Out-of-Home Care (OOHC) Health Pathway: A guide for Caseworkers – June 2022

Overview

The OOHC Health Pathway is a joint initiative of the Department of Communities and Justice (DCJ) and NSW Health aimed at ensuring that every child or young person entering statutory out-of-home care (OOHC) receives timely and appropriate **health, assessment, planning, services and ongoing review of their health needs.**

DCJ and PSP service provider caseworkers play an essential role in improving the health and wellbeing of children and young people through implementing the OOHC Health Pathway. This guide is designed to help Service Providers to implement the OOHC Health Pathway. DCJ caseworkers are able to access information about implementing the Health Pathway through the DCJ *Health Needs of Children in OOHC* Practice Mandate for caseworkers.

Why is the health of children and young people in OOHC important?

Research indicates that children and young people in OOHC have increased levels of unmet health need, compared with their peers. A child or young person's experience of abuse and trauma prior to entering care can significantly impact on their physical, developmental, and psychological health and wellbeing.

All caseworkers have a responsibility to respond to children's health needs and create opportunities to promote good physical and mental health so they can reach their potential. This will increase children's prospects and wellbeing into adulthood.

What is the OOHC Health Pathway?

The OOHC Health Pathway was established in 2010 to improve health outcomes for children and young people in statutory OOHC in NSW. The Pathway is a joint initiative of the Ministry of Health and DCJ and is underpinned by a Memorandum of Understanding (MoU) between both departments establishing the roles and responsibilities across the two sectors. The MoU is currently being reviewed by DCJ and the Ministry of Health.

The OOHC Health Pathway aims to improve health outcomes for children and young people in OOHC through the provision of:

- **Referral** – DCJ completes a health referral to place the child/young person on the OOHC Health Pathway
- **Initiating Health Assessment** –The OOHC Health Coordinator gathers relevant available health information regarding the child or young person.
- **Health assessment**

  All children and young people will receive:

The 2A – primary health assessment of their physical, developmental and mental health

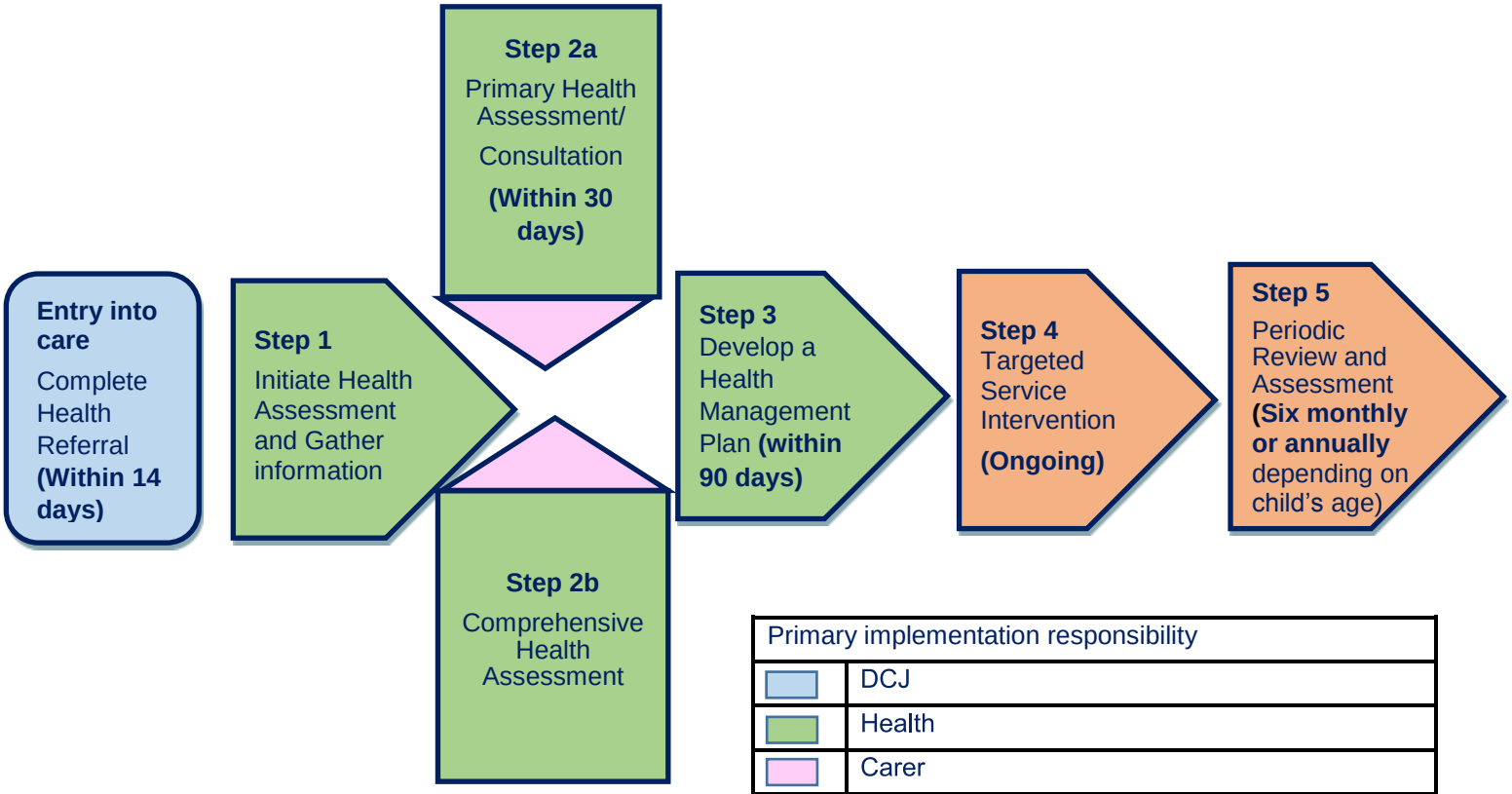
Some children and young people will receive:

The 2B – comprehensive health assessment depending on the outcome of their primary assessment where issues may have been identified for follow-up

- **Planning** – all children on the Pathway will receive a Health Management Plan which is a record of their health assessments and the services they require
- **Implementation** – OOHC Health Coordinator, caseworker, carers and birth parents (as appropriate) will work with the child/young person to obtain health services
- **Review** – should be initiated by the caseworker and occur at a minimum of six months for children under five and annually for children over five.

The Pathway is supported by an **OOHC Health Coordinator** employed in each local health district who is responsible for coordination of the health assessment, planning and review process. The key stakeholders that are responsible for implementing the Pathway include **the child or young person's caseworker, the OOHC Health Pathway Coordinator, other health practitioners, carers, birth parents and the child/ young person.**

This diagram shows an overview of the OOHC Health Pathway steps and their time frame for implementation. The diagram has been colour coded to show which stakeholders have primary implementation responsibility.



Primary implementation responsibility	
	DCJ
	Health
	Carer
	All stakeholders including NGO Service Provider or DCJ, carers, birth parents and children and young people

For PSP Service Providers the OOHC Health Pathway forms part of the Permanency Case Management Policy and the PSP Program Level Agreement.

Implementation of the OOHC Health Pathway also supports attainment of the NSW Child Safe Standards 8 and 9 for permanent care.

Who is eligible to participate on the OOHC Health Pathway?

To be eligible to participate in the OOHC Health Pathway children and young people must be in **statutory OOHC** and the **Minister must have parental responsibility for the aspect of the child's health.** Parental responsibility can be either **interim or final.**

Until recently, the OOHC Health Pathway has only been open to children and young people who entered statutory OOHC after 2010. Recently eligibility for the Pathway has been extended to allow for children/young people with a significant health need to be referred regardless of when they entered care. If a caseworker is unsure whether a child or young person that they are working with is eligible to be placed on the Pathway, they should contact their OOHC Health Coordinator to find out.

Young people that entered care prior to 2010 must be placed on the Pathway when they turn 15 years if they were not placed on the Pathway when they first entered care. It is important to remember that young people will need to provide their consent to participate on the Pathway.

Children and young people in Intensive Therapeutic Care (ITC) should also participate in the OOHC Health Pathway. The OOHC Health Coordinator and ITC Therapeutic Specialist should work together to avoid duplication of health assessment, planning and service provision.

Working with your OOHC Health Coordinator to implement the Pathway

Each local health district employs an OOHC Health Coordinator. The OOHC Health Coordinator is responsible for coordinating the Pathway process including the assessments that will occur and development of a Health Management Plan for a child or young person.

The way that OOHC Health Coordinators implement the OOHC Health Pathway in their local health district may differ depending on the resources available to them.

The contact details for your local OOHC Health Coordinator are available on the DCJ website. In most instances Health and DCJ Districts align but sometimes they do not. You can use the link below to check the Health District that a child lives in:

https://www.google.com/maps/d/viewer?mid=1Dv1JRTGmzlm83tBv7tb8vQcOQXY&ll=-33.811946892811505%2C151.40889702566142&z=9

Remember to contact your OOHC Health Coordinator if you have any questions about implementing the OOHC Health Pathway. The Coordinator can give you lots of resources and advice to help meet the child's health needs.

Steps of the OOHC Health Pathway and caseworker implementation responsibilities

Key Step	Description including the role of the caseworker in implementation
Referral	• DCJ completes the OOHC Health Pathway referral form and emails it to the OOHC Health Coordinator within **14 days** of the child's entry into statutory care so that their health needs can be identified and addressed as soon as possible. • If a Service Provider finds that a child or young person was not referred to the Pathway when they entered care they can complete the OOHC Health referral form. However, they cannot sign the back, this must be done by a DCJ Manager Casework or above before it is provided to the OOHC Health Coordinator. The local Child Family District Unit (CFDU) can provide more advice about this to Service Providers and help them access the form if needed via the DCJ internet. • The caseworker should explain the following to the child/young person as part of the referral process: ○ why they are being referred to the Pathway ○ how their participation will help to keep them healthy during their time in care ○ that if they demonstrate sufficient maturity to make their own decision regarding participation they must give their written consent. The child/young person does this by signing the referral form (note this is generally considered to be from age 14, though in some instances may be younger as advised by a medical practitioner) • The caseworker should explain the purpose of the Pathway to the carer and make sure that they understand their role in implementation e.g. taking the child/young person to appointments, implementing Health Management Plan recommendations. Provide the carer with the factsheet OOHC Health Pathway: A Carer's Guide • The DCJ caseworker should email the referral form to the OOHC Health Coordinator and save in ChildStory.
Step 1: Initiating health assessment and gathering information	• The OOHC Health Coordinator and their team will gather relevant information to undertake a health assessment.
Step 2A: The 2A-Primary Health Assessment	• The 2A or primary health assessment is undertaken for all children/young people in care by a primary health practitioner e.g. a General Practitioner, Child and Family Health Nurse, Youth Health Nurse or Aboriginal Medical Service. It should be undertaken within 30 days of the child/young person entering care and will include: physical examination, growth and development check, vision, hearing, mental health, dental screen, immunisation status review and nutrition. • The OOHC Health Coordinator will organise the 2A or primary health assessment and advise the carer of the details.

Key Step	Description including the role of the caseworker in implementation
	There is no need for caseworkers to organise separate – vision, hearing, pediatrician assessments for children/young people • It is not necessary for caseworkers to organise separate eyesight or hearing tests for children/young people as their vision and hearing will be assessed through their primary health assessment. The annual or six-monthly health review process should determine whether there are newly presenting issues with a child/young person's vision or hearing. • If a health professional identifies concerns with a child or young person's eyesight or hearing during the 2A assessment process they should refer them to an appropriate practitioner for a full assessment. • A child or young person will be referred to a pediatrician through the OOHC Health Pathway if required. It is not a requirement for caseworkers to organise an independent pediatrician assessment. **Caseworkers should support the 2A or Primary Health Assessment by:** • Reminding the carer to bring the child's Personal Health Record (Blue Book for 0-5 year old children). • Attending the appointment with the carer, birth parent (if appropriate) and child or young person where possible. • Saving any communication about the primary health assessment provided by the OOHC Health Coordinator into ChildStory or their organisation's record management system e.g. this could include: ○ an email from the Coordinator to indicate that the 2A assessment has occurred ○ copy of the 2A/primary assessment report from the health practitioner ○ other reports such as prenatal birth summary OOHC Health Coordinators may not necessarily provide caseworkers with a copy of the 2A primary health assessment or advise that it has occurred. Provision of this depends on how their district implements the Pathway.
Step 2B: The 2B-Comprehensive Health Assessment	• For some children and young people, the primary health assessment will identify that a 2B or comprehensive assessment should occur. This assessment may involve a range of health practitioners and appointments for assessment of physical, development, psychosocial, and/or mental health. The OOHC Health Coordinator or their team will coordinate the comprehensive health assessment. **Caseworkers should support the 2B or Comprehensive Health Assessment by:** • Checking with carers to ensure they know about and attend relevant appointments. • Saving copies of reports from health specialists after an assessment has occurred in ChildStory/their organisation's record management system.

Key Step	Description including the role of the caseworker in implementation
	• Providing the OOHC Health Coordinator with any assessment reports if they have been undertaken in the private health system as the Coordinator will not have access to these.
Step 3: Development of a Health Management Plan	• The OOHC Health Coordinator or team member will develop a Health Management Plan for the child/young person. The plan is a record of their health needs identified through their primary and comprehensive assessments and the services recommended to address these. The Health Management Plan should be developed within 90 days of the child/young person entering statutory care. **Caseworkers should support the Health Management Planning process by:** • Participating in the planning process if requested by the OOHC Health Coordinator and encouraging participation by children/young people, carers and birth parents were appropriate. • Saving the Health Management Plan in ChildStory/ or the organisation's record management system. • Ensuring key recommendations are incorporated into the health domain of the child/young person's case plan. If the Health Management Plan is not ready in time for integration into the child or young person's case plan, then incorporate findings from the Plan into their next case plan review. • Integrating other aspects of the Health Management Plan into the planning processes that occur for children/young people, this could include their care, cultural and personalised learning and support planning. • Giving a copy of the Health Management Plan to the child/young person's carer, birth parent if appropriate and make sure they are aware of the actions they will need to implement.
Step 4: Targeted Service Intervention	**Caseworkers are responsible for implementing the Health Management Plan** • Implementation of the Health Management Plan should occur in partnership with the OOHC Health Coordinator, other health practitioners, the carers, birth parents (were appropriate) and the child or young person. **Obtaining health services for children and young people:** • The health services that children require should be included in their Health Management Plan. These services could be provided by a general practitioner or health practitioner with a specialisation, for example, a speech therapist, physiotherapist, dentist, optometrist, psychologist or psychiatrist. The caseworker is also responsible for organising access to the National Disability Scheme or Early Childhood Early Intervention if this is required by the child or young person. • The OOHC Health Coordinator can provide the caseworker with more advice about specific health services available through the local health district for children and young people and how they operate.

Key Step	Description including the role of the caseworker in implementation
	• Wherever possible health services should be obtained through a **publically-funded health provider**. Where extraordinary services or supports are required that cannot be provided through the public health system or provided in a timely fashion, caseworkers should seek these through private providers. For children in DCJ managed placements, caseworkers should request contingency funds to cover costs. For children/young people in service provider managed placements services would be funded through the Child Needs Package, or if the issues the child/young person is experiencing are very complex, through application to the Complex Needs Payment. **Obtaining health services for Aboriginal children and young people:** • In some local health districts, elements of the OOHC Health Pathway are delivered by Aboriginal Community Controlled Health Services. This includes access to Aboriginal Medical Services and Aboriginal Health staff. • The OOHC Health Coordinator will be able to provide the caseworker with more information about services in their local health district that are available to meet the needs of Aboriginal children and young people in care. Information about Aboriginal Health Services operating in NSW can also be found on Australian Indigenous HealthInfoNet.

Step 5: Periodic Review and Assessment	• A child or young person in OOHC requires periodic health reviews and assessments in order to ensure that their Health Management Plan is being implemented and that it is effectively addressing their health needs. In addition, new and emerging health issues can also be identified during reviews and incorporated into the HMP.
	
	The caseworker is responsible for ensuring the Health Management Plan is reviewed by the OOHC Health Coordinator or by a health practitioner
	
	• Health Management Plan reviews should occur for:
	  ○ Children under the age of five years every six months.
	  ○ Children and young people over the age of five every 12 months.
	
	• Health Management Plans should also occur for:
	  ○ Children and young people with emerging needs that require a health assessment
	  ○ After a child or young person experiences a significant event (e.g. placement change, change in health condition)
	
	The caseworker should undertake the following to have the Health Management Plan reviewed:
	
	• Contact their local OOHC Health Coordinator and request that they review the Plan.
	
	If the OOHC Health Coordinator advises that they do not have capacity to review the Plan because of resource constraints they will advise the caseworker and provide advice about how to get the plan reviewed.

Key Step	Description including the role of the caseworker in implementation
	This advice may include that the caseworker use the relevant 2A Primary Health Assessment Form as a guide for review of the Health Management Plan. These forms are available on the DCJ website and are age specific. It is important that caseworker's do not design their own assessment forms and that the 2A form is always completed by a health practitioner. • Save the 2A form on ChildStory or your organisation's record management system and provide to the OOHC Health Coordinator to update the child/young person's Health Management Plan. • Ensure issues identified through the review are investigated and followed up. Request that the GP or health professional who reviewed the Plan organise referral(s) to be made to appropriate follow-up services or ask the OOHC Health Coordinator to make recommendations when they update the Plan.

Supporting young people preparing to leave care

The OOHC Health Pathway also includes a focus on young people aged 15-18 years. The process ensures that young people undertake an age appropriate health assessment. They will also have a Health Management Plan developed that includes strategies to increase their health literacy and their transition to adult health services.

The caseworker and OOHC Health Coordinator can support one another and discuss the following with young person before they leave care:

- ✓ Obtaining Medicare and Health Care Cards and providing information on their use
- ✓ My Health Record - information on what it is and how to access
- ✓ Prescriptions – Do they know how to fill?
- ✓ Private health insurance and health service costs
- ✓ Finding a GP who is accessible, affordable and culturally safe for medical concerns and referrals
- ✓ NDIS – is help to access needed?
- ✓ Advice on how to find health information e.g. websites, directories
- ✓ Information on how to find local health services, including promoting continuity of care and service provider if possible – especially for GP.
- ✓ How to access and pay for dental, optical, hearing, sexual health care
- ✓ Information on how to access to specialist health services such as youth health service, mental healthcare, drug and alcohol
- ✓ Consent to current assessment and sharing of information, including confidentiality

Advising the OOHC Health Coordinator when a child or young person's details change

An important part of implementing the OOHC Health Pathway is ensuring that the OOHC Health Coordinator is kept informed of any changes to a child or young person's details. The type of changes that are especially important for an OOHC Health Coordinator to know about include those related to the child or young person's

- Placement/carers
- Case management responsibility
- Legal status

OOHC Health Coordinators need this information so that they are aware of which children and young people should be on the Pathway in their district and can work effectively with caseworker's and carers to meet their health needs.

The caseworker should advise the OOHC Health Coordinator of a change of detail for a child/young person by completing the Change of Details form and emailing it to them. Service providers can access this form through the DCJ website. Caseworkers should save a copy of this form in ChildStory or their Record Management System.

Exiting a child/young person from the OOHC Pathway when they leave care

Children and young people should be discharged from the OOHC Health Pathway when they leave statutory care. This may occur as they have been restored to their parents, through adoption, guardianship or because of turning 18 years of age.

The caseworker should:

- Complete the Change of details form to advise the OOHC Health Coordinator that there has been a change in the child or young person's legal status and that they are no longer in care.
- Provide a copy of the Health Management Plan to the parent, guardian and make sure they understand how to meet the child/young person's health needs.

The OOHC Health Coordinator should:

- Exit the child/young person from the Pathway and update their medical records including the details of who can provide consent for their medical treatment.

If a child/young person re-enters care DCJ will need to refer them again to the OOHC Health Pathway. This is because they may have experienced violence, abuse or neglect that needs to be considered in a health assessment or have other health concerns.

Meeting the health needs of children/young people not eligible to participate on the OOHC Health Pathway because of when they entered care

A small number of children/young people will not be eligible to be on the Pathway because they entered care prior to 2010 and do not have significant health need. These children would also be aged under 15, because from this age onwards all children are eligible to be on the Pathway regardless of when they entered care.

If a child or young person in OOHC is not able to be placed on the Pathway, it is still important that they receive timely assessment, intervention, monitoring and review of their health needs. This can be done by utilising some of the tools used as part of the Pathway without the direct involvement of the District OOHC Health Coordinator.

The caseworker should:

- Use the OOHC Primary Health Assessment (2A) Form to determine the child's health needs. The form should be given to a GP or health practitioner to complete
- Follow up identified health issues through appropriate referrals made by the GP
- Incorporate health issues and actions identified from the 2A primary health assessment into the child/young person's case plan
- Continue to review the child/young person's health needs by using the 2A assessment

For further information:

See link to online learning module about the OOHC Health Pathway:

https://rise.articulate.com/share/b3Zb5JSk2GDs-CnWOzFQnCL2JrLQmMOS

See DCJ website: https://www.facs.nsw.gov.au/providers/children-families

Includes:

- **2A health assessment forms for specific age groups**
- **Current list of OOHC Health Coordinators**
- **My Health Record factsheets for caseworkers, carers, birth parents and young people**
- **Medicare processes for children and young people entering care**
- **Medical and Dental Consent Tool**

For questions about implementation of the OOHC Health Pathway or meeting the health needs of children in care email permanency.support@facs.nsw.gov.au