



19 March 2010

The Australian Association of Social Workers (AASW) is the key professional body representing professional social workers in Australia. It is also the accrediting body for all tertiary social work programs in Australia and also for the assessment of overseas qualified social workers. The AASW is a member of the National Primary Health Care Partnership (NPHCP).

We are delighted that as part of the National Framework for protecting Australia's children, Government is looking across portfolios and looking for expertise outside the normal sphere of organisations with an interest in child wellbeing and protection.

We have responded to the invitation to submit feedback using the template provided, and have in addition provided some extra points here.

Practical Barriers

The AASW notes certain practical barriers to adequate national standards for health checks in OOHHC. These include:

1. Foster Carers not receiving adequate information about child's health history – eg allergies, medications, Medicare cards. If the child is in short term or crisis care, it can take considerable time to obtain Medicare cards, blue books, immunisation history, etc, which prevent the delivery of good health care including health checks. A set of required documents should be available to foster carers as soon as practicable.
2. Caseworkers not having adequate training to recognise and discuss health issues that should be communicated to foster parents. Caseworkers need to have ongoing training and have access to more experienced staff. Children can come into care with limited medical information and considerable time can pass before a child has a medical examination.
3. Foster carers not being given significant information or information not clear on file notes - for example we are told of a case of a child in NSW who had been diagnosed with foetal alcohol syndrome who demonstrated significant behavioural disturbance, but the diagnosis was not recognised by the caseworker as it was unclear in the file notes, and so was not

communicated to the foster carers. The Senior Caseworker found the information in file some years later and child was referred to a paediatrician who made appropriate diagnosis and referrals – the child had had significant placement disruption by this time.

4. Consent of Director General or representative needs to consent for certain medical treatment such as anaesthetic and psychotropic drugs if the child is in the parental responsibility of the Minister - whilst this is in the best interests of the child it needs to be streamlined particularly in emergency situations. (This is the situation in NSW, and we assume that other States / Territories have similar requirements for similar medical procedures but have not had the opportunity to research this fully).
5. Approval for dental and other procedures such as counselling and psychometric testing that will cost more than \$500 can take considerable time and foster carers may wait sometime before the approval is granted. (Again, this is the case in NSW and likely to be repeated in other jurisdictions).

Leaving OOHC

There are also particular issues for young people transitioning out of OOHC into the community. There is considerable evidence that young people leaving OOHC are more likely than others to face multiple health disadvantages, including poor mental and physical health, early pregnancy and parenthood, and drug and alcohol use and misuse. (Mendes, Moslehuddin and Goodard, 2008). This evidence indicates that particular policy responses are required to address the multiple support needs of this group of young people, and health checks can be part of an integrated support service to ease the transition from OOHC into the community.

We acknowledge that the National Standards paper briefly refers to “transition planning that involves children and young people (into, during and exiting care)” on p.3, after care on p.8, and providing opportunities for more gradual transition from care and providing ongoing support particularly for those with mental health needs on p.18.

We would argue that the National Standards need to incorporate three key parameters concerning transitions from care:

1) A clear structure for providing ongoing support to care leavers based on levels of maturity and skill development rather than age

Care authorities should aim to approximate the ongoing and holistic support that responsible parents in the community typically provide to their children after they leave home till at least 25 years. The international research summarized by Stein (2008) argues that three key reforms are required to improve outcomes for care leavers: improving the quality of care, a more gradual and flexible transition from care, and more specialized after-care supports.

The first reform is improving the quality of care as positive in-care experiences involving a secure attachment with a supportive carer are essential in order to overcome damaging pre-care experiences of abuse or neglect. This involves providing stability and continuity, an opportunity if at all possible to maintain positive family links which contribute to a positive sense of identity, assistance to overcome educational deficits and holistic preparation. Foster care placements, small children's homes and residential care with a therapeutic orientation appear to be most successful in addressing young people's emotional and educational needs.

The second component is the transition from care which includes both preparation for leaving care, and the actual moving out from the placement into transitional or half-way supportive arrangements from approximately 16-21 years. An effective leaving care model would arguably include a flexible and functional process for transitioning from care based on levels of maturity and skill development rather than simply age, assistance with accessing and maintaining affordable and stable accommodation, help with renegotiating relationships with family members and to develop wider informal support networks and friendship groups, access to adequate health care including ongoing therapeutic support if necessary to overcome experiences of abuse and trauma, programs of parent support for young mothers, subsidies to undertake higher education, supported employment programs, and financial assistance to access appropriate furniture and household items and pay advance rent and bond if necessary.

The third component is ongoing support after care till approximately 25 years of age. This may involve a continuation of existing care and supports and/or specialist leaving care services in areas such as accommodation, finance, education and employment, health and social networks. The research evidence suggests that effective after-care interventions can facilitate 'turning points' that enable young people to overcome the adverse emotional impact of earlier traumatic experiences.

- 2) **A national legislative framework that provides for consistent and minimum uniform leaving care standards in the states and territories**
- 3) **Establishment of a national data base** similar to that of the UK freely available on the internet which will allow us to monitor care leavers, and measure outcomes in key areas such as education, employment, health, housing, parenthood, substance use, social connections, and involvement in crime.

Please see the attached response using the template provided for specific responses to the consultation questions.

Kind regards

Kandie Allen-Kelly
AASW CEO

References:

Mendes Philip, Moslehuddin, Badal, and Goddard, Chris, "Improving the physical and emotional health of young people transitioning from state out-of-home care", *Developing Practice*, No.20, Summer/Autumn 2008, pp.33-40.

Mendes, Philip, "Young people transitioning from out-of-home care: A critical analysis of Australian and international policy and practice", *Australian Social Work*, Volume 62, No.3, 2009, pp.389-403.

Mike Stein and Emily Munro (eds.) *Young People's Transitions from care to Adulthood: International Research and Practice*. Jessica Kingsley, London, 2008.

National Clinical Assessment Framework for Children and Young People in OOHC

AASW response to the Discussion Paper

March 2010



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Recommendations

The AASW recommends that the following changes be made to the Framework:

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Response to consultation questions

Consultation question	AASW response
1. Should the Framework identify specific measures that are appropriate for these diverse groups or should all measures identified be appropriate to all population groups? (Page 11)	There should be a minimum standard, but some flexibility to allow for difficulties that Rural and remote, ATSI and Disabled children and carers might have in accessing assessment services. If these groups are shown not to be able to achieve the time frames, more resources can be added.
2. Are the three key domains for assessments the right areas to focus on? Should mental health be a domain in its own right or continue to be combined with psychosocial health? (Page 11)	Increasingly the research shows that a baby's ability and style of emotional regulation indicates the kind of care they have received and their future mental health. Under psychosocial health, "self regulation" is mentioned. It is crucial and underlies all other development, so should be fleshed out some more and given more prominence.
3. Should the Framework be prescriptive on the areas to be addressed for each assessment or provide guidance on the areas to be addressed and their applicability for the type of assessment being conducted? (Page 13)	Provide guidance only. Practitioners' professional expertise should be allowed. Too much prescription curtails involvement and energy.
4. Does the tiered approach provide the right structure for assessments? What other models can be identified? (Page 15)	Tiered approach is a logical model. The importance of the assessors' relationship to the child is mentioned elsewhere. One model would be to identify particular professionals who are good at relating to children and direct most assessments to them where possible. Rather than only relying on appointments to be made by geography only.



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<p>5. How frequently should repeat assessments be conducted? Should the Framework including specific timings or should the implementation of the Framework be flexible to allow practitioners to determine the need and timing of assessment on a case by case basis? (Page 17)</p>	<p>Minimum standard for Repeat Primary Health assessments should be conducted 3 monthly for children under 2. 6 monthly for children under 5 and yearly for children after that, given that school settings can also pick up and notice the need for follow up sooner.</p>
<p>6. Should the Framework be prescriptive on the tools to be used for each assessment or provide guidance on the range of tools available and their applicability for this group? (Page 21)</p>	<p>Certain assessment tools should be standard. It will be helpful to have a generalised data base across Australia, for the individual child to be compared against as well as for national planning and evaluation. Should not be penalised if eg. rural and remote areas do not have qualified assessors though.</p>
<p>7. Should the Framework be prescriptive on which clinician, health professional or health worker should undertake the assessments or be more flexible? (Page 22)</p>	<p>Should be a list of possible assessors, but need some flexibility. Perhaps all those approved as Medicare Mental Health Care Providers could be included. Remote areas may not have mental health nurses, so general nurses might need to be included in those areas.</p>
<p>8. How should the results of the assessments and any follow up care be documented? The Framework proposes preparation of a health plan for each child or young person entering out of home care. (Page 24)</p>	<p>The idea of a health passport which the child carries with them is important. This hand held record needs to be treated as valuable as the child moves. Electronic records that protect privacy but allow sharing of health records are important also.</p>
<p>9. How should implementation of the Framework be monitored and evaluated? (Page 25)</p>	<p>Perhaps a central data base where the completion of the health checks is recorded as they are done. This would allow geographical areas having difficulty keeping to the time frame to be identified and resourced.</p> <p>The accessibility of health information as the child moves is important. Could this be tied into the Commonwealth Govts identity number system? Trialled with kids in OOHc?</p>



Other issues

[Note: Please identify any other issues deemed relevant to the ongoing development of the Framework or delete as appropriate]



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