of debate within the sphere of contemporary models of public health policy and practice. Given children and young people in OOHC are more vulnerable to mental health problems compared to their peers in the general population and their poor mental health is often under reported by carers, separating out mental health as a key domain within the Framework could have the benefit of raising its profile and providing clarity and expectation about the need for assessments to include a mental health component which is undertaken by a suitably trained and appropriately qualified professional. Detecting mental health problems at a pre-clinical stage and providing early intervention is vital for the future wellbeing of children and young people in OOHC.

On the other hand, current public health models reinforce the notion that all of the key health domains envisaged in the clinical assessment process are interdependent and inextricably linked, so much so that a holistic approach to health should be supported.[11] Early childhood is particularly critical for the development of positive attachments, security and stability of care and ultimately future wellbeing. Aligning mental health within the psychosocial stream of assessment helps to reinforce the complexity and interconnectedness mental health has with psychological health and social wellbeing and the necessity for incorporating a multidisciplinary approach to mental health assessments and interventions. This has particular resonance for children and young people who enter OOHC with complex psychosocial needs and may well require a range of service interventions including medical treatment, therapeutic intervention and social support from mental health practitioners and other allied health professionals.

If mental health remains within the psychosocial domain, the challenge will be to ensure that mental health assessments are not overlooked in the process. This may be achieved by offering clear (directive) guidance and protocols about certain categories of children and young people. For example, the need for every child and young person to have a multi-model mental health

[11] World Health Organisation, (2005) *Promoting mental health: concepts, emerging evidence, practice : report of the World Health Organization*, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne [eds: Herrman, H., Saxena,S., and Moodie, R.].

assessment upon entry into OOHC and where a child is identified as having potential mental health problems they receive a more comprehensive mental health assessment undertaken by a specialist mental health practitioner.[12]

In Phase 1 of our 2008/09 Case File Audit, 922 of the 2124 files reviewed (43%) indicated that the child or young person had mental health/behavioural problems. The Audit found that 6 out of 10 of these files included a mental health/behavioural assessment.

Further, where significantly challenging behaviours were occurring which indicated the need to develop a behaviour management plan, a current psychological/psychiatric assessment or a progress report was available on only 6 out of 10 of these files.

It was frequently noted on files that, while referrals or requests for assessment were made, there could be an extended waiting period for access to these services.

[12] As proposed by Royal Australian and New Zealand College of Psychiatrists. (2008). *The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry* and, Royal Australian and New Zealand College of Psychiatrists *Position Statement 59: The mental health needs of children in out-of-home care* (June 2009).

Consultation question 3
Should the Framework be prescriptive on the areas to be addressed for each assessment or provide guidance on the areas to be addressed and their applicability for the type of assessment being conducted?

The paper clearly identifies the range of areas to be addressed for each assessment and their applicability for the type of assessment being conducted.

However, given the complexities involved in responding to individual needs of children and young people in OOHC and the circumstances of each case, the clinical assessment framework is more likely to be effective if there is clear evidenced based guidance on the areas that can be covered and their applicability to the type of assessment being undertaken.

That said, there should also be scope for incorporating some prescription or recommended core/essential areas to be addressed. The need for both guidance and a more directive approach is best understood by reviewing each tier of the assessment process envisaged in the Framework.

Primary Health Check
At the primary health check stage, where children and young people first enter OOHC, there is a lot to be gained by being prescriptive on the areas to be covered as this is the critical point at which children and young people are screened for health problems, health information is consolidated, referrals for specific assessments can be progressed in a timely fashion and direction can be given to the comprehensive health and development assessment process.

The Children's Guardian's 2008/09 Case File Audit found the content of the initial health assessments held on file varied. Most commonly, they included a physical examination, a mental health/behavioural assessment, screening for pathological conditions, a developmental assessment and a medical history of the child/young person. Fewer than half of the assessments included a vision check, hearing check, immunisation register check or dental health check. Only one in seven initial health assessments included a medical history of the family.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)[13] argues that adequate assessment for potential mental health problems on entry into care is essential for effective diagnosis and treatment. RANZCP recommends a multi-model mental health assessment as part of the admission into care process for all children and young people, and retrospective assessment for those already in care who do not already have a

[13] Royal Australian and New Zealand College of Psychiatrists. *The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry* (2008). See also Royal Australian and New Zealand College of Psychiatrists *Position Statement 59 The mental health needs of children in out-of-home care* (June 2009)

diagnosis of mental illness. The Royal Australasian College of Physicians (RACP)[14] also recommends that mental health assessments should be conducted on children and young people entering care as a matter of course and that infants and toddlers should be assessed for attachment disorders. The Children's Guardian supports these recommendations.

Whether these psychosocial assessments take place at the primary health check or at the comprehensive stage is likely to depend upon on a number of factors, including the competency of the primary care practitioner to undertake the assessments and the presentation of the each individual case, for example, a child may be too traumatised to undertake such an assessment. In these circumstances, there should be clear protocols to ensure the psychosocial component of assessment is carried over into the comprehensive assessment stage.

Another critical issue at the primary health assessment stage is obtaining an accurate health record of the child or young person and that of their parents. This is an issue that has been recognised by RACP[15] as a barrier to effective health care provision.

Children and young people in OOHC should have health assessments which are informed by their previous health history and that of their parents. As pointed out by Child Welfare League of America[16] "[t]his information may be important in determining medical or mental health conditions that may affect the child as a result of genetic or hereditary factors".

Engaging parents and family members in the health assessment process, where it is safe to do so, or at the very least seeking their cooperation to share their medical history and the prenatal history of their child is an important and necessary step at the initial assessment stage.

The Children's Guardian's 2008/09 Case File Audit found only 16% of initial health assessments undertaken with children and young people in OOHC had information recorded about family medical history. Aboriginal and Torres Strait Islander children and young people were the least likely to have this information recorded.

With respect to casework files the Audit found that the medical history of the child/young person was available on fewer than half of all files. The type of information available ranged from very detailed hospital/medical records including birth history, to reports by health professionals based on interviews with family/carers, and historical information included in documents such as court affidavits or the child's "Blue Book". A medical history of the family was

[14] Royal Australasian College of Physicians. *Health of Children in "Out-of-Home" Care Paediatric Policy* 2008
[15] Ibid
[16] Child Welfare League of America Standards of Excellence for Health Care Services for Children in Out-of-Home Care (2007, p.40)

far less likely to be available (15%). Typically, this information was very brief, providing only minimal detail of health issues that could be relevant to the child/young person.

Furthermore, where children and young people have received expert assessments as part of court proceedings leading to their entry into OOHC, or were they are on interim care orders and are expected to receive such assessments, leave of court should be obtained to secure these assessments. This will avoid any undue duplication of work and minimise children's exposure to multiple assessments.

In summary, at the primary health care stage there needs to be a coordinated effort to gather health information at the outset with clear guidance and protocols as to who is best placed to do this within each jurisdiction as well as clear information sharing protocols between interagency partners.

Comprehensive Health and Developmental Assessment
Given the thorough health screening proposed at the primary health check stage and depending on the findings, there is likely to be more scope to be flexible about the composition of the multidisciplinary team and the areas for review in the comprehensive health and developmental assessment. Accordingly the Framework should provide guidance on the areas to be addressed, incorporating evidence based practice and possibly links to examples of best practice models or innovative practices across Australia.

Follow up assessments
This is possibly where the least prescription is required under the Framework as the primary health care team and the Health Management Plan, with oversight from the paediatrician and, as envisaged in the paper, a formal psychological assessments every two years should be capable of being responsive to the health needs of the child or young person, either through annual reviews or as the need arises.

With respect to children and young people with mental health or behavioural problems, the Children's Guardian Statutory Guidelines[17] do not require annual psychiatric or psychological assessments be conducted routinely. The Children's Guardian considers a currently relevant report should be available to inform the annual case plan review process. This may be either a thorough assessment or a progress report from the person who conducted the original assessment or from the current consultant. It is important that the clinical guidelines can accommodate requests for additional assessments where required.

RANZCP also recommends routine mental health assessments for children and young people with intellectual disabilities.

[17] Guidelines for Designated Agencies for Developing a Behaviour Management Policy. Available at www.kidsguardian.nsw.gov.au

In developing the clinical guidance, recommended areas for assessment should also take into account and contextualise the needs of children and young people who are about to transition a care arrangement, for example, due to restoration, leaving care (including the need to negotiate with adult services to access mental health and disability services) or entry into another type of OOHC care arrangement or the juvenile justice system. The areas currently proposed should also be periodically reviewed to incorporate contemporary public health issues, links to practice directions and examples of innovative practices. The UK's *Statutory Guidance on Promoting the Health and Well-being of Looked After Children* (2009) provides one example as to how such guidance may be framed.[18]

Recent consultations with children and young people in residential care confirmed that most received support with health related issues (NSW Children's Guardian, 2009).[19] However, the range of discussions with staff on health issues was variable, with important issues such as alcohol, drugs, contraception and safe sex being some of the issues that were least raised. It is important that clinicians are given guidance to recognise opportunities to explore preventative health issues with children and young people in OOHC, given not all will have a trusted health advisor with whom they can confide.

[18] *Statutory Guidelines on Promoting the Health and Well-being of Looked After Children* (2009, p.63) DfCSF and DoH

[19] Voices of Children and Young People In Residential OOHC, NSW Children's Guardian 2009 (not published)

Consultation question 4
Does the tiered approach provide the right structure for assessments? What other models can be identified?

The model currently being implemented in NSW as a result of *Keep Them Safe, a Shared Approach to Child Wellbeing 2009-2014,* as described in the paper, suggests that all children and young people will commence an initial primary health screening/consultation within 30 days of entering OOHC followed by a comprehensive assessment based on triage and the findings of the initial primary screening. The model described is silent on the issue of follow up assessments but it is clear from *Keep Them Safe,* that the third tier is also incorporated, namely the need for ongoing follow up assessments.

The NSW model under *Keep Them Safe* appears to be broadly comparable to the Framework proposed in the discussion paper except that different timeframes are contemplated for health reviews of children under the age of 5 and 1. This is discussed further under question 5.

The Children's Guardian is persuaded by the tiered approach proposed in the discussion paper, particularly in relation to the initial primary health assessment and comprehensive assessment stage. The tiered approach provides for a comprehensive and holistic coverage of all the key health domains with opportunities for specialist referrals where indicated and reinforces the importance of primary health care.

The Children's Guardian's 2008/09 Case File Audit found that of the 585 children and young people entering their placement in the 12 months prior to the audit, only a quarter had had an initial health assessment within 60 days of placement. Children in residential care and those in the older age groups (12 years and older) were least likely to receive these assessments within the stated timeframe.

The Children's Guardian's appreciates the difficulties encountered by agencies and individual workers in trying to obtain health information, access health services and maintain a balance with respect to the frequency of health assessments undertaken. The Case File Audit data strongly supports the need for a structured framework within which practitioners can implement clear information sharing protocols, have confidence in each others roles and responsibilities and a service system that is responsive to children and young people receiving health assessments upon entry into care and thereafter access to ongoing health services to meet their health needs.

Having a standardised assessment framework which embraces a holistic approach to health care with clear timeframes attached is an important step towards meeting the health needs of children and young people in OOHC.

Consultation question 5
How frequently should repeat assessments be conducted? Should the Framework include specific timings or should the implementation of the Framework be flexible to allow practitioners to determine the need and timing of assessment on a case by case basis?

As pointed out in the UK *Statutory Guidelines on Promoting the Health and Well-being of Looked After Children* [20] the health assessment process at the point of entry into care should not been viewed as an isolated event but is part of a continuous process that is monitored over time "to ensure the provision of high quality healthcare and positive discrimination for health which is managed through a clear process".

Where possible health care reviews should be planned so that they complement and inform the annual statutory case plan review process for children and young people in OOHC. Health information and planning must become an integral part of the case planning process if children and young people are to reach their optimum health.

The NSW Government's response to the Special Commission of Inquiry into Child Protection Services in NSW, *Keep Them Safe*, supports the following recommendations for the frequency of repeat health assessments:

- For children under the age of 5 years at the time of entering out-of-home care, the assessment should be repeated at 6 monthly intervals;
- For older children and young people, assessments should be undertaken annually.

In supporting these recommendations, the Children's Guardian acknowledges that it may be good practice to have an 'under 1 year' category as noted in the discussion paper. However, children under 5 years in NSW are also required to have more frequent assessments (at 6 monthly intervals) and we would strongly support that this also be included in the Framework.

The discussion paper suggests that that additional and ongoing, age appropriate assessment should be undertaken "in accordance with the child or young person's unmet health or development needs" (page 16) and then suggests that the frequency of follow up assessments will depend on the age of the child or young person, their stability in care and whether their health needs are being met or they are developmentally on track (page 17). Under this Framework it will be important to explore the criteria to be applied to assess whether the child or young person is stable in care, whether they have any unmet health needs and whether they are developmentally on track. It will also be important to confirm who will be responsible for making this decision.

[20] *Statutory Guidelines on Promoting the Health and Well-being of Looked After Children* (2009, p.63) DfCSF and DoH

For the older age groups (5 years and over), the Children's Guardian supports the frequency of assessments proposed by the NSW Government with the knowledge that children and young people will form their own views about the need for annual assessments and young people in particular may express their reluctance to attend. Being flexible on the timing and implementation of health reviews, to the extent that it accommodates the views of the child or young person, and availability of carers and parents, is an important aspect of health care planning and coordination.

Children and young people in OOHC complain that being in care often singles them out from their peers as being different. They can feel stigmatised – requiring them to have frequent health assessments may also do this.[21] Asking young people about how they would like to participate in their annual health assessment and helping them to create alternative ways to meet their health needs is one way this issue can be approached with the aim of facilitating their positive engagement with health services.

When evaluating the effectiveness of the Framework it will be important to take these types of issues into account.

Given what we know about the poor health outcomes for children and young people in OOHC and the under reporting of mental health difficulties it is vital that systems are in place to regularly review their health and health services are responsive to the need to arrange additional assessments where for example a child or young person is planning to leave care, whether it be due to restoration home, adoption or leaving care to live independently.

In our 2008/09 Case File Audit it was generally apparent from files that visits to the doctor and dentist were arranged on an 'as needed' basis to address day-to-day needs, although details of the visit and its outcomes were often not recorded. In post-audit discussions, agency representatives expressed the view that the need for annual health assessments for otherwise healthy children/young people would set them apart from their peers. Interestingly, the need for annual dental assessments was not seen as problematic.

Children and young people in OOHC have a right to expect the best possible health care. Offering preventative and health promotion advice is an important task for the primary health carer to undertake with this extremely vulnerable group. Regular opportunities given to children and young people to meet with health advisors can help to reinforce that someone cares about their health and is willing to keep the door open for future consultations.

[21] Mooney, A., Statham, J, and Monck, E. (2009) *Promoting the Health of Looked After Children. A Study to Inform Revision of the 2002 Guidance* DfCSF (p.30)

Consultation question 6
Should the Framework be prescriptive on the tools to be used for each assessment or provide guidance on the range of tools available and their applicability for this group?

The discussion paper proposes that a series of checklists will be developed to guide the practitioner completing assessments so as to improve the consistency of the primary and comprehensive health care assessments. This combined with using standardised assessment instruments will provide an important framework within which the practitioner will bring their expertise to bear.

Consultation question 7
Should the Framework be prescriptive on which clinician, health professional or health worker should undertake the assessments or be more flexible?

Under current arrangements in NSW the Children's Guardian does not require that assessments be conducted by a paediatrician, but accepts that assessments may be completed by general practitioners, paediatricians and other specialists, hospital clinics, Aboriginal Health Services or medical centres, depending on local resources and the individual health needs of the child or young person concerned.

The structured three tier approach to assessments as proposed in the discussion paper allows for some certainty in the assessment process as to who will be responsible for undertaking these assessments at the primary and comprehensive stages whilst still allowing for a degree of flexibility based on the needs of the child or young person. The Children's Guardian agrees with this approach.

There is less clarity about who will be responsible for undertaking ongoing assessments and whilst it may not be prudent to be prescriptive on this point, greater clarity about the options, including the role of the paediatrician (as stated on page 21-22) would be welcome.

The Children's Guardian is of the view that every child in OOHC should have a named health professional who is easily accessible to them, who can be an important advocate for them to access services and can facilitate effective annual health assessments. It is also important that service provision is culturally competent and wherever possible, and in keeping with the views of the child or young person, care should be taken to ensure Aboriginal and Torres Strait Islander children and young people access Aboriginal Health Services, or are supported by an Aboriginal or Torres Strait Islander health practitioner, where available.

A recent review undertaken in the UK to assist in the revision of statutory health guidelines for children and young people in OOHC confirmed that there was considerable variation as to who did health assessments. Some concerns were expressed regarding the quality of assessments undertaken by general practitioners, but also acknowledged the advantage they brought to the assessment process in 'normalising' the experience for children and young people. The role of the nurse was also said to bring certain benefits to the assessment process although it was stressed these nurses should be of senior grades. On the other hand the role of the paediatrician was highlighted as being important in the assessment process – bringing the necessary skill, expertise and "weight to push recommendations forward."[22]

[22] Mooney, A., Statham, J, and Monck, E. (2009) *Promoting the Health of Looked After Children. A Study to Inform Revision of the 2002 Guidance* DfCSF (p.29)

The discussion paper possibly offers a way forward by proposing (pages 21-22) the involvement of a paediatrician in developing and reviewing the Health Management Plan. The appointment of a named paediatrician for every child and young person in OOHC would secure a level of input from a senior medical practitioner with the necessary skill, expertise and authority in child health to oversee the progress of the child's or young person's health. It would also enable continuity of care to be provided by a primary health practitioner and the flexibility of approach required to meet the individual needs of the child and young person and a degree of responsiveness to local resource issues.

Arguably the greatest challenge will be ensuring that everyone involved in the assessment and ongoing health review process understands their role and agency protocols on sharing information. The clinical guidance will have an important role to play in providing information pertaining to clarity of roles. The Health Management Plan and the preparation of care pathways (page 22) in each jurisdiction will be important mechanisms by which clarity of roles and expectations can be defined.

Consultation question 8
How should the results of the assessments and any follow up care be documented? The Framework proposes preparation of a health plan for each child or young person entering OOHC.

The Children's Guardian supports the proposal to introduce Health Management Plans to both document and assist in the coordination of health care for children and young people in OOHC.

Furthermore the Children's Guardian supports the role proposed in the discussion paper for a named paediatrician to be involved in the development and review of these plans at least once every two years. Where an annual health review assessment identifies significant health issues, Health Management Plans should be updated with the paediatrician's involvement.

According to the RANZCP, a coordinated approach to providing physical, mental and developmental care is important for providing optimal health care and ensuring "access to and efficient use of services."[23] Further, it notes that the absence of such an approach increases the risk of referral to multiple clinical services, multiple diagnoses of distinct disorders, and the prescription of various treatment regimes. RANZCP recommends the development of treatment plans "to organise and prioritise interventions" and the sharing of information to everyone involved in the care of children and young people.[24] Similarly, noting that "there is often ambiguity in who has responsibility for coordinating health needs", RACP has also recommended the implementation of individual health plans. [25] These observations and recommendations are echoed in the Children's Guardian's 2008/09 Case File Audit findings.

Under current arrangements, the Children's Guardian expects that a health plan should be available for children and young people with significant and/or complex health issues. In our 2008/09 Case File Audit, of the 311 files (15%) where the child/young person had significant and/or complex health issues, only one in two indicated that a health plan had been developed.

This is not to say that children and young people did not receive treatment or services. Where applicable, around 9 out of 10 files included details of "other relevant health professionals" including specialists involved, and reports from those specialists currently providing services, while 8 out of 10 files included reports of specialist therapies which had been provided in the past.

However, it was not always evident that there was a consistent and coordinated approach. Children and young people had often been referred to

[23] Royal Australian and New Zealand College of Psychiatrists. *The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry* (2008)
[24] Ibid
[25] Royal Australasian College of Physicians. *Health of Children in "Out-of-Home" Care Paediatric Policy* (2008)

and treated by multiple services/therapists, and may have received a number of differing diagnoses and treatments. In the absence of a coordinated health plan, it could not be established that this was the most efficient or effective use of services for the individual. In addition, it is current good practice that an individual medical management plan is developed as part of the successful management of some conditions such as asthma, epilepsy and diabetes. The Audit found that a medical management plan was available on a little more than a third of applicable files.

In response to the Report from the Special Commission of Inquiry into Child Protection Services in NSW, the NSW Government has implemented a number of measures to support a more coordinated approach to health care planning for children and young people in OOHC. In particular, OOHC coordinators will be appointed to each Area Health Service (of which there are eight) and at the Children's Hospital Westmead. It is anticipated that the coordinators "will play a pivotal role in liaising with carers, caseworkers […] and the health system. They will facilitate comprehensive health assessments and reviews and facilitate access to health treatment for all children in care."[26]

The need for a systematic approach to gathering and sharing health related information is evident. The Guidance should be clear on the expectation that the Health Management Plan is to be shared with the child or young person, their carers, parents where applicable and the allocated OOHC caseworker. It is imperative that the health plan is made available so that it can be incorporated into the child's or young person's annual case planning process and the case plan.

The NSW Government supports the introduction of electronic health records as a priority and while progress is being made on this initiative, suggests an interim strategy should be developed "to examine a comprehensive medical record or a transferable record for children and young people in OOHC, which should be accessible to those who require it in order to promote and ensure the safety welfare and well-being of children and young people in OOHC."[27]

While the introduction of electronic health records is being explored, the NSW Government has committed to further development of the "Blue Book" to record health assessments and treatments in summary form for children in OOHC as a short-term strategy.

The Children's Guardian's notes that the Blue Book is only relevant for children under 5 years and is concerned that arrangements for the coordination of health information for older children and young people need to be improved.

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[26] *Keep Them Safe. A shared approach to child wellbeing* (2009 p.16)
[27] Ibid

Consultation question 9
How should implementation of the Framework be monitored and evaluated?

As the discussion paper points out, monitoring the implementation of the Framework and evaluating its effectiveness is essential to demonstrate whether or not progress has been made against stated objectives. Monitoring and evaluation also play an important part in strategic planning and continuous quality improvement – where identified gaps in service provision and evidence for service improvements can be usefully used to reform service delivery for the benefit of consumers.

With respect to monitoring, the Children's Guardian supports the approach to report against identified milestones in the implementation stage and agrees that this should be undertaken within each jurisdiction with due regard to the processes adopted to implement the Framework, regional variations and issues relating to resourcing. Regular feedback as to how different jurisdictions have implemented the Framework and examples of innovative practices could be invaluable at this stage of the implementation process as jurisdictions learn to adapt existing programs to meet the Framework's objectives.

With respect to evaluating the effectiveness of the Framework the Children Guardian suggests that there should be a sharp focus on evaluating whether the Framework is making a difference to the provision of good quality and coordinated health assessments and service provision to children and young people in OOHC.

The views of children and young people are particularly important in ensuring the development of services that meet their needs. Where possible their views should be surveyed, particularly with respect to their satisfaction with the quality of health service provision they are receiving. Feedback from children and young people and their carers can provide an important qualitative dimension to the evaluation process.

Finally, at the State level, the Children's Guardian has the distinct advantage of having already developed, implemented and refined a Case File Audit tool that has widespread support from the OOHC sector. Our partnership with NSW Health for the 2008/09 Case File Audit has already provided us with rich data as to the status of key health determinants for children and young people in OOHC. The Case File Audit program has the capacity for further expansion if required.