Health Assessment of Children and Young People in Out-of-Home-Care (Clinical Practice Guidelines)

Document Number  GL2013_010
Publication date  10-Oct-2013
Functional Sub group  Clinical/ Patient Services - Baby and child
                      Clinical/ Patient Services - Records
                      Population Health - Health Promotion
Summary  The guidelines aim to provide guidance to Local Health Districts and health professionals on the recommended approach to the health assessment process for children and young people in statutory Out-of-Home Care. They reflect NSW Health's approach to the implementation of the National Clinical Assessment Framework for Children and Young People in OOHC (2011).

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Audience  LHD Executive and Clinical staff, GPs, Paediatricians, Allied Health, Aboriginal Medical Services
Distributed to  Public Health System, Divisions of General Practice, Government Medical Officers, Ministry of Health, Private Hospitals and Day Procedure Centres
Review date  10-Oct-2016
Policy Manual  Not applicable
File No.  H13/58537-2
Status  Active
HEALTH ASSESSMENT OF CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME-CARE (CLINICAL PRACTICE GUIDELINES)

PURPOSE
These Guidelines are intended to provide best practice guidance to health professionals on the health assessment process, and appropriate assessment tools, for children and young people in statutory Out-of-Home Care (OOHC). They reflect NSW Health’s approach to the implementation of the National Clinical Assessment Framework for Children and Young People in OOHC (2011), released by the Commonwealth Department of Health and Ageing.

The Guidelines aim to support health practitioners in improving the consistency of service delivery for the OOHC population in NSW.

KEY PRINCIPLES
The key principles underpinning the health assessment process articulated by the Guidelines are:

- The health assessment process is to be child and young person centered and culturally respectful;
- A comprehensive and ecological approach should be applied to health assessments, with physical health, developmental health, and psychosocial and mental health domains considered during both primary screening and comprehensive assessments;
- The assessment process should apply a tiered approach, identifying the need for progression to further assessment or ongoing intervention within the domains of physical health, developmental health, and psychosocial and mental health;
- Where appropriate, assessments should be conducted using standardised, evidence based screening and assessment tools;
- Continuity of health care providers, and documentation of findings using standard templates so that health records are transferrable, are particularly important to children and young people in OOHC due to the mobility of this population;
- Children and young people should be engaged in the assessment process and educated about health services, their rights to confidential health care, and issues of consent;
- In NSW, the health assessment process for children and young people in statutory OOHC is guided by the Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering Out-of-Home Care (the Health Pathway) which is incorporated as an appendix to the guidelines.
USE OF THE GUIDELINE

Chief Executives, as the Executive Sponsors of the OOHC program in Local Health Districts (LHDs) should:

- Assign responsibility and personnel to implement the Guidelines in LHDs
- Develop LHD policies, procedures, protocols, guidelines and other documents relating to the provision of health services consistent with these Guidelines
- Ensure all LHD staff involved in the provision of health services for children and young people in OOHC understand and comply with the Guidelines and locally developed procedures and protocols for their implementation
- Ensure the promotion of the Guidelines to non-government health service providers such as General Practitioners, private allied health providers, and non-government agencies providing health services to children and young people in OOHC, and encourage their compliance with the Guidelines

Health professionals involved in the provision of health assessments, intervention and/or reviews of the health needs of children and young people in Out of Home Care should:

- Develop an understanding of the Guidelines – and their attached assessment templates.
- Ensure service provision is provided in alignment with the Guidelines

REVISION HISTORY

<table>
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<th>Version</th>
<th>Approved by</th>
<th>Amendment notes</th>
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<tr>
<td>October 2013 (PD2013_010)</td>
<td>Deputy Director General Population Health</td>
<td>New Guideline</td>
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1 EXECUTIVE SUMMARY

Children and young people in out-of-home care (OOHC) are recognised as a highly vulnerable group and often have a range of unidentified and untreated health issues. The time at which a child or young person enters OOHC provides an important opportunity for General Practitioners and other health professionals to assess the child’s health, development and wellbeing. This includes health and mental health issues, developmental delays, and risk factors for long-term health outcomes. One Australian study found that 97% of children in OOHC who received a comprehensive health screen had medical, developmental, emotional and/or behavioural problems. These health issues increase the risk of ongoing poor health and educational outcomes. Aboriginal and Torres Strait Islander children are known to have increased health problems compared with non-Indigenous children, as well as difficulties accessing culturally appropriate health services. These two issues may combine to lead to significant effects on well being when an Aboriginal or Torres Strait Islander child is taken into OOHC.

The purpose of these guidelines is to provide best practice guidance for health professionals on the health assessment process and appropriate assessment tools for all children and young people (aged 0-18 years of age) in statutory OOHC which reflects the National Clinical Assessment Framework for Children and Young People in OOHC (2011) released by the Commonwealth Department of Health and Ageing.

In NSW, an interagency approach between NSW Health and the Department of Family and Community Services, Community Services Division (FaCS-CS) supports the health assessment process. A “Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering OOHC” or ‘Health Pathway’ has been developed to ensure all children and young people entering OOHC receive health assessments.

The target audience for these guidelines are health practitioners who conduct routine health, developmental and psychosocial assessments for children and young people in statutory OOHC. This includes General Practitioners (GPs), Paediatricians, Aboriginal health services, community health/child and family health nurses, allied health professionals, and other health professionals who may be involved in conducting these health assessments.

This guideline aims to support health practitioners to improve the consistency of service delivery for the OOHC population across NSW. Further advice, training and support associated with the health assessment process will be undertaken as part of the next stage of implementation. The guideline draws on evidence based best practice and early intervention approaches to alert health practitioners to the health issues of this cohort to improve access and health outcomes for this vulnerable population group.
2 BACKGROUND

The *National Clinical Assessment Framework for Children and Young People in OOHC 2011* (‘National Framework’) released by the Commonwealth Department of Health and Ageing alerts health professionals to the health issues for children and young people in out of home care (OOHC); outlines the role of clinicians; and provides clarity on improving access to healthcare for this vulnerable population group. This document is intended to guide and support NSW health professionals in the state wide implementation of the National Framework.

In NSW, the provision and coordination of health screening, assessment and intervention for children and young people in statutory OOHC is based on the “*Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering OOHC*” (the ‘Health Pathway’) (Appendix 1).

The Health Pathway is an outcome of the Special Commission of Inquiry into Child Protection Services in NSW to address the health needs of children and young people in statutory OOHC. A Memorandum of Understanding between NSW Health and Family and Community Services - Community Services on *Health Screening, Assessment Intervention and Review for Children and Young People in Out-of-home-care* supports this collaboration. The journey of the child is at the core of the model, which also promotes close collaboration between NSW Health, Community Services, and OOHC service providers. The roles of health professionals, other government agencies, non-government agencies and carers are also articulated.

This guideline draws on evidence based best practice and early intervention approaches to inform and support health practitioners in their approach to health assessments for children and young people in OOHC. A literature review has been undertaken in the development of this Guideline (Appendix 2) which builds upon the literature review completed under the National Framework.

3 KEY TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Out-of-home care (OOHC)</td>
<td>Care and control of a child or young person at a place other than their usual home by a person that is not their parent. It includes care and control under an order of the Children’s Court or when they are a protected person for more than fourteen days or for a total of more than 28 days in any 12-month period. Children in OOHC may be in foster care, relative/kinship care or in a residential placement.</td>
</tr>
<tr>
<td>Statutory out-of-home care</td>
<td>Where the Minister for Family and Community Services has parental responsibility for a child or young person by virtue of an interim or final order of the Children’s Court. Most children and young people in statutory OOHC live with authorised foster carers, relative carers, or kinship carers. In some cases the child or young person may live in a residential care unit such as a group home.</td>
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**Clinical Practice Guidelines for the Health Assessment of Children and Young People in Out-of-Home Care**

**GUIDELINES**

**Carer**
Refers to a person who is authorised as a foster or relative/kinship carer by a designated agency.

**Child**
A child is defined by the Children and Young Person’s Care and Protection Act (1998) as a person who is under the age of 16 years.

**Young person**
A young person is defined by the Children’s Care and Protection Act (1998) as a person who is aged 16 years or above but is under the age of 18 years.

**Out-of-home care Coordinator**
An appointed person allocated in each Local Health District to co-ordinate the delivery of OOHC health assessments and reviews for children and young people in OOHC.

**Non-government organisation (NGO)**
Within this context, refers to agencies that are accredited by the Children’s Guardian and funded by FaCS-CS to provide OOHC services.

**FaCS-CS**
Department of Family and Community Services, Community Services Division.

**DEFINITIONS OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>ASQ</td>
<td>Ages and Stages Questionnaire</td>
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<tr>
<td>ASQ: SE</td>
<td>Ages and Stages Questionnaire: Social Emotional</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CFHN</td>
<td>Child and Family Health Nurse</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>FaCS-CS</td>
<td>Department of Family and Community Services, Community Services Division</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HMP</td>
<td>Health Management Plan</td>
</tr>
<tr>
<td>HRF</td>
<td>Health Referral Form</td>
</tr>
<tr>
<td>KTS</td>
<td>Keep Them Safe: A shared approach to child wellbeing</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>NGO’s</td>
<td>Non-government Organisations providing OOHC</td>
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<tr>
<td>OOHC</td>
<td>Out-of-Home Care</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australasian College of General Practice</td>
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<tr>
<td>S tEPS</td>
<td>State-wide Eyesight Preschool Screening program</td>
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4 HIGH LEVEL OVERVIEW OF NATIONAL FRAMEWORK AND NSW MODEL PATHWAY (THE HEALTH PATHWAY)

See Appendix 1 for the complete ‘Model Pathway for the Comprehensive Health and Developmental Assessment for all Children and Young People entering Out-of-Home Care’


### NATIONAL FRAMEWORK

**Tiered Approach to Assessments**
- Age-appropriate based on three domains:
  - Physical health
  - Developmental
  - Psychosocial and mental health

### NSW MODEL PATHWAY (THE HEALTH PATHWAY)

**Age-appropriate based on three domains:**
- Physical health
- Developmental
- Psychosocial and mental health

<table>
<thead>
<tr>
<th>Step 1- Initiating a health assessment</th>
<th>FaCS- CS initiates health referral by completing Health Referral Form. On receipt of referral, local OOHCo Coordinator initiates health services as per local procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2a- Primary health screening</td>
<td>All children and young people entering statutory OOHCo will receive a primary health screening/consultation.</td>
</tr>
<tr>
<td>Step 2b- Comprehensive assessment</td>
<td>If clinically indicated during the primary health screen (2a), a child/ young person will be referred to receive a comprehensive health assessment (2b).</td>
</tr>
<tr>
<td>Step 3- Documentation and development of a Health Management Plan</td>
<td>Health Management Plan details any health needs identified in 2a and/or 2b and how the needs/ issues will be addressed and by whom</td>
</tr>
<tr>
<td>Step 4- Targeted service intervention</td>
<td>Wherever available/ possible the health service/intervention will be provided by a publically funded healthcare provider.</td>
</tr>
<tr>
<td>Step 5- Periodic review and assessment</td>
<td>Under 5 years of age- minimum 6 monthly Over 5 years- minimum of annually OOHCo Coordinator will initiate review, FaCS - CS/ NGO’s/ Carers/ Child/ Young Person will engage in review process, Healthcare practitioner to perform health review</td>
</tr>
</tbody>
</table>
5 PRINCIPLES OF ASSESSMENT

5.1 Health Assessment Domains

Children entering OOHC are known to experience increased prevalence of a range of chronic and complex conditions, and are less likely to have undergone routine health checks, compared to other Australian children. The National Clinical Assessment Framework identifies three key domains of assessment to ensure the holistic health needs of children and young people are addressed, and that healthcare assessment and provision for OOHC children should include these three domains:

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

Elements of each domain should be considered during both the primary health screen and the comprehensive assessment.

5.2 Principles guiding health assessments

In NSW, the health assessment process of children and young people in statutory OOHC is guided by the Health Pathway (Appendix 1), with a focus on the individual child or young person’s circumstances and needs.

Key principles for health practitioners when completing health assessments are to:

- Be child and young person centred and culturally respectful including giving the child or young person information about their health-care rights and where to access health services
- Apply a comprehensive and ecological approach to assessment and integrate assessments and interventions to improve overall wellbeing and functioning of the child or young person in the home, school and community
- Be purposeful and outcome-focused. Document findings using standard templates, so that health records are transferable, as frequent changes of placement can disrupt continuity of health care
- Form part of a multidisciplinary team approach where appropriate. General Practitioners performing initial assessments should triage and refer to specialist and/or allied health services where required
- Identify need for progression for further assessment or ongoing intervention within the health assessment domains (physical health, developmental health and psychosocial and mental health) and the tiered approach to assessments. Focus on providing continuity of care for the child or young person and their carers. The foster carer should accompany the child or young person to the assessment along with the caseworker (where able) particularly if the child is under 12 years of age
- Be ethical, focusing on engagement with, and education about, health services and the child or young person’s rights to confidential health care and consent to their own treatment
• Apply medico legal principles, particularly in relation to consent and confidentiality. The limits of confidentiality need to be clearly explained to the child or young person as appropriate.

5.3 Process of assessment

In NSW, the health assessment process of children and young people in statutory OOHC is guided by the Health Pathway (Appendix 1), with a focus on the individual child or young person’s circumstances and needs.

The process of assessment should:

• Engage both the child or young person and their carer and caseworker. The foster carer accompanies the child or young person to the assessment as well as the caseworker (where possible). Children and young people over 14 years of age, who are able to provide consent, should be given the option of being seen on their own

• Use standardised, evidence-based screening tools and assessments when appropriate

• Ensure results are documented so that identified health needs are addressed, including:
  - Recording immunisations into the Australian Childhood Immunisation Register (ACIR)
  - Updating the NSW Personal Health Record (‘blue book’)
  - Updating the Personally Controlled Electronic Health Record, where applicable
  - Complying with Local Health District medical record documentation policies
  - Development of a Health Management Plan
  - Provision of all health professionals assessment reports and recommendations to the caseworker.

5.4 The impact of trauma

Children in OOHC are more likely to have experienced trauma from an early age than other children. As a result of parental abuse and neglect, these children are more likely to experience disturbed attachments and disrupted care, as well as adverse environmental factors such as poor perinatal conditions, poverty, and exposure to adult mental illness and drug and alcohol abuse. Such conditions lead to not only health and developmental problems, but also high rates of psychological issues and poor educational outcomes. These children may show complex mental health psychopathology, including attachment issues, relationship insecurity, disordered sexual behaviours, anxiety due to past trauma, behavioural issues such as inattention/hyperactivity, conduct problems and defiance, and other less common problems such as self-injury, excessive eating and other food maintenance issues.

Health assessments should be oriented to these issues and specifically focus on the strengths and difficulties experienced by each individual child or young person, and their carer, with referrals and services provided targeted to these. When assessing and treating the mental health of children and young people in OOHC, it is important to consider problems in their entirety, using an ecological approach to the child or young person’s health, rather than viewing each issue as a discrete diagnosis. Psychological support for
the child or young person and their carer is an important adjunct to treatment of diagnosed mental health disorders\textsuperscript{19}.

The Committee on Early Childhood, Adoption and Dependent Care (2000) has developed a framework to assessing developmental issues in children with a history of trauma. This includes:

- The implications and consequence of abuse, neglect, and placement in foster care on early brain development
- The importance and challenges of establishing a child’s attachment to caregivers
- The importance of considering a child’s changing sense of time in all aspects of foster care experience
- The child’s response to stress.

These elements should be considered in the 0-5 year old child health assessment.

5.5 The role of carers in health assessments

The role of the carer in the wellbeing of children in OOHC is critical, and the relationship between the child, the carer, and the foster family has potential to provide an important foundation for health and development outcomes\textsuperscript{20}. The strength of the relationship between the child and carer has a proven role in the success of health interventions\textsuperscript{21}. Factors such as the carer’s health and wellbeing, their capacity to be committed to the child or young person and their ability to cope with the child or young person’s needs should therefore be included in the health assessment process and in the Health Management Plan developed for the child\textsuperscript{22}.

Changes of carer within the OOHC system have been associated with adverse outcomes including disrupted identity, disruption to attachment relationships and poor educational outcomes\textsuperscript{23} and may limit the continuity of support available to manage these issues\textsuperscript{24}. Frequent placement changes are an important clinical indication of the need for comprehensive assessment.

Caring for children with increased rates of physical and mental health problems frequently leads to carer stress\textsuperscript{25}. In one study, carers reported significantly less time available to attend to their personal needs after taking a child into their care\textsuperscript{26}. Other studies have found that carers frequently lack the information and support they required to manage complex health issues\textsuperscript{27}. It is important to make the health assessment process as simple as possible for the carer, including consideration of transport, child care, information provision, and ensuring all the carer’s questions are answered\textsuperscript{28}. Carer health concerns usually require the creation of a medical file for the carer. It is the responsibility of the Foster Carers agency (FaCS- CS or NGO) to provide placement support, training and liaison on behalf of the carer. Within NSW, there are services dedicated to supporting carers in their Foster Care role (see section on Resources).

The carer is a key informant in the health assessment, however, it has been demonstrated that carers may underestimate the health needs of children in their care, particularly in the first few months of care. Carer reports should therefore not be used in isolation, but need to be considered in the context of broader clinical assessment, and may require support by
other informants such as teachers or childcare workers. Parenting issues also need to be addressed in the child's health plan to provide feedback to FaCS-CS or the managing NGO.

Although obtaining a medical history from the carer is important, the health professional may also need to spend time alone with the young person to address their health needs and concerns, whilst respecting their right for confidentiality. Neglect and abuse may occur in care and suspected risk of harm to the child or young person must be reported according to standard procedures.

5.6 Considerations when conducting health assessments for children and young people in OOHC

Children and young people in residential care facilities

In Australia approximately 6.5% of children and young people in OOHC are placed in residential care. A child or young person is usually placed in residential care when a foster care or relative or kinship care placement is not available or not suitable for the needs of the child/young person. A high turnover of staff, children, and young people within a residential care facility is not uncommon.

The majority of children in residential care are adolescents. There is evidence that adolescents placed in OOHC have lower employment rates compared to adolescents not in OOHC. They may also be more likely to be involved in the juvenile justice system. Children and young people placed in residential care often have a history of multiple placement breakdowns, are difficult to place and have high, complex support needs. Adolescents in OOHC have poorer mental health than younger children in OOHC, and children and young people in residential care have more mental health problems that those in other forms of OOHC care. Thus young people in residential care are a particularly high-risk group and it is recommended that all children and young people who are placed in residential care undergo a comprehensive health assessment.

When conducting a health assessment of a child or young person in a residential care facility, the following should be considered:

- A possible long history with the care and protection system and a long period of exposure to adversity and abuse. This is a key predictor of poor mental health outcomes. For many of these children and young people this includes adversity experienced within the foster care system. This increases their vulnerability and contributes to a lack of trust in system processes.
- These children and young people may be difficult to engage and have a different style of engagement. Services need to be more flexible with this population to ensure health services are available and responsive to their needs.
- These children and young people may be allocated a key worker, but may not always have a consistent, reliable health advocate. Ensuring continuity of care for this population is important.
• A high level of service coordination is required, as there are often multiple systems and services involved due to the complexity of their needs. These may include health, educational, behavioural, legal and mental health services.

• Interactions with other peers in the placement who are likely to also have high, complex needs and problems may influence the behaviour of a child or young person.

• Key attachment relationships formed at the residential care facility may be disrupted due to the frequent turnover of staff and residents.

Aboriginal and Torres Strait Islander children and young people

There is evidence that Aboriginal and Torres Strait Islander children in OOHC suffer a similar range of health, developmental, and psychological problems as other children in OOHC. However, their needs are often greater because of the social disadvantage often suffered by Aboriginal and Torres Strait Islander families. Aboriginal health has been defined as “not just the physical well-being of an individual, but the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being.” Despite these clear health needs, there is a lack of research specific to Aboriginal children in OOHC.

Aboriginal children and young people in OOHC are often placed in kinship placements. The needs of the carers are therefore critical in the health assessment of an Aboriginal child in OOHC. Social disadvantage is of particular relevance; one study found that barriers such as the availability of transport and the cost of parking were enough to prevent Aboriginal OOHC families from attending appointments. Due to previous experiences with Government agencies and health services, carers may also be reluctant to engage with health providers as they are viewed as positions of authority.

Due to these factors, the health assessment of a child or young person may be most appropriately conducted by services tailored to meet the community needs, such as Aboriginal Community Controlled Health Services. Within some Local Health Districts there may also be Aboriginal Health Workers (AHWs) employed to support access to health services. The role of the AHWs is to support Aboriginal and Torres Strait Islander children and their families, ensure they receive care that is culturally appropriate, and undertake health promotion.

There is evidence that Aboriginal children in OOHC of school age have significantly increased behavioural and mental health issues that have the potential to impact greatly on school performance. Collaboration with the Department of Education and Communities Education OOHC Coordinators in planning for school commencement, school placement or transition from school to appropriate occupational services should be considered.

There are a number of existing health assessments for Aboriginal and Torres Strait Islander people, including “Health assessment for Aboriginal and Torres Strait Islander People” (MBS Item 715), which can be accessed annually. This health assessment includes the assessment of a child or young person’s health, as well as their physical, psychological and social functioning and consideration of whether preventive health care and education is appropriate.
When selecting screening and assessment tools for this population, it is important to use screening and assessment tools developed specifically for Aboriginal and Torres Strait Islander children, such as the Westerman Aboriginal Symptom Checklist- Youth40.

**Children and young people from culturally and linguistically diverse (CALD) backgrounds, and refugees**

Children and young people in OOHC may be from a range of culturally and linguistically diverse backgrounds, and some may be refugees. A health assessment of these children should consider:

- The child’s cultural needs in health care – for example the gender of the examining physician
- The use of interpreter services for the child and/or the foster carer may be required
- Screening tools and assessments may require translation, and may have been developed using a different cultural group as the norm
- Awareness of any potential family trauma in migrating or moving to Australia, for example war in the home country; and other disruptive factors such as social isolation, financial pressures, and lack of previous access to education
- The child may experience fear when talking to people in authority due to previous experience of scrutiny, interrogation or detainment
- Additional physical health considerations, for example, communicable diseases, hepatitis B, mineral and vitamin deficiencies, and immunisation status.
- Whether consultation with the Department of Education and Communities Education OOHC Coordinators in planning for school commencement or school placement is appropriate.

**Children and young people with disabilities**

Children and young people in OOHC may have a diagnosed disability and be engaged with disability specific services. The process of health assessment may also lead children and young people to become eligible for disability services. There may already be an allocated caseworker for these children.

Further considerations for children and young people with disabilities include:

- Awareness of additional services that may be required, including those provided by:
  - Government agencies, for example Ageing Disability and Home Care
  - Non-Government agencies, for example the Cerebral Palsy Alliance and Northcott disability services
  - Private practitioners
- The child or young person may already be under the care of a health care team and comprehensive re-assessment through the Health Pathway. However, the child or young person may have missed out on some routine health services, for example oral health services
• Consideration of developmental age of the child or young person, with adaptation of communication strategies if required

• Developmental and standardised assessments may not be appropriate due to the level of disability or impairment

• The burden of care and impact of the child’s additional needs on the carer. Identification of further support and additional services, in conjunction with the caseworker, may be required

• Collaboration as appropriate with the Department of Education and Communities Education OOHC Coordinators in planning for school commencement, school placement or transition from school to appropriate occupational services

• Provision of clear explanations and education to the carer and caseworker following assessment. This should focus on the child’s strengths and abilities, and the importance of early intervention in improving health outcomes

• Potential to advocate for appropriate respite services to support the OOHC placement.
6 SCREENING AND ASSESSMENT TOOLS

The health assessment should be performed using a combination of clinical history and physical examination. As part of the health assessment, standardised assessment tools, including questionnaires and standard screening tools may be useful in identifying health, developmental and psychosocial concerns. These tools are designed for use as part of a comprehensive approach to assessment.

Only screening and assessment tools that meet the following criteria should be considered for use (Table 1):

- Evidence based and validated
- Age appropriate
- Normative and non-stigmatising
- Cost efficient
- Able to be used by the appropriate health professional, with the required level of training (or access training available to support use)
- Able to be administered within appropriate timeframe.
Table 1: Screening and assessment tools for consideration for use in health assessments of children in OOHC (Adapted from National Clinical Assessment Framework (2011))

<table>
<thead>
<tr>
<th>TOOL</th>
<th>DEFINITION AND RATIONALE FOR USE</th>
<th>EVIDENCE FOR USE</th>
<th>AGES</th>
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<tbody>
<tr>
<td><strong>PHYSICAL HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height and weight percentiles</td>
<td>Record in NSW Personal Health Record (‘blue book’)</td>
<td></td>
<td>Birth to 18 years</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>Weight in kg divided by (height in meters)$^2$</td>
<td>Children in OOHC more likely to be overweight and obese and BMI likely to increase while in OOHC (Hadfield and Preece 2008)</td>
<td>From 2 years onwards</td>
</tr>
<tr>
<td><strong>DEVELOPMENTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RECOMMENDED FOR PRIMARY HEALTH SCREEN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents Evaluation of Developmental Status (PEDS)</td>
<td>Questionnaire consisting of 10 items, completed by carers. Aims to facilitate communication between the carer and the health professional to ensure that developmental problems are detected and addressed. Validated means of screening for developmental delay that has high sensitivity and specificity in detecting need for further assessment and intervention (MacKrides and Ryherd 2011).</td>
<td>Validated tool in the non-OOHC population. Sensitivity 74-80%, specificity 70-80% (MacKrides and Ryherd 2011).</td>
<td>Birth to 8 years</td>
</tr>
<tr>
<td>Ages and Stages Questionnaire (ASQ3)</td>
<td>A set of 30 age-specific, carer completed items in a questionnaire covering five developmental domains: communication, gross motor, fine motor, problem solving &amp; personal-social.</td>
<td>Validated tool in the non-OOHC population. Some evidence that in combination with the ASQ:SE, ASQ can increase detection rate of developmental and psychosocial issues (Jee et al 2010). Sensitivity 85%, specificity 86% (MacKrides and Ryherd 2011).</td>
<td>1 month to 5 ½ years</td>
</tr>
<tr>
<td><strong>RECOMMENDED FOR COMPREHENSIVE HEALTH SCREEN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bayley Scales of Infant and Toddler Development (3rd Ed.)</td>
<td>Assessment tool for measuring developmental delays in very young children. Professional administered (following specific training).</td>
<td>Validated, standardised assessment in the non-OOHC population.</td>
<td>1 month to 42 months</td>
</tr>
<tr>
<td>TOOL</td>
<td>DEFINITION AND RATIONALE FOR USE</td>
<td>EVIDENCE FOR USE</td>
<td>AGES</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Language Development Survey (LDS)</td>
<td>Parental report of children’s expressive vocabularies and word combinations, and risk factors for language delays. Takes 10 minutes for parent to complete.</td>
<td>Validated tool in the non-OOHC population. High reliability and validity (Rescoria and Alley 2001)</td>
<td>18 to 35 months</td>
</tr>
<tr>
<td>Child Development Inventory (CDI)</td>
<td>300 item parental report on children’s development, symptoms, and adjustment.</td>
<td>Validated tool in the non-OOHC population. Sensitivity 80 to 100%, specificity 70% (MacKrides and Ryherd 2011).</td>
<td>15 months to 6 years</td>
</tr>
<tr>
<td>Griffiths Mental Development Scales</td>
<td>Assessment tool measuring rate of development and need for early intervention. Professional administered (following specific training).</td>
<td>Validated tool in the non-OOHC population. More predictive of general development, less predictive of language development (Sutcliffe et al 2010).</td>
<td>Birth to 8 years</td>
</tr>
<tr>
<td>Wechsler Preschool and Primary Scale of Intelligence (WPPSI).</td>
<td>Measure of intelligence in children. Professional administered (following specific training).</td>
<td>Validated tool in the non-OOHC population.</td>
<td>2 years 6 months to 7 years 3 months</td>
</tr>
<tr>
<td>Wechsler Intelligence Scale for Children (WISC- IV)</td>
<td>Measure of learning disabilities and attentional disorders in children. Professional administered (following specific training).</td>
<td>Validated tool in the non-OOHC population.</td>
<td>6 to 16 years</td>
</tr>
<tr>
<td>Wechsler Non-Verbal Scale of Ability (WNV)</td>
<td>WNV is a nonverbal measure of cognitive ability for those with language difficulties or for people who are not proficient in English.</td>
<td>Validated tool in the non-OOHC population.</td>
<td>4 to 21 years</td>
</tr>
<tr>
<td>Universal Non-Verbal Intelligence Test (UNIT)</td>
<td>The UNIT is a norm-referenced assessment of general intelligence with entirely nonverbal administration and response formats.</td>
<td>Validated tool in the non-OOHC population.</td>
<td>5 to 17 years</td>
</tr>
</tbody>
</table>

**PSYCHOSOCIAL AND MENTAL HEALTH**

<table>
<thead>
<tr>
<th>RECOMMENDED FOR PRIMARY HEALTH SCREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaire: Social and Emotional (ASQ: SE)</td>
</tr>
<tr>
<td>TOOL</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
</tr>
<tr>
<td>HEEADSS- Assessment Framework for teen health risks</td>
</tr>
<tr>
<td>Achenbach Child Behaviour Checklist (CBCL)- Teacher Report Form (TRF)</td>
</tr>
<tr>
<td>Achenbach Child Behavior Checklist (CBCL)- Youth Self Report Form</td>
</tr>
<tr>
<td>CRAFFT- screening tool for substance abuse</td>
</tr>
</tbody>
</table>

**RECOMMENDED FOR COMPREHENSIVE HEALTH SCREEN**
<table>
<thead>
<tr>
<th>TOOL</th>
<th>DEFINITION AND RATIONALE FOR USE</th>
<th>EVIDENCE FOR USE</th>
<th>AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kessler 10 (K-10)</strong></td>
<td>Youth self-report measure of psychological distress. 10 questions about negative mental states experienced in the 4-week period leading up to the assessment. A screening tool only, clinical judgement required to determine the need for further assessment.</td>
<td>Validated tool in the non-OOHC population. Commonly used and demonstrated to have high precision (Kessler et al 2002).</td>
<td>From 16 years onwards</td>
</tr>
<tr>
<td><strong>Assessment Checklist for Children (ACC)</strong></td>
<td>A behavioural rating scale for children in foster, kinship and residential care. Carer report, specific for children in care.</td>
<td>Validated for use in the OOHC population (Tarren-Sweeny and Hazell 2006)</td>
<td>For 4-18 year olds (however norms only available on 5-10 year olds)</td>
</tr>
<tr>
<td><strong>Parenting Stress Index (PSI)-3rd Edition (Short Form)</strong></td>
<td>Carer self-report 36-item questionnaire designed to identify potentially dysfunctional parent-child systems.</td>
<td>Validated, widely used and with high reliability in non-OOHC population (National Child Traumatic Stress Network 2012).</td>
<td>For carer of child 3 months to 10 years of age</td>
</tr>
<tr>
<td><strong>Westerman Aboriginal Symptom Checklist – Youth (WASC-Y)</strong></td>
<td>The WASC-Y is a symptom checklist measure to identify young Aboriginal people who are at risk of anxiety, depression and suicidal behaviours. The WASC-Y comprises 53 assessments in six subscales that represent the following concepts: depression, suicidal behaviour, substance abuse, impulsivity, anxiety and cultural resilience. The checklist provides an indication of risk and was not designed to be diagnostic.</td>
<td>It is a culturally validated measure.</td>
<td>Aboriginal people aged 13-17yrs</td>
</tr>
</tbody>
</table>
7 TIERED ASSESSMENTS IN THE CONTEXT OF THE HEALTH PATHWAY

7.1 Focus of age appropriate assessments in the National Framework

The National Framework has developed a guide outlining the proposed tiered elements of age-appropriate assessments across the domains of physical health, development and psychosocial and mental health. The National approach on the tiered structure for health assessments is:

- Preliminary Health Check
- Comprehensive Health and Developmental Assessment
- Ongoing monitoring and assessment

The National approach recognises that completion of each level of assessment may take more than one visit to a health practitioner. Guidance on the age appropriate assessment in the National Framework can be found at: http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc~ncaf-cyp-oohc-2~ncaf-cyp-oohc-2-2.4

Medicare Benefits Schedule (MBS)

There are a large number of Medicare Benefits Schedule (MBS) items that are appropriate to the various aspects of care provided to children and young people in OOHC (including health assessments outlined in the Health Pathway). Appendix C of the National Framework articulates the entitlements of children in OOHC to an extensive suite of MBS items. The list of items is for guidance only and covers the primary health assessment, comprehensive health assessment, development of a Health Management Plan and ongoing monitoring, assessment and care. For a list of MBS items visit Appendix C of the National Framework: http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc~ncaf-cyp-oohc-appc.

7.2 STEP 1 of the NSW Health Pathway:

- A Health Referral Form is completed by FaCS-CS caseworkers to notify Health that a child or young person has entered OOHC and needs a health assessment. This referral includes background health information such as birth discharge summaries and results of any previous health assessments; information regarding past interventions; copies of health reports; and reasons for entry into OOHC. Other reports such as school reports may also be included. The Health Referral Form also documents consent for the Health OOHC Coordinator to seek and access any relevant additional information about the child’s health and wellbeing.

- Following receipt of the Health Referral Form the Health OOHC Coordinator accesses and collates all available information to assist the health practitioners in undertaking the health assessment and forwards this information to the health practitioner (ie. GP, child and family health nurse).

- Results from the carer completed Ages and Stages Questionnaire (ASQ3) and Ages and States Questionnaire: social and emotional (ASQ:SE) is also provided to health practitioner by the OOHC Coordinator.
Refer to “Templates” section for a sample cover letter to a GP/primary health care practitioner by Local Health District when initiating a health assessment.

7.3 STEP 2A of the NSW Health Pathway: Primary health screening

A primary health screen is performed by a primary healthcare practitioner (eg. GP, Nurse Practitioner, Child and Family Health Nurse or other speciality nurse or Aboriginal Health Worker) and includes elements of the physical, developmental, psychosocial and mental health domains.

A primary health screen should address all domains to ensure children and young people are referred on for comprehensive assessment and intervention services where required. The primary health screen may initiate (or continue) a therapeutic primary care provider relationship with the aim of supporting the carer and child relationship, and identifying current and emerging health and behavioural issues.

A primary health screen should include:
- Gathering of medical and family history
- Physical examination
- Growth and development check
- Vision
- Hearing
- Psychosocial and mental health screening
- Oral Health screen
- Immunisation check
- Nutrition
- Sexual Health (adolescents only)
- Respond to any concerns raised by carers, or child or young person.

Criteria for referral to comprehensive assessment (2B)

Following the primary health screen a child or young person may be identified as requiring further comprehensive assessment. Comprehensive health assessments for children in OOHC have been demonstrated to detect previously unidentified health problems. Clinical indicators may assist in identifying children or young people who require a comprehensive level of assessment. These indicators should be used within the context of the primary health screen and do not replace clinical judgement.

Criteria for progression to further assessment or comprehensive assessment (‘red flags’)

Under 1 year olds: ‘red flags’ for progression to comprehensive assessment

1. Any physical, developmental or psychosocial health concerns requiring further assessment, including if infant required medication for neonatal abstinence syndrome.
2. Any infant (over one month) on Ages and Stages Questionnaire (ASQ3) assessment scoring in the “needs monitoring” or “concerns exist” zone.
3. Any infant (over 3 months) on Ages and Stages Questionnaire: Social Emotional (ASQ: SE) assessment scoring in the “clinically significant” range.
4. Any sensory concerns, for example, with vision or hearing.
5. Any concerns identified at childcare or by the carer or caseworker that are not able to be addressed in the primary health screen.
6. More than one OOHC placement breakdown or unexpected OOHC placement change.
7. Concerns regarding carer’s wellbeing and capacity to meet the infant’s needs.

1-5 year olds: ‘red flags’ for progression to comprehensive assessment

1. Any physical, developmental or psychosocial health concerns requiring further assessment.
2. Any child on Ages and Stages Questionnaire (ASQ3) scoring in the “needs monitoring” or “concerns exist” zone.
3. Any child on Ages and Stages Questionnaire: Social Emotional (ASQ:SE) scoring in the “clinically significant” range.
4. Any sensory concerns, for example, with vision or hearing.
5. Placement history concerns, for example, more than one placement breakdown or unexpected placement change, or a placement change because of child’s behaviour.
6. Any concern identified at childcare or pre-school that was unable to be addressed in the primary health screen.
7. Concerns regarding carer’s wellbeing and capacity to meet the child’s needs.

6-11 year olds: ‘red flags’ for progression to comprehensive assessment

1. Any physical health concerns requiring further assessment.
2. Any developmental concerns, which may include:
   • Relationship issues and social concerns
   • Concerns about school not able to be addressed in the primary health screen
   • Academic concerns or learning difficulties.
3. Any psychosocial or mental health concerns, which may include:
   • Diagnosis of mental health problem and/or mental health professional involved
   • Carer or clinician identified clinically significant symptoms of emotional or behavioural disturbance
   • Child on medications prescribed to help emotional or behavioural problems
   • Identity concerns such as belonging, connection to significant people and places in their past, family of origin, culture and heritage
   • Clinically significant concerns noted on the Strengths and Difficulties Questionnaire (SDQ).
4. Placement history concerns, for example, more than one placement breakdown or an unexpected placement change because of child’s behaviour.
5. Concerns regarding carer’s wellbeing and capacity to meet the child’s needs.

12-18 year olds: ‘red flags’ for progression to comprehensive assessment

1. Any physical health concerns requiring further assessment.
2. Any developmental concerns, which may include:
   • Relationship issues and social concerns
   • Concerns about school not able to be addressed in the primary health screen
   • Academic concerns or learning difficulties
3. Any psychosocial or mental health concerns, which may include:
4. Placement history concerns, for example, more than one placement breakdown or unexpected placement change because of the child or young person’s behaviour.

5. Concerns regarding carer’s wellbeing and capacity to meet the child or young person’s needs.

Refer to “Templates” section for age appropriate assessment templates for the primary health screen.

7.4 STEP 2B of the NSW Health Pathway: Comprehensive assessment

A comprehensive assessment is conducted based on findings of the primary health screen. It is typically led by a key health practitioner (e.g. paediatrician or medical officer) and usually requires input from a multidisciplinary team according to the specific needs of the child or young person. The provision of multiple complex services to OOHC children in a timely, efficient and effective manner has not been well researched. Clinical judgement is required in determining the needs of individual children and an ecological approach, with a focus on positive outcomes for the child or young person, is required.

A comprehensive assessment should incorporate the following:

- Access, review and summarise child and family’s known health records from FaCS-CS, birth parents, carers, health units and hospitals.
- A full clinical assessment which is likely to involve a range of health professionals and should include:
  - Physical health
  - Developmental health
  - Psychosocial and mental health, including impact of abuse and neglect and separation from biological parents, for example trauma and attachment disorders
  - Specialist input as required, for example: Genetics, Ear Nose and Throat, Neurology.
- Identify, plan and refer on for any further specialist assessments, multidisciplinary clinical services, and intervention services as required.
- Documentation of all information in the Child’s Personal Health Record (‘blue book’) or personally controlled electronic health record or current health record. The information should also be documented in the Local Health District medical records system e.g. medical records, CHIME or CERNER.
- Formulation of a Health Management Plan including a plan for review.
- A copy of the written report, Health Management Plan and any other outcomes of the assessment should be provided to the relevant:
- OOH Coordinator
- GP or other primary healthcare practitioner
- FaCS-CS caseworker or NGO caseworker
- Carer
- Child or young person

Refer to “Templates” section for age appropriate comprehensive health assessments templates for children and young people in OOH.

7.4.1 CRITERIA FOR VISION, HEARING AND ORAL HEALTH SCREENING AND ASSESSMENT

Audiometry/ hearing screening and assessment

Children and young people entering OOH should have their hearing reviewed to determine if a formal hearing assessment is required. Although all babies in NSW should have a hearing check at birth as part of the State-wide Infant Screening Hearing (SWISH) program, children may suffer hearing loss during childhood due to progressive hearing loss.

Risk factors associated with delayed-onset or progressive hearing loss in childhood include caregiver concern, family history of hearing loss, neonatal intensive care, in utero infections, craniofacial anomalies, syndromes associated with hearing loss, neurodegenerative disorders, culture positive postnatal infections (herpes, meningitis), head trauma requiring hospitalisation and chemotherapy. For full details of risk factors, consult the SWISH program guidelines (GL2010_002) available on the NSW Health website.

In addition, some temporary or fluctuating hearing impairment occurs due to complications of middle ear infections. Risk factors for middle ear infection include exposure to environmental tobacco smoke and the presence of structural abnormalities, including cleft palate and Down syndrome. Due to the significantly higher rates of otitis media in Aboriginal children, Aboriginality should also be considered a risk factor.

Hearing tests must be recommended if:

- The child did not undergo SWISH screening at birth or the results are unknown
- There are carer, caseworker or teacher concerns regarding the child’s hearing and/or speech and language development
- There is a history of recurrent ear infections
- The child has dysmorphic features or concerns exist regarding a genetic condition
- There is an abnormality on examination of the child’s ears
- The child is Aboriginal.
Vision screening and assessment

Children and young people should have a vision screen as part of their primary health assessment. Primary healthcare providers will only be able to assess verbal children who can name pictures (such as Kay Picture test) or are able to match letters (Sheridan Gardiner Test), or recognise letters (Snellen Test). All children 0-5 years of age should undertake the vision surveillance program in accordance with the recommended NSW Personal Health Record (PHR) or ‘blue book’ child health checks. There is a section in the PHR entitled Newborn Examination which involves a health practitioner checking the newborn’s eyes. In addition to this, children should have their vision screened through the State-wide Eyesight Preschool screening program (StEPS).

The StEPS program actively identifies all four year old children in NSW to provide a monocular visual acuity screen. StEPS recognises the importance of all children in NSW having their vision screened prior to school entry.

All children and young people in OOHC should receive the StEPS service at 4 years. If the child has been seen through StEPS and passed the visual acuity screen, they should not require another vision assessment unless there is a concern.

Children and young people 6-18 years of age in OOHC must be referred to an eye health professional for vision screening or assessment if:

- They are older than four years of age and have not received a StEPS vision screening assessment or “blue book” 4 year old child health check
- There are carer, caseworker, teacher, or child or young person concerns regarding the child’s vision
- There is an unusual appearance of the eye, including asymmetry, turned eye, or lazy eyelid
- There is any family history of eye problems or past history of physical trauma or head injury
- The child or young person has a learning difficulty or symptoms such as headaches.

Oral health screening and assessment

Oral health checks are recommended for all children under 18 years of age through public oral health services.

- All children less than one year old should have their teeth screened by child health professionals with oral health training
- All children and young people who are aged 1 year or older should have an oral health assessment by a dental professional
- Frequency of dental visits will depend on the child’s or young person's individual risk and it should be recommended that oral health services place OOHC children on a managed care program.
Referral should be made to public oral health services on referral to the Health Pathway unless the child has had a normal oral health check within the previous 12 months and there are no new concerns.

The NSW Personal Health Record (‘blue book’) recommends an oral health assessment (“lift the lip” mouth inspection and oral health risk assessment) be performed at a child’s 6 month health check. This assessment should be repeated at 12 months, 18 months, 2 years, 3 years and 4 years of age. If minor concerns are identified, oral health is discussed with parents and the child is reassessed at the next scheduled health check.

Alternatively, the child may require referral to an oral health service. A child may be referred to an oral health service from 6 months of age.

An oral health service should provide the following:

1. An oral health assessment
2. Individualised oral health education and guidance for the child or young person and carer, with provision of appropriate resources for home
3. Treatment of teeth as required.

7.5 **STEP 3 of the NSW Health Pathway: Development of a Health Management Plan**

The Health Management Plan is a health record which identifies the child or young person’s state of health, required intervention(s) and review process by a health practitioner(s). It is the key component to facilitate health coordination and continuity of care for the identified health needs of a child or young person in OOHC and can be developed following a primary health assessment and/or a comprehensive health assessment.

The Health Management Plan is integrated as part of the child or young person’s case file by Community Services/NGO caseworkers, and accompanies the child or young person if they change placement, are restored or transition from OOHC. The Health Management Plan may also be integrated in the child or young person’s education plan (where appropriate) by Community Services/NGO caseworkers. FaCS-CS/NGOs provide a copy of the Health Management Plan, where appropriate to birth parents and others involved including new carers where there is a change of placement.

Clinical recommendations, intervention/s and or ongoing care as determined on the Health Management Plan are to be followed by the carer and carers are encouraged to take the Health Management Plan and the Child’s Personal Health Record (Blue Book) to health appointments.

**Guiding principles in developing a Health Management Plan**

- The Health Management Plan is developed in consultation with health practitioners, carers, FaCS-CS/NGO caseworkers and children and young people (where appropriate) and is a transferable health record.

- Minimal background information is to be included in the Health Management Plan. In particular, no identifying information of the birth parent or their history should be included. Where relevant, this information should be included in the health professional’s assessment report.
• The Health Management Plan should be developed promptly to minimise the time between assessment and intervention(s). The recommended guideline for the development of a Health Management Plan is within 3 weeks of the finalisation of all assessment results.

• The Health Management Plan should be clearly documented and easy to read. It should be written so that it can be understood by the child or young person and carer. All children and young people should be engaged in the process of health assessment and, where appropriate, have explained to them that a health plan will be developed.

• The child or young person should be involved in the development and implementation of the Health Management Plan and this plan should be reviewed at least once every 6 months (for children under 5 years of age) and once every 12 months (for children and young people over 5 years of age). In rural and remote areas, the responsible care coordinator should ensure that access to appropriate services is arranged according to the needs of the child or young person.

Processes for Health Management Plan

• LHD’s should nominate appropriate clinical positions with expertise to create the Health Management Plan and liaise with FaCS- CS or the allocated NGO case workers to ensure that the Health Management Plan is implemented.

• All children and young people should be engaged in the process of health assessment and, where appropriate, have explained to them that a health plan will be developed.

• Young people, particularly those 12 years of age and over, should have a key role in the health assessment process and contribute, where they are able, to the development of the Health Management Plan. This includes the young person providing informed consent about who receives copies of the Health Management Plan.

• The Health Management Plan may require contribution from relevant health professionals. Contribution to the Health Management Plan may involve:
  • Recommendations following health screens or assessments being sent back to a coordinating point (for example, to the health case manager or OOHC coordinator)
  • Input provided from the minutes of a case conference format or team discussion
  • Circulation of the draft Health Management Plan to health professionals who provided the screen or assessment for review prior to completion and distribution.

• Caseworkers and Managers should be named and appropriate contact details included. Where case management has been transferred to an NGO, NGO caseworkers, agency details and contact details must be included.

• Carers’ names are not to be included in the plan but referred to as “carer”. This is to ensure the anonymity of carers.

• A copy of the Health Management Plan should be provided to the carer, Community Services/NGO case worker, healthcare practitioner (e.g. GP/ Child and family health nurse) and child or young person.
Minimum components of a Health Management Plan

The following five core elements have been developed as a guide to outline the minimum requirements when developing a Health Management Plan.

1. Child/young person’s identifying details, including date of birth, gender, Aboriginal, Torres Strait Islander and/or cultural background and languages spoken at home
2. Health Case Management Status, including the date of the Health Management Plan, contact details of who developed the Health Management Plan and who participated
3. Type of health assessments conducted and their outcomes, including the date of primary and comprehensive assessments conducted
4. Identification of health services for targeted intervention and ongoing care
5. Documentation of appropriate review process of the Health Management Plan:
   - If under 5 years old: minimum of 6 monthly
   - If over 5 years old: minimum of annually; or
   - More frequently if required based on clinical assessment.

Refer to “Templates” section for a copy of the Health Management Plan template

7.6 STEP 4 of the NSW Health Pathway: Targeted service intervention

Children and young people will be provided with initial and ongoing intervention as determined in their Health Management Plan. Publicly funded providers should be sought where possible. Where a private provider has an established therapeutic relationship, careful clinical consideration should be made before transitioning from this provider. In addition to publicly funded providers, some children and young people will be entitled to access alternate services such as: private practitioners using appropriate MBS items; access to treatment under the Enhanced Primary Care Scheme; or access to Department of Families, Housing, Community Services and Indigenous Affairs funding including “Helping Children with Autism package”, “Better Start for Children with a Disability initiative”, or “MBS Better Access initiative for mental health services”.

Targeted services intervention refers to the identified health needs of a child or young person as stated in their Health Management Plan. Services that may provide care include:

- Aboriginal Community Controlled Health Services
- Allied Health Services, including speech pathologists, dieticians, occupational therapists, physiotherapists and audiologists
- Child, Adolescent and Family Health Services and Mental Health Services
- Child Health Nursing Service
- Child Protection Counselling Services (Previously known as PANOC)
- Diagnostic and Assessment Centres
• Youth-specific services, including drug and alcohol services, headspace, New Street Adolescent Services, Sexual Health services, Youth Health, and Youth Mental Health Services
• Foster family systems psychological interventions e.g. Reparative Parenting Program (Alternate Care Clinic, Redbank House), Connecting Carers NSW (Karitane)
• General Practitioner for ongoing care, for example Immunisation catch up program
• Paediatric specialist care, transitioning to adult specialist care if required
• Refugee Health Services
• Sexual Assault Services
• Specialist disability service providers e.g. Department of Family and Community Services, Ageing Disability and Home Care (ADHC)
• Specialist programs for families where parents have mental health and/or drug and alcohol problems (e.g. COPMI- Children of Parents with a Mental Illness)
• Transcultural Mental Health Services.

Health promotion is also an important aspect of intervention in children and young people in OOHC. The primary health care practitioner has the necessary skills to address a broad range of health promotion and preventative health areas.

7.7 STEP 5 of the Health Pathway: Ongoing review and assessment

A best practice approach to the health care of children in OOHC involves ongoing continuity of care rather than a model focused primarily on assessment. For example there is evidence that the risk for developmental delay for children who are neglected or abused remains high for many years after their initial maltreatment. There is therefore a need for ongoing monitoring and review of developmental progress to ensure emerging or new issues are identified.

In rural and remote areas, the responsible care coordinator should ensure that access to appropriate services is arranged according to the needs of the child or young person.

The child or young person will be reviewed and receive regular case management services by their allocated caseworker within FaCS-CS, or the allocated NGO. The caseworker will support the carer and child or young person to ensure recommendations developed in the Health Management Plan are followed and, where issues arise, to engage with relevant health professionals.

The Health Pathway identifies the roles and functions of agencies involved (FACS-CS, ADHC, NGOs, Health); health professionals; and carers. Complementary, systematic planning and active coordination among these parties is required to ensure that children and young people in OOHC receive the health care services they require.

The review process also includes a “Health Review”. A health review is initiated by the Health OOHC Coordinator and is defined as a process that engages key players in the child or young person’s care team including the case worker, carer, health professionals, health case manager, and child or young person where appropriate.
A health review incorporates both the revision of a child’s or young person’s Health Management Plan and a health assessment of any identified health, developmental or psychosocial and mental health concerns. Reviews are to be undertaken by a primary healthcare practitioner. Children under 5 years of age will have a health review at least every 6 months, or as clinically indicated. Children over 5 years of age will have a health review at least annually, or as clinically indicated.

Other events may trigger the need for more frequent review, including change of placement, change in health condition or emerging needs that require health assessment.
### PRIMARY HEALTH ASSESSMENT (Step 2a of the NSW Health Pathway)

A primary health screening/assessment should be commenced within 30 days of the child or young person entering out of home care (OOHC). (Royal Australasian College of Physicians, *Health of Children in “Out-of-Home” Care: Paediatric Policy*)

<table>
<thead>
<tr>
<th>Before the appointment</th>
<th>Conduct a primary health assessment</th>
<th>Develop a Health Management Plan</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health OOHC Coordinator will provide you with:</td>
<td></td>
<td>If referral is not required, the GP/primary health care practitioner OR nominated clinical practitioner in Local Health District completes a <em>Health Management Plan</em> based on outcome of primary health assessment. Mail, fax or email the <em>Health Management Plan</em> to the Health OOHC Coordinator.</td>
<td>Health care practitioner recommends review period in Health Management Plan (at least every 6 months for children under 5 years, every 12 months for children/young people over 5 years). Follow up is provided as indicated on Health Management Plan.</td>
</tr>
<tr>
<td>• Letter to GP/primary healthcare practitioner requesting a primary health screen</td>
<td>Conduct a Primary Health Assessment</td>
<td>Where further comprehensive health assessment is recommended, the Health Management Plan may require contributions from other relevant professionals. The nominated Local Health District staff (e.g. Health Case Manager, lead clinician, or OOHC Coordinator) will compile this into a consolidated Health Management Plan and send a copy to the primary healthcare practitioner.</td>
<td></td>
</tr>
<tr>
<td>• Health Summary: including the child or young person’s known medical history and background, and other available health information summaries/medical records</td>
<td>Using the primary health assessment templates, GP/primary healthcare practitioner assesses the child’s health across the domains of physical health, development, psychosocial, and mental health according to the age of the child. Mail, fax or email the completed primary assessment template or copy of clinical notes to the Health OOHC Coordinator.</td>
<td>A copy of the Health Management Plan is retained by the child’s caseworker, carer and OOHC Coordinator and is integrated in the child or young person’s case plan by Community Services.</td>
<td></td>
</tr>
<tr>
<td>• Carer response to ASQ and ASQ:SE (if available)</td>
<td>Complete a referral letter detailing required follow up and/or referral appointments (if required)</td>
<td>A Health Management Plan can be developed following a primary OR comprehensive health assessment based on the healthcare needs of the child or young person.</td>
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<tr>
<td>• Copies of the primary health assessment templates according to the age of the child</td>
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</tr>
<tr>
<td>- Under 1</td>
<td>• GP/primary health care practitioner completes a referral letter to appropriate follow-up services where ‘red flags’ in the primary health assessment template indicate a need for further assessment or intervention. Mail, fax or email the referral letter to the Health OOHC Coordinator.</td>
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<tr>
<td>- 6 – 11 years</td>
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<td></td>
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<tr>
<td>- 12 – 18 years</td>
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</tbody>
</table>

*See attached templates for sample letter from Health OOHC Coordinator (includes contact details)*

*See attached templates for age specific primary health assessment templates*

*See website link*
## COMPREHENSIVE HEALTH ASSESSMENT (Step 2b of the NSW Health Pathway)

The comprehensive health assessment should be completed within 3 months of the child or young person entering out of home care (OOHC) (National Clinical Assessment Framework for children and young people in OOHC)

### Before the appointment

<table>
<thead>
<tr>
<th>The Health OOHC Coordinator will provide you with:</th>
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<tbody>
<tr>
<td>• Referral letter from primary healthcare practitioner (if available)</td>
</tr>
<tr>
<td>• Health Summary: including the child or young person’s known medical history, background, and other health information summaries/medical records</td>
</tr>
<tr>
<td>• Copy of completed Primary health assessment template by primary health care practitioner (if available)</td>
</tr>
<tr>
<td>• Copies of the comprehensive health assessment templates according to the age of the child or young person</td>
</tr>
<tr>
<td>- Under 1</td>
</tr>
<tr>
<td>- 0 – 5 years</td>
</tr>
<tr>
<td>- 6 – 11 years</td>
</tr>
<tr>
<td>- 12 – 18 years</td>
</tr>
</tbody>
</table>

### Conduct a comprehensive health assessment

<table>
<thead>
<tr>
<th>Conduct a Comprehensive Health Assessment</th>
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</thead>
<tbody>
<tr>
<td>Health care practitioner assesses the child’s health across the assessment domains of physical health, development, psychosocial, and mental health using the comprehensive health assessment templates provided</td>
</tr>
<tr>
<td>Mail, fax or email the completed comprehensive assessment template or copy of clinical notes to the Health OOHC Coordinator.</td>
</tr>
</tbody>
</table>

### Check MBS items for comprehensive health assessments

See attached templates for sample referral letter

### Develop a Health Management Plan

| • The health care practitioner OR nominated clinical practitioner in Local Health District completes a Health Management Plan based on outcome of comprehensive health assessment. Mail, fax or email the Health Management Plan to the Health OOHC Coordinator. |
| • The Health Management Plan may require contribution from other relevant professionals, in which case the nominated Local Health District staff (e.g. Health Case Manager, lead clinician, or Health OOHC Coordinator) will compile this into a consolidated Health Management Plan and provide a copy to healthcare practitioner(s) |
| • A copy of the Health Management Plan is retained by the child’s caseworker, carer and OOHC Coordinator and is integrated into the child or young person’s case plan by Community Services. |

A Health Management Plan can be developed following a primary OR comprehensive health assessment based on the healthcare needs of the child or young person.

### Follow up

| Health care practitioner recommends review period on Health Management Plan. |
| Follow up is provided as indicated on the Health Management Plan. If child or young person is under 5 years, the review period is six monthly, if over 5 years annually, or as clinically recommended. |
Endnotes

1 Nathanson and Tzioumi 2007
2 RACP 2006
3 RACP 2006
4 Nathanson and Tzioumi 2007
5 Vimpani 2012
6 Ramen et al 2011
7 Tarren-Sweeny 2008
8 Ramen et al 2011
9 Webster 2012
10 Webster 2012
11 Ramen et al 2011
12 Tarren-Sweeny 2008
13 Chambers et al 2010
14 Chambers et al 2010, Tarren-Sweeny 2008
15 Chambers et al 2010
16 Tarren-Sweeny and Hazell 2006
17 Chambers et al 2010
18 Tarren-Sweeny and Hazell 2006
19 Tarren-Sweeny and Hazell 2006
20 Chambers et al 2010
21 Chambers et al 2010
22 Murray et al 2011
23 Chambers et al 2010
24 Nathanson and Tzioumi 2007
25 Chambers et al 2010
26 Carbone et al 2007
27 Pasztor et al 2006
28 Chambers et al 2010
29 AIHW 2012
30 Buys et al 2011
31 Neely-Barnes and Whitted 2011
32 Tarren-Sweeny 2008
33 Tarren-Sweeny 2008
34 Ramen et al 2011
36 Ramen et al 2011
37 Ramen et al 2011
38 Ramen et al 2011
39 Ramen et al 2011
40 McDermott 2010
41 McCue Horwitz et al 2000
42 Nathanson and Tzioumi 2007
43 McCue Horwitz 2000
44 Tarren-Sweeny 2008
45 Hill and Watkins 2003
46 Vimpani et al 2012
47 Barth et al 2008
9 APPENDICES

1. The Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering OOHC

2. Literature review – health assessments for children and young people in out of home care (OOHC)
## Appendix 1: A Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering Out Of Home Care

### The Child’s Journey

<table>
<thead>
<tr>
<th>Prior to entry into Care</th>
<th>Step 1 – Day 1</th>
<th>Step 2 – within 30 days</th>
<th>Step 3 Development of a Health Management Plan as part of the Child’s Case Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>● The majority of children and young people will have had a history of abuse / neglect prior to entry into care.</td>
<td>The child or young person has entered statutory OOHC. Children’s Court action has been initiated by CS that they are in need of care. (N.B. in some case children enter care via voluntary arrangements)</td>
<td>The child/yp with have been in OOHC for up to 30 days. They may now be clearly exhibiting behaviours and symptoms which indicate health needs e.g. aggression, enuresis. This may be a reflection of the unsettling experience of separation from primary care-givers and/or transition from an abusive environment. For others, it will be an indicator of likely continuing psychopathology which will require therapeutic intervention for both carers and child/yp to resolve.</td>
<td>Children &amp; young people should, as much as possible, participate in decisions affecting them and be given copies of relevant information.</td>
</tr>
<tr>
<td>● Many children and young people will not have had access to ongoing health care.</td>
<td>Most will have been placed in foster care or in relative /kinship care. (A small proportion of young people may be in residential or supported accommodation)</td>
<td>They are likely to remain unsettled due to the high level of uncertainty in their lives.</td>
<td></td>
</tr>
<tr>
<td>● Some children and young people would have recently undergone a medical examination (as per s173 of the Act) to identify abuse.</td>
<td>The placement may be in a different location from where they live.</td>
<td>They are likely to be having regular (supervised) contact with their parents, siblings and significant others. (If a baby, this would be several times per week).</td>
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<tr>
<td>● A small number of children (e.g. newborns) ‘enter care’ in hospital.</td>
<td>The relationship between carer and child or young person is developing.</td>
<td>They will have appeared at least once at the Children’s Court. They may also have been referred to the Children’s Court clinic for an assessment.</td>
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<tr>
<td></td>
<td></td>
<td>They are likely to remain unsettled due to the high level of uncertainty in their lives.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>They will have appeared at least once at the Children’s Court. They may also have been referred to the Children’s Court clinic for an assessment.</td>
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<td></td>
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<td>It is likely that they have changed schools/childcare.</td>
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</tbody>
</table>

### Roles and Functions

<table>
<thead>
<tr>
<th>Roles and Functions</th>
<th>NSW Health responsibilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to a child’s entry into care a health service may have already have conducted an assessment and have established</td>
<td>Respond to immediate health and development issues when the child/young person enters care e.g. medication, scabies, asthma,</td>
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<td></td>
<td>G.P. (ideally the child’s existing GP, if known)</td>
</tr>
</tbody>
</table>

### Step 2 Individual Components by Who?

| Step 2a – Commence an initial Community based Primary Health Screening / Consultation, within 30 days, according to LHD protocols and | Child and Family Health Nurse (esp. for 0-5years), |
| | GP (for 6-17 year olds), or |

### Step 3

<table>
<thead>
<tr>
<th>Who?</th>
<th>Health Manager to provide results of assessment to carer, family, where appropriate the young person and CS for</th>
</tr>
</thead>
</table>

### Step 4

<table>
<thead>
<tr>
<th>Step 4 Targeted Services Intervention</th>
<th>Provide initial and ongoing intervention as determined in the health care plan. This, wherever possible will be provided by a publically funded</th>
</tr>
</thead>
</table>

### Step 5

<table>
<thead>
<tr>
<th>Step 5 Periodic Review and assessment</th>
<th>Children - under 5 years need health reviews at least every 6 months, and over 5 years of age, at least annually, or as recommended in the Health Plan by the relevant specialist.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other events may trigger the need for a review – e.g. change of placement, health condition</td>
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</tbody>
</table>
| referrals to services for the child and their family. | nutrition | using evidence based tools wherever possible. The screening/consultation will include:  
- physical examination  
- growth and developmental check  
- vision  
- hearing  
- mental health  
- dental screen  
- immunisation status review  
- nutrition  
- Respond to carer’s/child’s concerns  
- Add OOHC section to PHR for child and ensure all information is recorded  
- Triage cases for intervention according to need and priority and refer for comprehensive assessment. | Aboriginal Medical Services  
In all cases a therapeutic primary health care provider relationship is commenced and promoted with the aim of supporting the carer/child relationship, and managing current and emerging health and behavioural issues | recording in file  
- Develop Health Plan in consultation with carer, CS, family, where appropriate young person and in some cases OOHC NGO. Ensure that case planning includes review process as appropriate i.e. at least 6 monthly if under 5 years, at least annually if over 5 years.  
- Health plan is to include identification of Health Care manager, carer, CS/NGO case Manager and the OOHC Coordinator is to be informed of these roles.  
- Refer to service/s for targeted intervention/s and/or ongoing care by OOHC team (dependent on LHD model and available local services)  
- The health plan needs to take into account where the child / yp currently living as well as the possibility of placement change / restoration or leaving care.  
- In instances where child / young person is to be restored to their family the OOHC coordinator needs to ensure that health care plan and follow-up is communicated to parent  
- Child Protection Counselling Services (previously PANOC)  
- Sexual Assault Services  
- New St or Rural New St Adolescent Services, services for Children under 10 with sexually abusive behaviour  
- Child and Adolescent Mental Health Services including child and adolescent psychiatry  
- Drug and Alcohol Services  
- Youth Mental Health Services, including psychiatry  
- Specialist programs for families where parents have mental health and/or drug and alcohol problems (COPMI/COPDA)  
- Foster Family systems psychological interventions (eg Reparative Parenting Training Program (ACC), Karitane and Foster Care Support Group  
- Drugs and Alcohol  
- Mental Health  
- Child and Family  
- Aboriginal  
- Foster Care  
- Drug and Alcohol  
- Mental Health | provider. Care may involve, but is not limited to:  
- paediatric specialist care  
- immunisation catch up program  
- developmental assessment and intervention  
- allied health services:  
- hearing  
- oral health  
- optometrist  
- speech path  
- dietician  
- Child Protection Counselling Services (previously PANOC)  
- Sexual Assault Services  
- New St or Rural New St Adolescent Services, services for Children under 10 with sexually abusive behaviour  
- Child and Adolescent Mental Health Services including child and adolescent psychiatry  
- Drug and Alcohol Services  
- Youth Mental Health Services, including psychiatry  
- Specialist programs for families where parents have mental health and/or drug and alcohol problems (COPMI/COPDA)  
- Foster Family systems psychological interventions (eg Reparative Parenting Training Program (ACC), Karitane and Foster Care Support Group  
- Drugs and Alcohol  
- Mental Health  
- Child and Family  
- Aboriginal  
- Foster Care  
- Drug and Alcohol  
- Mental Health | Reviews will involve consideration of what is in the best child’s interest should any change in a provider be proposed (e.g. should a public health service becomes available.)  
OOHC coordinator is updated on actions. Amendments to Health Plan are communicated to CS Case Manager for inclusion in Care Plan and also to carer.  
OOHC team will respond to new and emerging issues.  
When child or young person moves to another LHD OOHC coordinator will refer, liaise and handover to LHD’s OOHC Coordinator  

referrals to services for the child and their family.

• Receive information from CS on child and any initial known health background. This should also include information about the general impact trauma on client and possible behavioural and health consequences.

• Register entry of child into OOHC database.

• Access known LHD records.

• Identify/flag in health records that child is in OOHC (note: may need to

Step 2b – A comprehensive assessment is conducted, based on triage & findings of Step 2a. It is likely to involve staff from a range of disciplines & may incorporate the following:

- Access and review child’s & family’s known health records from CS, parents, Carers, health units & hospitals.

- Conduct full clinical assessment of physical health, developmental health, mental health, including impact of abuse/neglect (eg attachment disorders) specialist needs as

Local Health District models may vary, but will require an identified health case manager to coordinate the assessment, planning and any referrals. Disciplines likely to be involved are

- Paediatrician
- C & F Health
- CNS
- Nurse Practitioner
- Social Worker
- Psychologist
- C & A Psychiatrist
- Speech Pathologist
- Occupational therapist

OOHC Coordinator receives all information.

[OOHC Coordinator is responsible for oversight and coordination of how Steps 2a & 2b are delivered in the

- Aboriginal
- Foster Care
- Drug and Alcohol
- Mental Health

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consider privacy legislation if using flagging

- Triage case according to priority of need for assessment.
- Schedule appointments for 2a and 2b in consultation with carer, primary health provider and CS

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Carer or Relative/ Kinship Carer responsibilities:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Observe and report to CS any identified medical issues.</td>
<td>• Take child to all appointments and provide support.</td>
<td>Authorised carer can consent to medical and dental treatment not involving surgery as per s157 of CYP (C &amp; P) Act and needs to participate in development of the health plan.</td>
<td>Authorised carer must use 'best endeavours' to give effect to health plan, as per the Carer Code of Conduct (Schedule 1 of the C/YP (C&amp;P) OOHC Reg. 2003.</td>
<td>Take child to appointment and actively participate in review process.</td>
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<tr>
<td>Take child to medical practitioner, to address immediate needs.</td>
<td>• Take PHR (Blue Book) to all appointments</td>
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<tr>
<td></td>
<td>• Follow up child’s immediate needs identified at health assessments and recorded on PHR</td>
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<td></td>
<td>• Seek assistance from caseworker where there are barriers to accessing health assessments or intervention</td>
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<tr>
<td></td>
<td>• Observe and report to CS any identified medical issues.</td>
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</tbody>
</table>

LHD. The Coordinator is also responsible for mapping local service providers.

Consultation as required with:-
- Specialist Paediatrician
- CAMHS
- Addiction Medicine Specialist
- Aboriginal Health Worker
- multicultural health worker
- sexual health
- oral health
- youth health worker
- Service for the Treatment & Rehabilitation of Torture and Trauma Survivors (STARTTS)

• Contact ADHC Information, Referral and Intake (IRI) team for possible referral for ADHC or ADHC funded therapy services which may include: Occupational Therapy, Physiotherapy, Speech Pathology, Community Nurse, Dietetics and Behaviour Support

Foster Carer or Relative/ Kinship Carer responsibilities:

- Authorised carer can consent to medical and dental treatment not involving surgery as per s157 of CYP (C & P) Act and needs to participate in development of the health plan.
- Authorised carer must use 'best endeavours' to give effect to health plan, as per the Carer Code of Conduct (Schedule 1 of the C/YP (C&P) OOHC Reg. 2003.
- Take child to treatment/intervention services and provide support
- Participate in child’s therapeutic program as required.
- Seek assistance from caseworker where there are barriers to accessing health assessments/interventions
- Along with the CS/ NGO OOH worker, ensure all health information, including the child’s PHR is provided to new carers

In the event carers seek independent health advice for the child/yp, carers should ensure that information is forwarded to CS/NGO and Health for incorporation into Health Plan and Care Plan.
<table>
<thead>
<tr>
<th>Department of Family and Community Services, Community Services (CS) / OOHc agency responsibilities:</th>
<th>Step 1</th>
<th>Who?</th>
<th>Step 2</th>
<th>Who?</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify known health needs of the child prior to entry into care, including the result of any medical examination.</td>
<td>[When a child is removed, CS assumes care responsibility. A Care Application to Children’s Court will normally result in an interim order allocating parental responsibility to CS. To place a child in care, CS must have sufficient evidence to satisfy the Court that the action is necessary for the child’s wellbeing.]</td>
<td>CS caseworker</td>
<td>• Where a CS Psychologist, a Children’s Court Clinician or another private clinician has already conducted an assessment any findings relevant to the health needs of the child are to be provided to NSW Health to contribute to the comprehensive assessment.</td>
<td>CS Caseworker</td>
<td>The Health Plan is to be integrated into the child’s case plan.</td>
<td>Aim to ensure that all treatments / interventions occur.</td>
<td>Case Manager to ensure review occurs when due and liaises with OOHc coordinator. (N.B. If child is in NGO agency care this will be NGO worker’s responsibility.)</td>
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<td></td>
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<td>• Initiate assessment as soon as practicable after the child has entered care by direct referral to NSW Health.</td>
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<td>• Obtain key health information, including using the standardised health referral form: - Medicare Number - known medical conditions - medications and dosage - infant feeding/ sleeping patterns/ needs - allergies - immunisations - hospital of birth - Blue Book and - any other</td>
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<td>CS caseworker</td>
<td>• Assist carer to ensure that the child attends the required appointment and that it is scheduled with consideration being given to other events occurring e.g. contact</td>
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<td>• Be actively involved in facilitating information to inform the assessment and providing previous reports eg medical, psychological, school, pre-school, developmental assessments etc</td>
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<td>• Caseworker to advise the OOHc coordinator of assessments and observations by</td>
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</table>
available background information from the child’s family, including Children’s Courts Reports if permission from the Court is granted and provide to carer and NSW Health
- Check with the ADHC Information, Referral and Intake (IRI) team to determine whether the child is a client of ADHC and include relevant information in the health referral form.
- Identify to NSW Health whether the child is Aboriginal or from a CALD background
- Explain and provide written advice to carer on process required for health assessment to carer
- Provide carer with all available medical information as per s144 of the C/YP (C&P) Act.

other agencies which indicate additional health needs e.g. education
- Provide ongoing follow up to carer regarding results of assessments to ensure any barriers to accessing health care are addressed

<table>
<thead>
<tr>
<th>INFORMATION FLOW</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CS CW → Health OOHC Co</td>
<td>Health OOHC Co → Health CM</td>
<td>Health CM → CS/NGO CW</td>
<td>Health CM → Health specialists as required</td>
<td>Health CM → Health OOHC Co &amp; CS/NGO CW</td>
</tr>
<tr>
<td></td>
<td>CS CW → Health OOHC Co</td>
<td>Health CM → Health OOHC Co</td>
<td>Health CM → CS/NGO CW</td>
<td>Health CM → Health OOHC Co</td>
<td>Health CM → Health OOHC Co</td>
</tr>
<tr>
<td></td>
<td>CS CW → Health OOHC Co</td>
<td>Health CM &amp; CS NGO CW ↔ c/yp or carer where appropriate</td>
<td>Health CM &amp; CS NGO CW ↔ c/yp or carer where appropriate</td>
<td>Health CM &amp; CS NGO CW ↔ c/yp or carer where appropriate</td>
<td>Health CM &amp; CS NGO CW ↔ c/yp or carer where appropriate</td>
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</table>

Note:
- CS/NGO CW = CS Case Worker
- Health OOHC Co = Health OOHC Coordinator
- Health CM = Health Case Manager
APPENDIX 2: LITERATURE REVIEW - HEALTH ASSESSMENTS FOR CHILDREN AND YOUNG PEOPLE IN OUT OF HOME CARE

1. Introduction

This review builds upon the literature review completed for the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care Subcommittee [1]. The National Clinical Assessment Framework for Children and Young People in Out-of-Home Care literature review provides an overview of the health care needs of children and young people in out-of-home care (OOHC) and identifies current models of practice both within Australia and internationally. It does not provide a method in order to replicate the search strategy to capture new literature post 2010. Further, assessment and assessment tools applicable to children and young people in OOHC were not extensively reviewed within the National Framework literature review. The purpose of this literature review is to address these gaps and inform and support the development of the NSW Clinical Guidelines for the Health Assessment of Children and Young People in Out-of-home Care.

2. Objective

To review health assessments applicable to children and young people in out-of-home care

3. Method

A Medline search strategy was developed initially and modified appropriately for other databases. The search strategy is listed below:

- **Out of home care**: Out of home care, foster home care, child custody, kinship care, looked after, alternate care, as well as; “incare!” adj3 (child$ or teen$ or adolescent$ or youth$ or young people).
- (altern$ or substitute$ adj3 care$ adj3 (child$ or teen$ or adolescent$)
- **Health**: Adolescent health services/ or exp child care/ or exp mental health services, Mental Health, health, Mental Disorders, child welfare
- **Assessment**: Heath Services Needs and Demand, diagnostic services, needs assessment, health services accessibility, psychological tests, physical examination,
- Limits included: children, English
- Databases that were searched included- Medline, Cochrane, Embase, PsycINFO, Scopus, Web of Science.

4. Results

Studies were included in the review based on clinical applicability to the guidelines. This included a direct reference in the publication to assessment and health outcomes for children and young people in out-of-home care. Using this premise, 60 studies were identified as being suitable for inclusion. A panel of experts were assembled to review and validate the included papers.

The Children and Young Persons (Care and Protection) Act 1998 (s135, s151, s153, s156) provides the legal definitions on the types of OOHC:
Statutory OOHC - Where the Department of Family and Community Services has parental responsibility for a child or a young person by virtue of an interim or final order of the Children’s Court.

Supported OOHC - OOHC arranged, provided or otherwise supported by Community Services following determination that a child or young person is in need of care and protection. One aim of supported OOHC care is to help prevent the child or young person from entering statutory OOHC. Supported OOHC includes: temporary care arrangements, other supported OOHC arrangements and voluntary OOHC.

There are three main types of OOHC:
- Foster Care: where care is provided in the private home of a substitute family who receives payment that is intended to cover the child’s living expenses;
- Kinship care: where the caregiver is a family member or a person with a pre-existing relationship with the child; and
- Residential care: where placement is in a residential building whose purpose is to provide placement for children and where there are paid staff.

5. OOHC in Australian and NSW context

In the most recent statistics published by the Australian Institute of Health and Welfare (AIHW) [3], there were 37,648 children living across Australia in OOHC. As at 30th June 2011 this was a rate of 7.3 children and young people per 1000 aged 0-17 years of age. Despite a multitude of child protective service reforms over the past decade, numbers of children in OOHC continue to rise, with the number of children in OOHC increasing every year over the last 10 years [3]. From 2002 to 2011 the number of children in OOHC has almost doubled (a rise of 97%) [2], resulting in an increased burden on child protection and health services.

Aboriginal and Torres Strait Islander children and young people are over-represented in OOHC. There were 12,358 Aboriginal and Torres Strait Islander children in OOHC in Australia as of 30 June 2011– this is a placement rate of 51.7 per 1,000 children [2]. This rate is over eight times the rate of other children in care [4].

NSW has both the highest number of children and young people in OOHC and rate per population [3]. Within NSW, as of June 2011, there were 16,740 children and young people living in OOHC an increase from 16,175 in June 2010. Over the past 10 years, since June 2002, the numbers reported in OOHC have doubled with a progressive increase each year [3].

There is no national data detailing why children and young people enter OOHC, however, neglect, abuse and parental inability to care for the child or young person are frequently cited as reasons [5-7]. Within NSW, children and young people must reach the threshold of Risk of Significant Harm (ROSH) to be assessed for entry into OOHC. Children and young people once placed in OOHC have a range of care arrangements. Within Australia this includes placement into; foster care 45%, relative/kinship care 46%, other home based care 2.5% and residential care 6.5% [3]. Amongst those living in OOHC, under 5 year olds are the most prevalent with 42% being under 5 years of age whereas 23% are aged 5-9 years and 24% aged 10-14 years. Adolescents aged 15-17 years make up only
11% of those living in OOHC [3]. 82% of children and young people are in care for greater than a year, 31% for a period of 2-5 years and 36% for more than 5 years [3]. These data tell us that children and young people in OOHC are a growing population group. They are most likely to be under 5 years of age, living with either kinship or foster carers and spend at least 12 months in OOHC arrangements.

6. Key themes

A series of key themes were identified which will be outlined in this paper. These include; (i) access to services and systems as barriers and enablers to health care, (ii) the health needs of children and young people in OOHC (including physical, developmental, psychosocial and mental health needs), (iii) clinical assessment processes including models of assessment and assessment tools to consider, and (iv) foster carer considerations in the assessment process.

6.1 Access to services and systems as barriers and enablers to health care

In response to a need to address the increased pressure on health and community services as a result of children entering OOHC, the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care [1] was published.

A 2002 paper [10] outlines a model of healthcare provision for children in OOHC that is similar to current systems and processes within NSW. This includes initial health screening, comprehensive health assessment, developmental and mental health evaluation, provision of primary care and monitoring of children’s health status, the transfer of medical information and the impact of foster care placement on children [10]. However, no evaluation of this model has been published. Simkiss [11] outlined the integration of services across sectors in Birmingham, the largest local authority in England with 2300 children in care, focusing on access to health assessments in the publication of the National Framework in the United Kingdom, “Promoting the health of looked after children”.

Improved systems and processes in NSW have partially addressed systemic and interagency problems that represent barriers to children and young people in OOHC accessing health services. However, detailed information on the clinical implications of health assessment and progression through the tiered assessment process to support the implementation is not yet available. The provision of multiple complex services to OOHC children in a timely, efficient and effective manner has not been well researched [12].

**Systems and processes impact on continuity of care**

Children and young people who have spent time in foster care are a vulnerable group who are more likely than their peers to suffer adverse outcomes. This includes poor educational outcomes, poor health, teen pregnancy, homelessness and incarceration [13]. Children and young people in OOHC have significant, unrecognised and often unmet health needs. Their health needs are complex due to a number of factors including their lack of health history, their reasons for entering the care system (for example,
neglect, trauma and abuse), removal from their biological family, and movement through the care system. Their health issues cross key health domains and impact on their physical, developmental, psychosocial and mental health [1, 6, 7, 14-18]. These health needs are consistent internationally [14, 16, 18-20] and within Australia [1, 6, 7, 15, 21, 22]. The health needs of children and young people have been well documented in the National Framework (2011) and within literature reviews in relevant position papers in this area over the past two decades [23, 24].

A number of barriers have been identified for children and young people in OOHC in achieving continuity of health care services. These include lack of health history, lack of a consistent advocate for the child or young person, and placement changes. Furthermore, there are a number of system factors that compound these issues. Fragmented systems and processes often mean that the health needs of children and young people in OOHC are not addressed, health information and medical history is lost and there is a lack of continuity of care [15].

To ensure these vulnerable children and young people have access to health care commensurate with their needs, the system requires streamlined interagency processes to be developed, in particular between health and community services to ensure assessment occurs, recommendations are followed and intervention is received [7] [6]. To address the vulnerabilities of this population group, systems need to focus on early identification, ongoing support and integration of services [13]. Health services need to be comprehensive, coordinated, continuous, and supportive of children and their families [13].

6.2 The health needs of children and young people in OOHC

Aboriginal and Torres Strait Islander children and young people in OOHC

Despite evidence that Aboriginal and Torres Strait Islander children are over represented in OOHC numbers, there is very limited evidence documenting the specific health needs of this population group. One Australian study by Raman et al [22] aimed to identify the health and wellbeing needs of Aboriginal children entering OOHC. This paper outlined a partnership between Community Services, Health and an Aboriginal specific non-government organisation in Sydney’s South West (KARI). One hundred children were recruited on entry to OOHC, aged between 2 months and 12.5 years, with 64% being under 5 years of age. This study found that Aboriginal children in OOHC have a similar range of identified health needs as non-Aboriginal children in care, with immunisation rates being much lower (50%).

Young people in out of home care

Youth in OOHC are a particularly vulnerable group, yet little is known about how to provide evidence based assessment and intervention [25]. There is limited evidence specific to youth in OOHC and their health needs. An Australian study that gathered data from 65 youth in care and their primary care providers reported higher unemployment rates [26]. Even when employed, the age of commencement of paid work was earlier resulting in lower incomes, slower career progression and poorer educational outcomes.
for the youth. Youth in OOHC with emotional, psychosocial, mental health or behavioural problems are known to have increased rates of unemployment and depression [26]. Therefore, one recommendation is for youth health assessment to consider not only mental health status, but employment options and opportunities [26].

An intervention study investigated the outcomes of behavioural health services in two groups of youth: in OOHC placement or in their own home. These youth were identified as being high risk for becoming involved with foster care and Juvenile Justice systems. Neely-Barnes and Whitted [27] aimed to assess the social, emotional and behavioural symptoms experienced by these youth using the Strengths and Difficulties Questionnaire (SDQ). Of the 2575 youth aged 11-19 years of age recruited into the study 61.2% were male and 38.8% were female, with 38.2% identified as African-American. There was stratification of living arrangements (OOHC vs. living at home). Results indicated 49.4% had scores in the borderline or abnormal range. These results highlight the high health needs of youth involved in the child welfare and justice systems [27].

**Developmental needs for children and young people in OOHC**

The nature and extent of developmental health needs for children and young people, particularly those under 5 years of age, in OOHC have been well documented in the literature. Pears and Fisher [28] aimed to identify the types of developmental delays observed in children aged 3-6 years in foster care and how placement and maltreatment experiences for these children were associated with developmental delays. Two groups of children were recruited, with 99 foster children in one group and 54 non-maltreated children living with their biological parents in the control group. There were no significant differences between groups by age, gender and ethnicity. This study highlights two key findings. Firstly, that pre-school aged foster children have delays across a number of developmental domains, placing them at increased risk for further delays and behavioural and emotional problems. Secondly the experience of neglect or emotional abuse as the primary reason for placement into foster care was significantly negatively associated with a number of different developmental domains including height for age, visuospatial processing, memory, executive function, and language delay.

This vulnerability of children with a history of neglect has also been supported in a study by Barber and Delfabbro [5] that found that neglected children within OOHC differ significantly from non-neglected children and suffer relative disadvantage in relation to multiple forms of maltreatment, birth family contact and family restoration. The Committee on Early Childhood, Adoption and Dependent Care [29] on developmental issues in young children in foster care provides a framework to assessing developmental issues. This includes: (i) the implications and consequence of abuse, neglect, and placement in foster care on early brain development; (ii) the importance and challenges of establishing a child’s attachment to caregivers; (iii) the importance of considering a child’s changing sense of time in all aspects of foster care experience; and; (iv) the child’s response to stress. These are important elements to consider for 0-5 year old children in their comprehensive health assessment.

Reams [30] reported on provision and timeliness of health exams for children entering care in Oregon, USA. 144 children aged 0-48 months were assessed on average 69
days after placement via children’s assessment services. The children were only assessed in areas where they were not already receiving intervention services. They used a standardised series of assessments to examine sensory function, parent-child play interaction, interview of carer, Child Behaviour Checklist (CBCL), Batelle Developmental Inventory, social skills rating schedule and infant/toddler symptom checklist. Despite the number of assessments used, the paper reports that more comprehensive assessment for this age group is warranted. Of the children that were assessed, 83% received referrals for needed services, including 33% referred for mental health services and 76% referred for developmental services.

Within the published literature, children in OOHC have identified language delays that range from 35%–73% [31]. Stock and Fisher [31] report on the increased risk of language delays among children in foster care. Delays in language skill acquisition impacts on literacy, social competence and school readiness. Therefore, placing an increased emphasis on assessment of language skills, in particular for those children under 6 years of age, is important in order to access appropriate intervention. Barth and colleagues [32] report that the risk for developmental delay for children who are maltreated is high and remains high years after their initial maltreatment. This evidence supports a system approach that provides ongoing monitoring and review of developmental progress to ensure emerging or new issues are identified.

**Psychosocial and mental health needs**

Studies of the mental health of children in OOHC have established that more than half of children in care have mental health problems of sufficient scale and severity to warrant provision of mental health services [33]. A study by Chambers and colleagues [7] comprehensively assessed the physical, mental health and developmental difficulties of children aged between 4 months and 12 years in long-term foster care, and found that 53% of children required referral for further psychological assessment. Presenting issues included aggression, non-compliance, sleep disturbances, attention and concentration difficulties, emotional dysregulation and disturbances following contact with birth family.

A NSW research program described caregiver patterns of mental health service use for 347 pre-adolescent children in foster and kinship care in NSW [33, 34]. Caregiver questionnaires on the rate of mental health service use for children in their care were sent to all 4-9 year olds in NSW with parental responsibility to the Minister and living in foster or kinship care (621 eligible children). Questionnaires used included the Child behaviour Checklist (CBCL) and the Assessment Checklist for Children (ACC). The sample included 347 children, 176 boys and 171 girls, with a mean age of 7.8 years, 86% were in foster care and 14% in kinship care. With an overall response rate of 56%, results indicate that children in care may manifest complex psychopathology, characterised by attachment difficulties, relationship insecurity, problematic sexual behaviour, trauma related anxiety, conduct problems and defiance, inattention/hyperactivity as well as less common problems such as self-injury, excessive eating and other food maintenance issues. These behaviours are important to consider in an assessment to ensure support is provided and children and young people have access to services [33, 34].
Furthermore, the overall health and wellbeing of children in OOHC has been found to have a negative impact on their quality of life. Carbone and colleagues (2007) compared health related quality of life of 326 children and adolescents (aged 6-17 years) living in home based foster care to an age-matched normative sample of 3582 children aged 6-17 years living in the general community. Two measures were used; the Child Health Questionnaire (caregivers and young people aged 13-17 years) and the Child Behaviour Checklist (CBCL) (caregivers and youth self-report 13-17 years).

Across a wide range of domains, the health related quality of life of children in foster care was poorer than that of children in the general community. These results suggest that children in care experience problems across a broad range of areas associated with their mental and physical health, and limitations in their quality of life [35].

6.3 Clinical assessment processes including models of assessment and assessment tools to consider

Assessments need to be trauma informed and consider the unique needs of this population group. Children and young people in OOHC have often experienced violence, physical abuse, sexual abuse, parental addiction and/ or neglect in their birth home and therefore need an assessment that takes into account different health manifestations and consequences related to these circumstances. This must include not only their physical health, but also developmental, psychosocial and mental health assessment and evaluation in the context of recent removal from their families [36, 37].

In a study of 120 children primary community providers were able to identify medical and educational needs but not recognise developmental and mental health needs of young children newly entering foster care. This demonstrates that whilst physical health needs are often addressed during health assessment; there is poorer identification of developmental and psychosocial issues [12]. Therefore, primary health care providers should be supported in the use of standardised screening tools as well as guidance on common developmental and psychosocial concerns to consider in assessment. Some of these children may then benefit from a more comprehensive assessment that incorporates the principal of a tiered assessment process [10, 23, 29].

More recently Kaltner and Rissel [21] aimed to quantify health needs of children on entry into OOHC from a Queensland perspective and compare these to outcomes of a New South Wales based study by Nathanson and Tzioumi [15]. The study included 63 children, predominantly under 5 years of age, undergoing health assessment on entry into OOHC. A high proportion of children in care within this sample required referrals and further follow-up, with 70% requiring two or more health referrals. Further, there was consistency in the health needs reported between Queensland and New South Wales. The results provide further evidence of the high health needs and poor preventative health utilisation of Australian children in OOHC.

One suggested approach to providing comprehensive assessment and care to children who are at risk of multiple complex health problems is a multidisciplinary team approach (Kaltner and Rissel, 2011 [37]. Blatt and colleagues reported on a multidisciplinary
approach in a sample of 548 participants on entry into OOHC in an outpatient clinic. This descriptive study was supportive of a team approach to care.

Assessment tools

Assessment tools may be useful in identifying health, developmental and psychosocial concerns, however, a combination of clinical assessment, questionnaires, physical examination, interview and standardised tools are required to form a holistic assessment. There is a range of assessment and screening tools that have been utilised with the OOHC population, however, very few have been normed specifically on children or young people in OOHC. Assessment tools have been identified as being beneficial in the detection of health concerns, in particular in the areas of developmental and psychosocial health [12].

The Ages and Stages Questionnaire: Social and Emotional (ASQ: SE) was used in a prospective cohort study and administered to 3169 children in a general outpatient paediatric urban health setting [38]. The ASQ: SE was supported as a tool to identify the social, emotional status of young children (6 months to 3 years of age) presenting to a primary care practice. The domains addressed included development, sleep, behaviour, psychosocial concerns and mental health. This study, whilst not specific to the OOHC population, supports the co-location of medical practitioners with child psychologists and the use of the ASQ: SE as a screening tool as being effective in identifying young children requiring further psychological assessment.

A recent study of children and young people in OOHC by Jee et al [39] focused on determining whether systemic use of a social-emotional screening tool improves the rate of detection of social emotional problems compared to reliance on clinical judgement; the relative effectiveness of two validated instruments (Ages and Stages Questionnaire- ASQ and ASQ:SE) to screen for social-emotional problems; and the patterns of social-emotional problems among children in foster care. This study involved retrospective chart reviews of children in foster care aged between 6 months and 5.5 years. The screening used the ASQ and the ASQ: SE and was conducted in a primary healthcare setting.

Results indicated that the ASQ alone was not sufficient in identifying social-emotional problems and that the specific tool ASQ: SE increased the detection rate for social-emotional problems among young children in foster care compared to provider surveillance and the ASQ. This finding supports the combined use of the ASQ and ASQ: SE in complementing the health professional’s clinical reasoning to ensure developmental and psychosocial concerns are identified.

A study by Goodman & Goodman [40] of children in OOHC versus children in the general population supported the use of the Strengths and Difficulties Questionnaire (SDQ) as a genuinely dimensional measure of mental health in children in OOHC and provided accurate estimates of disorder prevalence. This study examined 1391 children and young people aged between 5-16 years of age, which included a random sample of children and young people in OOHC.
Sprang et al [41] published a descriptive paper on the development and implementation of a comprehensive assessment and training service project for children in foster care. The paper provides an outline of the model, which incorporates a key focus on psychosocial assessments. This model utilised the Crowell procedure to assess parent-child interaction and the attachment relationship as well as assessment of parent-child reunion and completion of the Parenting Stress Index (PSI).

**Skills required by health care assessors**

The identification of appropriate health professionals to conduct health screening and assessment for children and young people in OOHC is a key theme in the literature. Primary healthcare professionals have been recognised as appropriate professionals to conduct screening assessments. A paper by Simpson [42] highlights the complex needs of children in OOHC and examines factors contributing to their poor health outcomes. In particular, it outlines the role of the specialist nurse in conducting assessments for this population group. Registered nurses across domains may be appropriate health professionals to conduct primary health screens.

Webster and Temple-Smith [43] published a qualitative study that explored the views of a purposive sample of 20 General Practitioners in Victoria, Australia about what would influence their willingness and readiness to undertake comprehensive assessments for children entering OOHC. Ethical concerns, training, professional development needs, medico-legal issues, workforce and financial pressures and communication problems with the child protection sector were among key factors identified. The study also identified that GP's would be more motivated to complete assessments if the GP was to be the ongoing care-provider rather than only providing an initial, preliminary assessment.

An Australian discussion paper [44] describes the current health assessment practices for children and young people in OOHC and highlights the need for ongoing continuity of care rather than a model focused primarily on assessment. The paper also raises the need for a triage tool so that children and young people can be identified from a primary health screen as being in need of a comprehensive health assessment. This was identified as an important component to include in the development of the guidelines.

**Health promotion in the assessment process**

Health promotion is an important component of any health assessment process. The focus too often is on health assessment and not always inclusive of health promotion and preventative health. The National Framework incorporates the assessment criteria of “health literature” as an important assessment component.

There were limited studies that highlighted the role of health promotion in assessment and management of children and young people in OOHC. Hill and Watkins [14] studied 59 children in OOHC who attended a statutory health assessment in an English City Council. The health problems were categorized into physical health, sensory, learning, emotional/behavioural issues. This paper also reiterates the need for health assessment, with a focus on screening for health issues as well as an opportunity for health
They state that in order for health assessments to be effective they must not just focus on disease screening but rather on health promotion delivered by professionals that are skilled to address a broad range of health needs, for example primary healthcare providers [14].

Hadfield and Preece [45], assessed the frequency of obesity or overweight problems in looked after children following receipt into care. They conducted a retrospective chart analysis of 106 children over 5 years of age and reported height and weight. The results indicated that looked after children are more likely to be overweight and obese compared with the typical population and that 35% of children’s BMI increased once in care. This study supports BMI as an important component of health assessment and supports preventative health promotion and education with carers regarding the importance of good nutrition and exercise.

A review conducted by Jee et al [46] examined recent literature on foster care assessment for paediatricians. This reinforced international findings on health needs for children and young people in OOHC. However, the concept of anticipatory guidance and education for foster carers was also reported as an important aspect of care.

6.5 Foster carer considerations in the assessment process

There is an increasing expectation that foster and kinship carers are required to undertake a therapeutic, reparative role in their care provision that goes above the typical demands of parenting [7, 47]. For this reason, foster carers form a critical component of the assessment process. The reparative role of foster families means that assessment of the child/carer relationship as well as carer stress should be included in any assessment and treatment planning. [7].

A small study based in New Zealand by Murray et al [47] conducted semi-structured interviews with 17 foster carers in order to determine their perceived need for support and training, referenced to their estimates of burden of care. Two carer report measures, the Parenting Stress Index (PSI) and the Caregiver Behavioural Encounters Index (CBEI) were used. The findings indicated that providing day-to-day care for children in foster families places a high burden of stress on carers and requires parenting skills that are well outside the norm. Foster carers compared with parents of children in the general community report significantly more limitations in the time available for their personal needs because of the physical and mental health problems of children in their care [35].

A report by Pasztor and colleagues [48] from a National study in the United States of America looked at the role of foster parents in the health and mental health services for foster children. Reportedly, foster parents were not receiving the role clarity, training, information and support they needed to help address increasingly complex health and mental health challenges. The study included 55 foster carers who participated in a survey and follow-up focus groups. There were four major areas of concern identified by foster carers (i) the developmental, health and mental health needs of children in care; (ii) access to health and mental health services for the children, and continuity in service provision; (iii) communication challenges with case work staff and other service providers; and (iv) foster parents role limitations.
Foster carers are not always reliable informants of health concerns of children in their care [21, 49]. An Australian study by Kaltner and Rissel [21] found that carers may underestimate the health needs of children in their care at least within the first few months of placement. This provides evidence that foster carers’ evaluation of child health concerns may underestimate the health need, highlighting the necessity of child health training and support for carers.

In 2004, a study to determine if foster parents are reliable informants of foster children’s behavioural and emotional problems was conducted. The study included 47 children in long-term foster aged between 5 and 11 years. Foster carers completed the Child Behaviour Checklist (CBCL), whilst teachers completed the CBCL- Teacher Report Form (TRF). Although the sample size was small, results indicated that foster parents of children in long-term care, and teachers, demonstrated moderate to high agreement in identifying externalising problems, social-attention-thought problems and total problem behaviour of children in care. However, there was poor agreement in reporting internalizing problems such as depression, being withdrawn or excessive sleeping [49]. Therefore, carer report or questionnaires should not be used in isolation but need to be considered in the context of a broader clinical assessment and perhaps include other informants such as teachers or childcare workers.

7. Conclusion and Recommendations

Children and young people in OOHC are at an increased risk of experiencing unidentified, unmet and complex health needs. However, the current evidence available in this area is neither extensive nor conclusive. The majority of studies were largely descriptive by design. This was consistent with the literature review completed of the National Framework. Therefore, due to the lack of high quality research studies to guide clinical practice, there is a need for clinical guidelines to standardise current processes and guide practice.

The key recommendations for health assessment of children and young people in OOHC include:

i. A standardised assessment protocol
ii. A tiered assessment process that is clearly documented that facilitates progression to next level of assessment and referral on if and when required
iii. Assessment needs to be holistic, inclusive of physical, developmental, psychosocial and mental health domains
iv. Where possible, a multidisciplinary approach is beneficial
v. Foster carers are key to the assessment process, however carer report needs to be considered in conjunction with clinical assessment of the child.

There are identified gaps in the available literature and recommendations for further research include identification of health needs and health assessment process for youth in OOHC, assessment of problematic sexualised behaviour in children and young people in OOHC, further research into the health needs of Aboriginal and Torres Strait Islander children and young people in OOHC, research into methods of assessment, and cultural considerations for assessing children and young people in OOHC from culturally and linguistically diverse backgrounds. The development of clinical guidelines for health
assessments for children and young people in OOHC is an important step in facilitating further research into the health needs of this vulnerable population.

**Literature Review References:**

10 RESOURCES

List of useful resources and websites for reference:

Legislative framework and policy context for the provision of OOHC

- **Children and Young Persons (Care and Protection) Act 1998 (NSW)**
  The Children and Young Persons (Care and Protection) Act 1998 (s135, s151, s153, s156) provides the legal definitions on the types of OOHC. Chapter 16A and Section 248 relate to information exchange, Section 173 describes notice requiring medical examination

  *Ministerial Guidelines on the provision of assistance after leaving OOHC* published pursuant to Section 165(4) of the Children and Young Persons (Care and Protection) Act 1998 (the Act).

- **Memorandum of Understanding between Department of Family and Community Services, Community Services division and NSW Health on Health Screening, Assessment, Intervention and Review for Children and Young People in statutory out-of-home care**

- **NSW Standards for Statutory Out-of-Home Care**, NSW Children’s Guardian sets the NSW OOHC standards for designated agencies providing OOHC. For health related OOHC standards, there is a standard on ‘Health’ (Standard 9) and ‘Emotional and Social Development’ (Standard 8)


- **An Outline of National Standards for Out-of-Home Care 2011** Commonwealth Department of Families, Housing Community Services and Indigenous Affairs

Medicare Benefits Schedule

- **Appendix C of National Clinical Assessment Framework for Children and Young People in out-of-home care 2011**. Department of Health and Ageing provides an analysis of the capacity of existing Medicare items to meet the primary health needs of children in OOHC

  As the list of items in Appendix C is for guidance only, practitioners are advised to check full eligibility criteria at MBS online
  There may be other Medicare items that are suitable at each stage of the assessment and care of children in out-of-home care. MBS item numbers available at

- **Medicare Benefits Schedule Primary Care**. The Medicare Benefits Schedule (MBS) primary care items

- **Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative** The Better Access initiative provides better access to mental health practitioners through Medicare.
NSW Health Publications and resources

- **NSW Health Frontline Procedures for the Protection of Children and Young People (2000)**. These procedures provide direction for health staff responding to risk of harm concerns about children and young people.
  

- **Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds** (2nd Ed. NSW CAAH and NSW Transcultural Mental Health Centre, 2008) Chown, P., Kang, M., Sanci, L., Newnham, V. and Bennett, D. Adolescent Health
  


- **NSW STI Programs Unit – STI Testing Tool**
  

- **NSW Personal Health Record (‘blue book’) provides the recommended schedule of primary health screening for all children 0-5 years eg hearing, vision, immunisation, growth and development screening etc.** The book allows for documentation of the child’s growth, health and development in order to maintain their health records.
  

- **State-wide Eyesight Pre-schooler Screening Program (STEPS). The STEPS program offers all 4-year old children free vision screening.**
  

- **Statewide Infant Screening - Hearing (SWISH) Program Guideline (GL2010_002). The document sets out guidelines for the SWISH program including screening protocols and referral pathways.**
  

Other resources

- **The Guidelines for preventive activities in general practice** 8th edition (the red book) is a synthesis of evidence-based guidelines from Australian and international sources and provides recommendations for everyday use in general practice.
  

- **Australian guide to healthy eating: children and teenagers** Department of Health and Ageing, National Health and Medical Research Council
  

- **Infant Feeding Guidelines for Health Workers** Department of Health and Ageing, National Health and Medical Research Council
  

- **Helping Children with Autism Package** Department of Families, Housing, Community Services and Indigenous Affairs
  

- **Better Start for Children with Disability initiative** Department of Families, Housing, Community Services and Indigenous Affairs
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 Royal Australian and New Zealand College of Psychiatrists


Aboriginal and Torres Strait Islander resources
- National Guide to a preventative health assessment for Aboriginal and Torres Strait Islander people

  The Aboriginal Child, Family & Community Care State Secretariat (NSW) (AbSec) A peak NSW Aboriginal body providing child protection and out-of-home care (OOHC) policy advice to the government and non government sector on issues affecting Aboriginal families involved in child protection and OOHC system
  http://absec.org.au/services-we-provide/foster-care.html


Carer resources
- Connecting Carers NSW Connecting Carers NSW (CCNSW) gives Foster, Kinship and Relative Carers across NSW access to free ongoing training, education and peer support.

  Foster Care Association of NSW. The Association offers its members advocacy, peer support and information and keeps them up to date with regard to changes in the foster care system in NSW

Children and young people resources
- CREATE Foundation is a peak agency representing the voices of all children and young people in OOHC
  http://www.create.org.au/

  Charter of rights for children and young people in out of home care provides children and young people in OOHC with a clear statement of their rights and responsibilities. The Charter of Rights has been developed in two comic-style booklets for: Aged 7 – 12 years and 13 – 18 years
  http://www.community.nsw.gov.au/docs_menu/parents_carers_and_families/for_young_people/are_you_in_care(chart of rights.html
11 ACKNOWLEDGEMENTS

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Pauline Mackiewicz  Director Respite Options, Ageing Disability and Home Care
Dr Wendy Foote       Deputy CEO Association of Children’s Welfare Agencies (ACWA)
Bill Pritchard       Chief Executive, Aboriginal Child, Family and Community Care State Secretariat (NSW)
Fiona Robards        Senior Analyst, Youth Health and Wellbeing, NSW Kids and Families
Tania Skippen        A/Associate Director, Specialist Programs, MH-Children and Young People, Mental Health Drug and Alcohol Office
Robyn Bale           A/Director Student Welfare Department of Education and Communities (DEC)

Members of the Out-of-Home Care Clinical Working Group

Clare Godfrey        Clinical Program Director, Priority Populations, Sydney Children’s Hospital Network (Chair)
Dr Jackie Andrews    Paediatrician, Lismore Hospital
Lyn Biviano          Allied Health Director, Sydney Children’s Hospital Network
Stacey Black         Social Worker, Child Protection Unit, Sydney Children’s Hospital (Westmead)
Karen Booth          Vice President, Australian Practice Nurses Association
Tish Bruce           Area Director, Primary and Community Health, South East Sydney LHD
Dr Megan Chambers    Child and Adolescent Psychiatrist, Redbank House
Leanne Crittenden    Coordinator Northern Child Health Network (NCHN)
Karyn Fahy           Coordinator Western Child Health Network (WCHN)
Beth Fulton           Out-of-Home Care Advisor, Sydney Children’s Hospital Network (Westmead)
Dr Margaret Ginger   General Practitioner, Director of Medical Education WentWest
Sally Hibbert        Dental Consultant, Sydney Children’s Hospital Network (Westmead)
Dr Melissa Kang      Senior Lecturer in General Practice, University of Sydney
Margaret Kelly Coordinator, Greater Eastern Southern Child Health Network (GESCHN)
Anne McKenzie NSW Child and Family Health Nursing, CNC Network
Nick Petrovic Clinic Coordinator and Psychologist, KARI Clinic
Dr Anne Piper Consultant Paediatrician, Kaleidoscope Children’s Services, HNE LHD
Mr John Skinner A/Director, Centre for Oral Health Strategy
Tanya Schinkewitsch Senior Policy Analyst & Early Childhood Oral Health State-wide Coordinator
Tania Skippen A/Associate Director, Specialist Programs, MH-Children and Young People, Mental Health Drug and Alcohol Office
Dr Anna Stachurska Consultant Paediatrician, Child Protection Unit, Sydney Children’s Hospital (Westmead)
Prof Katherine Steinbeck Chair of Adolescent Medicine, Westmead Hospital
Dr Sue Towns Department Head, Adolescent Medicine Unit, Sydney Children’s Hospital (Westmead)
Dr Dimitra Tzioumi Consultant Paediatrician, Sydney Children’s Hospital Network (Randwick)
Sue Witherspoon Child and Family Health Nursing Association

Other Clinical Experts
Francine Eades Aboriginal Health Manager Advisor Sydney Children’s Hospital Network
Margaret Goldfinch Senior Clinical Psychologist, Alternate Care Clinic, Redbank House Western Sydney Local Health District
Robyn Lamb Allied Health Head, Child Protection Unit, Children’s Hospital at Westmead
Susan Marks Medical Head, Child Protection Unit, Children’s Hospital at Westmead
Dale Tolliday Clinical Advisor, New Street Services Sydney Children’s Hospital Network
12 REFERENCES


Hamrin V, Magorno M. Assessment of Adolescents for Depression in the Paediatric Primary Care Setting. Paediatric Nursing 2010. 36(2):103-111.


13 Attachments: Templates

Attachment 1: Sample cover letter to GP/Primary healthcare provider
Attachment 2: Out of Home Care Primary Health Screen (2A): Under 1 yr
Attachment 3: Out of Home Care Primary Health Screen (2A): 1 - 5 yrs
Attachment 4: Out of Home Care Primary Health Screen (2A): 6 - 11 yrs
Attachment 5: Out of Home Care Primary Health Screen (2A): 12 - 18 yrs
Attachment 6: Out of Home Care Comprehensive Health Assessment (2B): Under 1yr
Attachment 7: Out of Home Care Comprehensive Health Assessment (2B): 1 - 5 yrs
Attachment 8: Out of Home Care Comprehensive Health Assessment (2B): 6 - 11yrs
Attachment 9: Out of Home Care Comprehensive Health Assessment (2B): 12 - 18 yrs
Attachment 10: Out of Home Care Health Management Plan
Name of General Practitioner/ Primary Healthcare Practitioner

EMAIL:  
FAX NO:  
Date

Dear ,

Re: [name of child/young person], [Date of Birth]

Health assessment for a child/young person in Out of Home Care

Children and young people in out of home care (OOHC) often have high and unmet health needs and are more disadvantaged and vulnerable than other children in general. Thank you for agreeing to undertake a health screen/assessment for [name of child/young person].

As outlined in the “National Clinical Assessment Framework for Children and Young People in Out of Home Care” a tiered approach to assessment is recommended, including:

- A preliminary health check
- A comprehensive health and developmental assessment
- Ongoing monitoring and review

To assist in this process, please find attached the following templates to support the assessment and recording of health information:

- A Primary Health Screen template (the following age specific templates have been developed: Under 1; 0 – 5 years ; 6 – 11 years ; 12 – 18 years)
- A Health Management Plan template

Also attached for your information is [name of child/young person] known medical history. Consent has been obtained to exchange information and link this child/young person to health services.

Please record your findings on the enclosed age specific [Primary Health Screen/Health Management Plan] template or print a copy of your clinical notes and forward these to the OOHC Coordinator (contact details below) to support the provision of coordinated health care for this child/young person.

A number of Medicare items may be accessed when undertaking health checks and/or providing ongoing treatment and monitoring for children in OOHC. Further information can be found at http://health.gov.au/internet/publications/publishing.nsf/Content/ncaf-cyp-oohc-toc-ncaf-cyp-oohc-appc.

Thank you for undertaking the health assessment for [name of child/young person]. Please contact me if you have any questions on [insert details].

Yours sincerely,

Out of Home Care Coordinator  
NSW Local Health District  [Insert name of LHD]
Red flags indicate need for further assessment or Comprehensive Health Assessment (2B).

To assist with the assessment, carers have been requested to complete relevant pages in the NSW Personal Health Record ("blue book") and bring this to the appointment.

 DETAILS OF THE CHILD

Country of birth

Preferred language:

Interpreter Required: No ☐ Yes ☐

Type:

Refugee No ☐ Yes ☐

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Neither Aboriginal or Torres Strait Islander ☐

 Biological Family Health History

Child’s past and present health concerns (including pregnancy and birth information)

Medications (name, dose frequency, include medication prescribed for neonatal abstinence syndrome)

 PHYSICAL HEALTH SCREEN

Immunisation status Up to date ☐ Catch up required ☐ (Include follow-up actions on Health Management Plan)

Allergies No ☐ Yes ☐ Specify:

Issues arising from physical health screen

 PHYSICAL EXAMINATION

Length cm centile

Weight kg centile

Head circumference cm centile

Growth concerns NO ☐ YES ☐

Oral Health 'Lift the lip' check No Concerns ☐ Concerns exist ☐ (refer to oral health)

Hearing No Concerns ☐ Concerns exist ☐ (refer to audiology)

Vision No Concerns ☐ Concerns exist ☐ (refer to eye specialist)

Findings on physical examination

 DEVELOPMENTAL HEALTH SCREEN

Developmental concerns (carer and/or clinician) No Concerns ☐ Concerns exist ☐

Specify:

Ages and Stages Questionnaire No concerns ☐ Concerns exist ☐

 PSYCHOSOCIAL AND MENTAL HEALTH SCREEN

Ages and Stages: Social and Emotional Questionnaire No concerns ☐ Concerns exist ☐

Relationship to carer: No concerns ☐ Concerns exist ☐

Emotional development (sleep, routines, settling, crying, feeding, separation issues) No concerns ☐ Concerns exist ☐

 CARER CONCERNS REGARDING PLACEMENT

Carer wellbeing and capacity to meet the needs of the child/young person No concerns ☐ Concerns exist ☐

 COMPREHENSIVE ASSESSMENT REQUIRED YES ☐ Referral made to:

NO ☐ If no, please complete Health Management Plan (SMR060.720 (NH606661))

Assessment completed by:

(Name and designation)

Signature: Date:

Page 1 of 1
This form provides a guide to ensure all domains of health are addressed in the Primary Health Screen (2A). Red flags indicate the need for further assessment or Comprehensive Health Assessment (2B).

To assist with the assessment, carers have been requested to complete relevant pages in the NSW Personal Health Record (“blue book”) and bring this to the appointment.

DETAILS OF THE CHILD

Country of birth
Preferred language:
Interpreter Required: No ☐ Yes ☐
Type:

Refugee No ☐ Yes ☐
Aboriginal ☐ Torres Strait Islander ☐
Aboriginal and Torres Strait Islander ☐
Neither Aboriginal or Torres Strait Islander ☐

Biological Family Health History

Child’s past and present health concerns, including pregnancy and birth information

Medications (name, dose frequency, include medication prescribed for emotional or behavioural reasons)

PHYSICAL HEALTH SCREEN

Immunisation status Up to date ☐ Catch up required ☐ (Include follow-up actions on Health Management Plan)

Allergies No ☐ Yes ☐ Specify:

Issues arising from physical health screen

PHYSICAL EXAMINATION

Height cm centile
Weight kg centile
Head circumference cm centile
BMI (over 2 years)

Growth concerns NO ☐ YES ☐

Oral Health ‘Lift the lip’ check No Concerns ☐ Concerns exist ☐ (refer to oral health)
Hearing No Concerns ☐ Concerns exist ☐ (refer to audiology)
Vision No Concerns ☐ Concerns exist ☐ (refer to eye specialist)

Findings on physical examination

DEVELOPMENTAL HEALTH SCREEN

Developmental concerns (carer and/or clinician) No Concerns ☐ Concerns exist ☐
Specify:

Ages and Stages Questionnaire No Concerns ☐ Concerns exist ☐

PSYCHOSOCIAL AND MENTAL HEALTH SCREEN

Ages and Stages: Social and Emotional Questionnaire No Concerns ☐ Concerns exist ☐
Relationship to carer: No Concerns ☐ Concerns exist ☐
Emotional development (behaviour, routines, sleep, self-regulation, social, separation issues) No Concerns ☐ Concerns exist ☐

CARER CONCERNS REGARDING PLACEMENT

Carer wellbeing and capacity to meet the needs of the child/young person No Concerns ☐ Concerns exist ☐

COMPREHENSIVE ASSESSMENT REQUIRED YES ☐ Referral made to:

Assessment completed by: (Name and designation)
Signature: Date:

NO WRITING
Red flags indicate need for progression for further assessment or Comprehensive Health Assessment (2B).

To assist with the assessment, carers are asked to complete the Strengths and Difficulties Questionnaires (SDQ) and bring this to the appointment.

**DETAILS OF THE CHILD**

- **Country of birth**
- **Preferred language:**
  - Interpreter Required: No ☐ Yes ☐
  - Type: 
    - Refugee No ☐ Yes ☐
    - Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐
    - Neither Aboriginal or Torres Strait Islander ☐

**Biological Family Health History**

- Child’s past and present health concerns
- Medications (name, dose frequency, include medication prescribed for emotional or behavioural issues)

**PHYSICAL HEALTH SCREEN**

- **Immunisation status**: Up to date ☐ Catch up required ☐
  (Include follow-up actions on Health Management Plan)

- **Allergies**: No ☐ Yes ☐
  Specify:

**PHYSICAL EXAMINATION**

- **Height cm centile**
- **Weight kg centile**
- **Head Circumference cm centile**
- **BMI**

**Growth concerns**: NO ☐ YES ☐

- **Oral Health annual check?**
  - Completed ☐ Referral required ☐

- **Hearing**
  - No Concerns ☐ Concerns exist ☐ (refer to audiology)

- **Vision**
  - No Concerns ☐ Concerns exist ☐ (refer to eye specialist)

**Findings on physical examination**

**DEVELOPMENTAL HEALTH SCREEN**

- **Developmental concerns (Language, play skills, gross motor, fine motor, self-help, cognitive skills)**
  - Within normal limits ☐ Concerns exist ☐
  Specify:

**PSYCHOSOCIAL AND MENTAL HEALTH SCREEN**

- **Mental health diagnosis present?**
  - No ☐ Yes ☐

- **Relationship issues**: No concerns ☐ Concerns exist ☐

- **School/academic issues**: No concerns ☐ Concerns exist ☐

- **Child in a residential care placement?**
  - No ☐ Yes ☐

**EMOTIONAL DEVELOPMENT/BEHAVIOURAL CONCERNS**

- **Anxious, aggressive, emotional regulation issues**
  - No concerns ☐ Concerns exist ☐

**CARER CONCERNS REGARDING PLACEMENT**

- **Carer wellbeing and capacity to meet the needs of the child/young person**
  - No concerns ☐ Concerns exist ☐

**STRENGTHS AND DIFFICULTIES QUESTIONNAIRE**

- Complete results at http://www.sdqscore.org/
- Clinically significant difficulties No ☐ Yes ☐

**COMPREHENSIVE ASSESSMENT REQUIRED**

- YES ☐ Referral made to:
  - NO ☐ If no, please complete Health Management Plan (SMR060.720 (NH606661))

**Assessment completed by:**

- (Name and designation)
- Signature: __________________________
- Date: __________________________
Red flags indicate need for progression for further assessment or Comprehensive Health Assessment (2B). Carers are asked to bring a completed the Strengths and Difficulties Questionnaires (SDQ) to the appointment.

** DETAILS OF THE CHILD/YOUNG PERSON**

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Preferred language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee No ☐ Yes ☐</td>
<td>Interpreter Required: No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

| Type: | Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander ☐ |

Biological Family Health History

Child/Young person’s past and present health concerns

Medications (name, dose frequency, include medication prescribed for emotional or behavioural issues)

** PHYSICAL HEALTH SCREEN**

Immunisation status Up to date ☐ Catch up required ☐ (Include follow-up actions on Health Management Plan)

Allergies No ☐ Yes ☐ Specify:

Issues arising from physical health screen

** PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>Height cm</th>
<th>Weight kg</th>
<th>Head Circumference cm</th>
<th>BMI</th>
</tr>
</thead>
</table>

Physical development/growth concerns NO ☐ YES ☐ Specify:

Oral Health annual check? Completed ☐ Referral required ☐

Hearing No Concerns ☐ Concerns exist ☐ (refer to audiology)

Vision No Concerns ☐ Concerns exist ☐ (refer to eye specialist)

Findings on physical examination

**DEVELOPMENTAL HEALTH SCREEN**

Developmental concerns (School, academic, employment, cognitive development, activities of daily living) Within normal limits ☐ Concerns exist ☐ Specify:

** PSYCHOSOCIAL AND MENTAL HEALTH SCREEN**


<table>
<thead>
<tr>
<th>H - Home</th>
<th>E - Education, Employment</th>
<th>E - Eating, Exercise</th>
<th>A - Activities, Hobbies &amp; Peer Relationships</th>
<th>D - Drug Use</th>
<th>S - Sexual Activity &amp; Sexuality</th>
<th>S - Suicide, Depression &amp; Mental Health</th>
<th>S - Safety</th>
<th>Kessler 10 Score 16 or above (med/high risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No concerns ☐ Concerns exist ☐</td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

History of violence or aggression: No concerns ☐ Concerns exist ☐

** CARER CONCERNS REGARDING PLACEMENT:**

Carer wellbeing and capacity to meet the needs of the child/young person No concerns ☐ Concerns exist ☐

** STRENGTHS AND DIFFICULTIES QUESTIONNAIRE:** Complete results at http://www.sdqscore.org/

Clinically significant difficulties No ☐ Yes ☐

** COMPREHENSIVE ASSESSMENT REQUIRED YES ☐ Referral made to: NO ☐ If no, please complete Health Management Plan (SMR060.720 (NH606661))**

Assessment completed by: 
(Name and designation) 
Signature: Date:

---

Facility:

** OUT OF HOME CARE PRIMARY HEALTH SCREEN (2A): 12-18 YEARS**

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

OUT OF HOME CARE PRIMARY HEALTH SCREEN:

12-18 YEARS

FAMILY NAME | MRN
---|---
GIVEN NAME | D.O.B. _______ / _______ / _______ M.O.
ADDRESS | LOCATION / WARD

SMR060.724

OUT OF HOME CARE PRIMARY HEALTH SCREEN (2A) 12-18 years_200813.indd   1
20/08/2013   9:15:02 AM
Facility:

OUT OF HOME CARE
COMPREHENSIVE HEALTH
ASSESSMENT (2B): UNDER 1 YEAR

DETAILS OF THE CHILD

COUNTRY OF BIRTH

Preferred language:

Interpreter Required:

Yes ☐ No ☐

Type:

OUT-OF-HOME CARE (OOHC) DETAILS

TOTAL LENGTH OF TIME IN OOHC

LENGTH WITH CURRENT CARER (THIS PLACEMENT)

NO. OF PREV. PLACEMENTS

REASONS FOR ENTRY INTO OOHC

Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Neglect ☐ Domestic Violence ☐

Parental drug and alcohol use ☐ Parental mental health issues ☐

PLACEMENT HISTORY

More than one placement breakdown or unexpected placement change? Yes ☐ No ☐

Placement change due to the child’s high needs? Yes ☐ No ☐

PREGNANCY HISTORY AND BIRTH INFORMATION

NOT AVAILABLE ☐

GESTATION

Weeks

APGARS

BIRTH LENGTH

HEAD CIRCUMFERENCE

BIRTH WEIGHT

Medical complications of pregnancy and birth

BIOLGICAL FAMILY HEALTH HISTORY

(Mental Health, Developmental Disability, Learning problems, Drug/Alcohol, Genetic Concerns)

CHILD’ S PAST AND PRESENT HEALTH CONCERNS

MEDICATIONS (name, frequency, include medication prescribed for emotional/behavioural reasons)

Child Health Checks Completed (as per “blue book” schedule)

YES ☐ NO ☐

COMPREHENSIVE PHYSICAL HEALTH ASSESSMENT

IMMUNISATION STATUS

UP TO DATE ☐ CATCH UP REQUIRED ☐ (include follow-up actions on Health Management Plan)

ALLERGIES

(specify)

YES ☐ NO ☐

FEEDING CONCERNS

(specify)

YES ☐ NO ☐

OTHER FINDINGS

PHYSICAL EXAMINATION

HEIGHT

cm centile

WEIGHT

kg centile

HEAD CIRCUMFERENCE

cm centile

GROWTH CONCERNS

YES ☐ NO ☐ SPECIFY

COMMENTS

NO WRITING
**OUT OF HOME CARE COMPREHENSIVE HEALTH ASSESSMENT (2B): UNDER 1 YEAR**

**FAMILY NAME**

**MRN**

**GIVEN NAME**

**D.O.B. _______/_____/______ M.O.**

**ADDRESS**

**LOCATION / WARD**

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

<table>
<thead>
<tr>
<th>ORAL HEALTH STATUS</th>
<th>No concerns ☐</th>
<th>Under treatment ☐</th>
<th>Referral required ☐</th>
</tr>
</thead>
</table>

**COMPREHENSIVE DEVELOPMENTAL HEALTH ASSESSMENT**

**CONCERNS OR RED FLAGS NOTED IN PRIMARY 2A ASSESSMENT**

**YES ☐ NO ☐**

**EARLY DEVELOPMENTAL MILESTONES**

Within normal limits ☐ Concerns exist ☐

**COMMUNICATION**

Within normal limits ☐ Concerns exist ☐

**GROSS AND FINE MOTOR FUNCTION**

Within normal limits ☐ Concerns exist ☐

**PLAY SKILLS**

Within normal limits ☐ Concerns exist ☐

**COGNITIVE DEVELOPMENT**

Within normal limits ☐ Concerns exist ☐

**SENSORY SCREENING (HEARING AND VISION) OUTCOME**

Within normal limits ☐ Concerns exist ☐

**STANDARDISED DEVELOPMENTAL ASSESSMENT**

**ASSESSMENT TOOL**

Assessment completed by

**CLINICAL OBSERVATIONS**

**DEVELOPMENTAL FOLLOW UP REQUIRED**

**YES ☐ NO ☐**

**COMPREHENSIVE PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT**

**CONCERNS OR RED FLAGS IDENTIFIED IN PRIMARY ASSESSMENT**

**YES ☐ NO ☐**

**OBSERVATIONS OF CARER/ INFANT RELATIONSHIP (ATTACHMENT)**

**CHILD IN CURRENT PLACEMENT**

**CLINICALLY SIGNIFICANT EMOTIONAL/ SOCIAL OR ATTACHMENT CONCERNS**

**HOW WELL IS THE CARER ABLE TO MANAGE/ RESPOND TO THESE?**

**CHILD CARE ISSUES**

**QUESTIONNAIRES**

**QUESTIONNAIRE**

**PARENTING STRESS INDEX**

Yes ☐ No ☐ Clinically Significant ☐ Comments ☐

**AGES & STAGES QUESTIONNAIRE: SOCIAL EMOTIONAL (ASQ: SE)**

Yes ☐ No ☐ Clinically Significant ☐ Comments ☐

**CARERS HEALTH AND WELL-BEING**

Concerns regarding carers ability to care for this child? No Concerns ☐ Needs monitoring/concerns exist ☐

Is the carer finding the placement stressful? Yes ☐ No ☐

Is the carer asking for further support? Yes ☐ No ☐

**PSYCHOSOCIAL/ PSYCHOLOGICAL/ MENTAL HEALTH FOLLOW UP REQUIRED**

**YES ☐ NO ☐**

**ACTION REQUIRED**

Please complete Health Management Plan (SMR060.720(NH606661))

Form completed by: (Name and designation) Signature: Date:
OUT OF HOME CARE COMPREHENSIVE HEALTH ASSESSMENT (2B): 1 TO 5 YEARS

DETAILS OF THE CHILD

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Preferred language:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interpreter Required:</td>
</tr>
<tr>
<td></td>
<td>No ☐ Yes ☐ Type:</td>
</tr>
</tbody>
</table>

OUT-OF-HOME CARE (OOHC) DETAILS

<table>
<thead>
<tr>
<th>Total Length of Time in OOHC</th>
<th>Length with Current Carer (This Placement)</th>
<th>No. of Prev. Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Reasons for Entry into OOHC

<table>
<thead>
<tr>
<th>Physical Abuse</th>
<th>Emotional Abuse</th>
<th>Sexual Abuse</th>
<th>Neglect</th>
<th>Domestic Violence</th>
<th>Parental drug and alcohol use</th>
<th>Parental mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Placement History

- More than one placement breakdown or unexpected placement change? Yes ☐ No ☐
- Placement change due to the child’s high needs? Yes ☐ No ☐

Pregnancy History and Birth Information

- Gestation Weeks:
- Birth Length:
- Head Circumference:
- Birth Weight:

Medical complications of birth and infancy

Biological Family Health History

(Mental Health, Developmental Disability, Learning problems, Drug/Alcohol, Genetic Concerns)

Child’s Past and Present Health Concerns

Medications (name, dosage, frequency, include medication prescribed for emotional/behavioural reasons)

Child Health Checks Completed (as per “blue book” schedule) Yes ☐ No ☐

Comprehensive Physical Health Assessment

Concerns or Red Flags Noted in Primary Health Screen (2A) Yes ☐ No ☐

Immunisation Status

- Up to Date ☐ Catch Up Required ☐ (include follow-up actions on Health Management Plan)

Allergies (Specify)

- Yes ☐ No ☐

Dietary Concerns (Specify)

- Yes ☐ No ☐

Other Findings

Physical Examination

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>Head Circumference (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BMI

- Total centile:
- Growth Concerns Yes ☐ No ☐

Comments

No Writing
### Facility
OUT OF HOME CARE  
COMPREHENSIVE HEALTH ASSESSMENT (2B): 1 TO 5 YEARS

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIVEN NAME</td>
<td></td>
</tr>
<tr>
<td>D.O.B.</td>
<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
</tbody>
</table>

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

---

| FACILITY | OUT OF HOME CARE  
COMPREHENSIVE HEALTH ASSESSMENT (2B): 1 TO 5 YEARS |
|----------|--------------------------------------------------|

**ORAL HEALTH STATUS**

- No concerns 
- Under treatment 
- Referral required

**COMPREHENSIVE DEVELOPMENTAL HEALTH ASSESSMENT (Attach reports)**

<table>
<thead>
<tr>
<th>CONCERNS OR RED FLAGS NOTED IN PRIMARY 2A ASSESSMENT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

| EARLY DEVELOPMENTAL MILESTONES                      |     |
| SPEECH, LANGUAGE, COMMUNICATION                     |     |
| GROSS AND FINE MOTOR FUNCTION                       |     |
| PLAY SKILLS                                          |     |
| COGNITIVE DEVELOPMENT                                |     |

**SENSORY SCREENING (HEARING AND VISION) OUTCOME**

- Within normal limits
- Concerns exist

**STANDARDISED DEVELOPMENTAL ASSESSMENT**

**ASSESSMENT TOOL**

Assessment completed by

**CLINICAL OBSERVATIONS**

**DEVELOPMENTAL FOLLOW UP REQUIRED**

- YES
- NO

**COMPREHENSIVE PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT (Attach reports)**

<table>
<thead>
<tr>
<th>CONCERNS OR RED FLAGS IDENTIFIED IN PRIMARY ASSESSMENT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**OBSERVATIONS OF SEMI STRUCTURED PLAY**

**CHILD IN CURRENT PLACEMENT**

<table>
<thead>
<tr>
<th>CLINICALLY SIGNIFICANT EMOTIONAL/ SOCIAL OR ATTACHMENT CONCERNS</th>
</tr>
</thead>
</table>

**CHILD CARE ISSUES**

**QUESTIONNAIRES**

<table>
<thead>
<tr>
<th>QUESTIONNAIRE</th>
<th>COMPLETED</th>
<th>CLINICALLY SIGNIFICANT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD BEHAVIOUR CHECKLIST</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>PARENTING STRESS INDEX</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>STRENGTHS AND DIFFICULTIES QUESTIONNAIRE</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

**CARERS HEALTH AND WELL-BEING**

Concerns regarding carers ability to care for this child?

- No Concerns
- Needs monitoring/concerns exist

Is the carer finding the placement stressful?

- YES
- NO

Is the carer asking for further support?

- YES
- NO

**PSYCHOSOCIAL/ PSYCHOLOGICAL/ MENTAL HEALTH FOLLOW UP REQUIRED**

- YES
- NO

**ACTION REQUIRED**

Please complete Health Management Plan (SMR060.720(NH606661))

Form completed by:

(Name and designation)

Signature: Date:

Page 2 of 2

---
**Facility:**

OUT OF HOME CARE COMPREHENSIVE HEALTH ASSESSMENT (2B): 6 TO 11 YEARS

** Date:** 21/08/2013

**Page 1 of 2**

### DETAILS OF THE CHILD

<table>
<thead>
<tr>
<th>COUNTRY OF BIRTH</th>
<th>Preferred language:</th>
<th>Interpreter Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No ☐ Yes ☐ ☐</td>
</tr>
</tbody>
</table>

**REFUGEE** ☐

**ABORIGINAL** ☐

**ABORIGINAL & TORRES STRAIT ISLANDER** ☐

**NEITHER ABORIGINAL OR TORRES STRAIT ISLANDER** ☐

**INTERPRETER:** No ☐ Yes ☐ ☐

**TYPE:** ☐

**OUT-OF-HOME CARE (OOHC) DETAILS**

<table>
<thead>
<tr>
<th>TOTAL LENGTH OF TIME IN OOHC</th>
<th>LENGTH WITH CURRENT CARER (THIS PLACEMENT)</th>
<th>NO. OF PREV. PLACEMENTS</th>
</tr>
</thead>
</table>

**REASONS FOR ENTRY INTO OOHC**

- Physical Abuse ☐
- Emotional Abuse ☐
- Sexual Abuse ☐
- Neglect ☐
- Domestic Violence ☐
- Parental drug and alcohol use ☐
- Parental mental health issues ☐

**PLACEMENT HISTORY**

- More than one placement breakdown or unexpected placement change? Yes ☐ No ☐
- Placement change due to the child’s high needs? Yes ☐ No ☐

**PREGNANCY HISTORY AND BIRTH INFORMATION**

- Medical complications of birth and infancy

**BIOLOGICAL FAMILY HEALTH HISTORY**

(Mental Health, Developmental Disability, Learning problems, Drug/Alcohol, Genetic Concerns)

**CHILD’S PAST AND PRESENT HEALTH CONCERNS**

**MEDICATIONS** (name, dosage, frequency, include medication prescribed for emotional/behavioural reasons)

**Child Health Checks Completed** (as per “blue book” schedule)

**YES** ☐ **NO** ☐

**COMPREHENSIVE PHYSICAL HEALTH ASSESSMENT**

**CONCERNS OR RED FLAGS NOTED IN PRIMARY HEALTH SCREEN (2A)**

- **IMMUNISATION STATUS**
  - Up to date ☐
  - Catch up required ☐

- **ALLERGIES** (specify)
  - Yes ☐ No ☐

- **DIETARY CONCERNS** (specify)
  - Yes ☐ No ☐

**OTHER FINDINGS**

**PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>cm centile</th>
<th>WEIGHT</th>
<th>kg centile</th>
<th>HEAD CIRCUMFERENCE</th>
<th>cm centile</th>
</tr>
</thead>
</table>

**BMI**

- Total centile

**GROWTH CONCERNS**

Yes ☐ No ☐

**COMMENTS**

**ORAL HEALTH STATUS**

- No concerns ☐
- Under treatment ☐
- Referral required ☐

**NO WRITING**
## OUT OF HOME CARE COMPREHENSIVE HEALTH ASSESSMENT (2B): 6 TO 11 YEARS

### COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GIVEN NAME</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>D.O.B.</th>
<th>M.O.</th>
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<tbody>
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<tr>
<td>_______ /</td>
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</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>LOCATION / WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**COMPREHENSIVE DEVELOPMENTAL HEALTH ASSESSMENT**

**Concerns or red flags noted in primary 2A assessment**

<table>
<thead>
<tr>
<th>Category</th>
<th>Within normal limits</th>
<th>Concerns exist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early developmental milestones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech, language, communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross and fine motor function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self help skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory processing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sensory screening (hearing and vision) outcome**

- Within normal limits [ ]
- Concerns exist [ ]

**Standardised developmental assessment**

**Assessment tool**

- Assessment completed by [ ]

**Clinical observations**

**Developmental follow up required**

- Yes [ ]
- No [ ]

**Comprehensive psychosocial and mental health assessment**

**Concerns or red flags identified in primary assessment**

- Yes [ ]
- No [ ]

**Observations of semi-structured play**

**Child in current placement**

- Clinically significant emotional/ social or behavioural concerns [ ]

**How well is the carer able to manage/ respond to these?**

**Child care issues**

**Questionnaires**

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Completed</th>
<th>Clinically significant</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child behaviour checklist</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td></td>
</tr>
<tr>
<td>Teacher report form</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td></td>
</tr>
<tr>
<td>Parenting stress index</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td></td>
</tr>
<tr>
<td>Other (list)</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td></td>
</tr>
</tbody>
</table>

**Carers health and well-being**

- Concerns regarding carers ability to care for this child? [ ]
- Needs monitoring/concerns exist [ ]

- Is the carer finding the placement stressful? [ ]
- No [ ]

- Is the carer asking for further support? [ ]
- No [ ]

**Psychosocial/ psychological/ mental health follow up required**

- Yes [ ]
- No [ ]

**Action required**

- Please complete Health Management Plan (SMR060.720(NH606661))

Form completed by: [ ]

Signature: [ ]

Date: [ ]

Page 2 of 2
Facility:

OUT OF HOME CARE COMPREHENSIVE HEALTH ASSESSMENT (2B): 12 TO 18 YEARS

DETAILS OF THE CHILD/YOUNG PERSON

COUNTRY OF BIRTH

Preferred language: 
Interpreter Required: No ☐ Yes ☐ Type:

REFUGEE ☐ ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ ABORIGINAL & TORRES STRAIT ISLANDER ☐ NEITHER ABORIGINAL OR TORRES STRAIT ISLANDER ☐

OUT-OF-HOME CARE (OOHC) DETAILS

TOTAL LENGTH OF TIME IN OOHC

LENGTH WITH CURRENT CARER (THIS PLACEMENT)

NO. OF PREV. PLACEMENTS

REASONS FOR ENTRY INTO OOHC

Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Neglect ☐ Domestic Violence ☐ Parental drug and alcohol use ☐ Parental mental health issues ☐

PLACEMENT HISTORY

More than one placement breakdown or unexpected placement change? YES ☐ NO ☐
Placement change due to the child/young person’s high needs? YES ☐ NO ☐
Child/young person in residential placement? YES ☐ NO ☐

PREGNANCY HISTORY AND BIRTH INFORMATION

NOT AVAILABLE ☐

BIOLOGICAL FAMILY HEALTH HISTORY

(Mental Health, Developmental Disability, Learning problems, Drug/Alcohol, Genetic Concerns)

CHILD/YOUNG PERSON’ S PAST AND PRESENT HEALTH CONCERNS

MEDICATIONS (name, dosage, frequency, include medication prescribed for emotional/behavioural reasons)

Child Health Checks Completed (as per “blue book” schedule) YES ☐ NO ☐

COMPREHENSIVE PHYSICAL HEALTH ASSESSMENT

CONCERNS OR RED FLAGS NOTED IN PRIMARY HEALTH SCREEN (2A) YES ☐ NO ☐

IMMUNISATION STATUS

UP TO DATE ☐ CATCH UP REQUIRED ☐ (include follow-up actions on Health Management Plan)

ALLERGIES (SPECIFY) YES ☐ NO ☐

DIETARY CONCERNS (SPECIFY) YES ☐ NO ☐

DRUG AND ALCOHOL USE

OTHER FINDINGS

PHYSICAL EXAMINATION

HEIGHT cm centile WEIGHT kg centile HEAD CIRCUMFERENCE cm centile

BMI

Tanner Stage (Girls - Breasts; Boys-Genitalia) 1 2 3 4 5

PHYSICAL/DEVELOPMENTAL CONCERNS YES ☐ NO ☐

COMMENTS

ORAL HEALTH STATUS

No concerns ☐ Under treatment ☐ Referral required ☐

NO WRITING
### OUT OF HOME CARE

**COMPREHENSIVE HEALTH ASSESSMENT (2B): 12 TO 18 YEARS**

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIVEN NAME</td>
<td></td>
</tr>
<tr>
<td>D.O.B.</td>
<td>M.O.</td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
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</tbody>
</table>

**LOCATION / WARD**

**Holes Punched as per AS2828.1: 2012**

### COMPREHENSIVE DEVELOPMENTAL HEALTH ASSESSMENT (Attach reports of assessments)

<table>
<thead>
<tr>
<th>CONCERNS OR RED FLAGS NOTED IN PRIMARY 2A ASSESSMENT</th>
<th>YES ☐</th>
<th>NO ☐</th>
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</thead>
<tbody>
<tr>
<td>DEVELOPMENTAL MILESTONES</td>
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<tr>
<td>ACADEMIC HISTORY</td>
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<tr>
<td>SPEECH, LANGUAGE, COMMUNICATION</td>
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<td>SCHOOL CONCERNS</td>
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<td>ACTIVITIES OF DAILY LIVING</td>
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<td>EMPLOYMENT CONCERNS</td>
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<td>COGNITIVE DEVELOPMENT</td>
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<tr>
<td>SENSORY SCREENING (HEARING AND VISION) OUTCOME</td>
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<tr>
<td>STANDARDISED DEVELOPMENTAL/COGNITIVE/PSYCHOMETRIC ASSESSMENTS (Attach reports)</td>
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<td>ASSESSMENT TOOL</td>
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<tr>
<td>CLINICAL OBSERVATIONS</td>
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<tr>
<td>DEVELOPMENTAL FOLLOW UP REQUIRED</td>
<td>YES ☐</td>
<td>NO ☐</td>
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<tr>
<td>COMPREHENSIVE PSYCHOSOCIAL AND MENTAL HEALTH ASSESSMENT (Attach reports)</td>
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</tr>
<tr>
<td>CONCERNS OR RED FLAGS IDENTIFIED IN PRIMARY ASSESSMENT</td>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
<tr>
<td>KESSLER 10 PSYCHOLOGICAL ASSESSMENT</td>
<td>LOW OR NO RISK (10-15) ☐</td>
<td>MEDIUM RISK (16-29) ☐</td>
</tr>
<tr>
<td>STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ): Complete results at <a href="http://www.sdqscore.org/">http://www.sdqscore.org/</a> Clinically significant difficulties</td>
<td>YES ☐ NO ☐</td>
<td></td>
</tr>
<tr>
<td>HEEADSSS ASSESSMENT</td>
<td>H - Home ☐ E - Education, Employment ☐ E - Eating, Exercise ☐ A - Activities, Hobbies &amp; Peer Relationships ☐ D - Drug Use ☐ S - Sexual Activity &amp; Sexuality ☐ S - Suicide, Depression &amp; Mental Health ☐ S - Safety ☐</td>
<td></td>
</tr>
<tr>
<td>TEACHER REPORT FORM Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER QUESTIONNAIRES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL STATE OBSERVATIONS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARERS HEALTH AND WELL-BEING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns regarding carers ability to care for this child/young person?</td>
<td>No Concerns ☐</td>
<td>Needs monitoring/concerns exist ☐</td>
</tr>
<tr>
<td>Is the carer finding the placement stressful?</td>
<td>YES ☐ NO ☐</td>
<td></td>
</tr>
<tr>
<td>Is the carer asking for further support?</td>
<td>YES ☐ NO ☐</td>
<td></td>
</tr>
<tr>
<td>PSYCHOSOCIAL/ PSYCHOLOGICAL/ MENTAL HEALTH FOLLOW UP REQUIRED</td>
<td>YES ☐ NO ☐</td>
<td></td>
</tr>
<tr>
<td>ACTION REQUIRED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please complete Health Management Plan (SMR060.720(NH606661))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form completed by: Form completed by: Signature: Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 2 of 2
OUT OF HOME CARE HEALTH MANAGEMENT PLAN

Date child or young person entered out of home care:

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander ☐

Cultural / Religious Background: Preferred Language: Interpreters Required: Yes ☐ No ☐

This Health Management Plan developed following:

Primary Screen (2a) ☐ Comprehensive Health Assessment (2b) ☐

Date Primary (2a) Screen completed:

Comprehensive Assessment (2b) required: Yes ☐ No ☐

Date Comprehensive Assessment (2b) completed: Yes ☐ No ☐

Date this Health Management Plan will be reviewed on:

(Minimum of 6 monthly for children under 5 years and annually for children / young people over 5 years or as clinically indicated)

Within 6 months Review Date: _______________________

Within 12 months Review Date: _______________________

Other (based on clinical assessment) Review Date(s): _________________________________________________

ASSESSMENTS THAT INFORM THIS HEALTH MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>Type of Assessment conducted (e.g. medical/physical, developmental, speech, mental health)</th>
<th>Date conducted</th>
<th>Assessment Conducted by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Name</td>
</tr>
</tbody>
</table>

OUT OF HOME CARE HEALTH MANAGEMENT PLAN

NH606661   Out of Home Care Health Management Plan_190813.indd   1
19/08/2013   2:54:32 PM
### OUTCOMES FOLLOWING ASSESSMENT AND TARGETED INTERVENTIONS

<table>
<thead>
<tr>
<th>Health Issue(s) identified</th>
<th>Actions and Tasks required (eg referral to specialist)</th>
<th>By whom (Name, designation contact details)</th>
<th>Timeframe for completion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Additional notes/comments:**

---

**WHO PARTICIPATED IN THE DEVELOPMENT OF THIS HEALTH PLAN?**

- Did the child or young person participate in the development of this Health Management Plan: **Yes □ No □**
- Did the carer participate in the development of this Health Management Plan: **Yes □ No □**

**Other Participants:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation (if applicable)</th>
</tr>
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<tbody>
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**HEALTH MANAGEMENT PLAN PREPARED BY:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
<th>Designation:</th>
<th>Signature:</th>
<th>Date:</th>
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