GUIDELINE	
Children in Care – managing referrals for assessment	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS

This document should be read in conjunction with this DISCLAIMER

Aim

To enable community health staff to meet legislative and departmental requirements for referral management within the health care planning pathway for children in care (CIC).

Risk

Failure to follow this guideline may result in a:

- child's health / developmental needs not identified or addressed in a timely manner
- failure to meet performance indicators.

Key Points

- Children in care are a group at high risk of poor physical, developmental and psychosocial health outcomes.
- The Department of Communities Child Protection and Family Services (CPFS) Chief Executive Officer (CEO) assumes parental responsibility for most children in care as described in the Children and Community Services Act 2004.This means that for those children, the CEO delegates authority to a case manager, in lieu of a parent, to provide consent, and develop and implement a child's care plan.
- Health assessments inform the health component of the child's care plan, comprise the physical, developmental and psychosocial domains of health and wellbeing and are reviewed annually.
- Community health staff will support the CPFS case managers and carers to be responsive to, and plan for, the health needs of children in care.
- The best interests of the child are the paramount consideration. Healthcare planning should be a collaborative process between the child, CPFS case manager, carer (if appropriate) and most appropriate health service provider.
- The health service system in WA is complex and CPFS case managers and the child's carer need to be informed and supported to enable a child in care to access the appropriate service.
- Difficulties in communication with a CPFS case manager will be escalated to the relevant CPFS team leader as required. See *Guidelines for Protecting Children 2020* for further information.

- If a Nurse is aware that a child in care is overdue for a health assessment, the nurse can advocate for further action from CPFS.
- Nurses must inform CPFS, via the relevant case manager, regarding any concerns, decisions and/or consent for referrals, and provide all relevant information pertaining to the child's assessment or referral.
- Nurses should follow up with CPFS to ensure that actions or referrals arising from the comprehensive assessment have been actioned.
- Children in Care should be placed on the relevant Client of Concern list, with any actions and or referrals arising from their CIC assessment noted, to ensure adequate follow up.

Background

Children who come into care are traumatised and vulnerable. Children are entering care at a younger age and staying in care for longer[1]. Aboriginal[*] children are over-represented, currently constituting 55% of children in care in WA[2]. Most commonly, children enter care as a result of emotional abuse or neglect[1]. Family and domestic violence, mental health issues and drug and alcohol misuse are significant contributing factors, as are intergenerational trauma and social disadvantage[3, 4]. The impact of these factors can persist resulting in children having complex health needs and being at high risk of poor physical, developmental and psychosocial health outcomes[5, 6]. Opportunistic health care is an inadequate long term solution to meeting the chronic and complex health needs of these children.

The National Clinical Assessment Framework for Children and Young People in Out-of-Home Care 2011[7] (children in out-of-home care are known as "children in care" in WA) is aligned under the National Framework for Protecting Australia's Children 2009-2020[8]. The former Framework describes the scope and focus of health assessments for children in care according to specified age groups.

The Act [9] is the legal framework guiding the protection and care of children in WA. CPFS administers the Act and is the key government organisation providing child safety and family support services. The Act requires children in care to have a care plan which identifies their needs while they are in care, and outlines measures to address those needs.

The healthcare planning pathway for children in care is informed by *Guidelines for Protecting Children* 2020, *Bilateral Schedule between the Department for Child Protection and Family Support and WA Health for collaborative responses to: child abuse and neglect identified by WA health; and children in care*[10], the *Level 1 Strategic Bilateral MOU between WA Health and Department for Child Protection 2011-2015*[11], *Schedule Between the Department for Child Protection and Family Support and WA Health Care Planning for Children in Care (January 2015)*[12] and *Joint guidelines on information sharing between WA Health and CPFS*[13].

CPFS and WA Health are signatories to the Cabinet endorsed Rapid Response framework[14], which prioritises access to services for a child in the CEO's care. The Schedule[12] states that all health service providers should prioritise services on the basis of clinical need and acknowledges children in care have high needs.

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[*] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Role of Department of Communities Child Protection and Family Support

CPFS is responsible for the wellbeing of children in care in WA[3]. The Chief Executive Officer (CEO) assumes parental responsibility for most children in care as described in the Act. In practice for those children, the CEO delegates authority to give consent, and develop and implement a child's care plan, to a case manager, in lieu of a parent.

In most cases consent for the provision of health services must be obtained from CPFS before the service is provided. Where the CEO does not have responsibility for a child under the Act, or an agreement under a negotiated placement agreement to provide consent on behalf of a child who is not a mature minor, consent from the person with parental responsibility for that child needs to be sought by the case manager (see Information Sharing, Communication and Consent).

CPFS must ensure each child in care has a care plan which identifies their needs across nine areas of care planning, including health needs, and outline measures to address those needs. The CPFS case manager is responsible for developing and implementing a child's care plan. This includes responsibility for making decisions regarding any medical or dental examination, treatment or procedure on behalf of the child (The Act; S29(2) and 29(3A))[9]. A child's appointed carer is responsible for their day to day physical and emotional care, including universal child health schedule contacts (see CAHS *Consent for Services* operational policy).

Role of Community Health Staff

Children in care will have been exposed to a range of adverse experiences[1, 15], and are at high risk of health and developmental vulnerability[5, 6]. For this reason, Health Service Providers should prioritise undertaking comprehensive health assessments and health care planning to identify and address any health and development concerns.

For a child new to the CEO's care, the health assessment will be undertaken **within 30 business days** (6 weeks) of either Child and Adolescent Health Service - Community Health (CAHS-CH) or WA Country Health Service (WACHS) receiving a completed referral from CPFS[12]. For all other children in the care of CPFS, the timeframe to undertake the assessment will be based on clinical need, acknowledging that children in care have high needs[12], and availability of resources. Community health staff will aim to complete annual assessments **within 30 business days** (6 weeks) of receiving a completed referral.

Community health staff must send a report on the assessment outcomes **within five business days** (1 week) of the assessment. This report must be **written in a way that may be understood by a lay person** with a focus on a child's health needs, priorities and actions required to inform the development of a 12 month health care plan. The report must also identify the consequences for the child if the recommendations are not followed.

Community health staff must liaise with relevant parties and implement strategies which will produce the best outcome for the child. This may include **liaising with the child, the child's case manager, carer, other health service providers, teacher, student service team and others** who may have information about the child's physical, developmental and or psychosocial wellbeing. Obtaining information from multiple sources is important to corroborate information or identify inconsistencies which may highlight areas of concern.

The development of the health plan is intended to be a collaborative process between a child's case manager and those health professionals informing the plan. Community health

staff may be consulted to support this process, as CPFS staff may not have a health background and their knowledge of the health system may be limited.

Community health staff may also be asked to support CPFS case managers in identifying an appropriate health service provider for a child, particularly where they assess the child's health needs would be better managed by an alternative provider.

The Healthcare Planning Pathway

The Schedule[12] to the Strategic Bilateral Memorandum of Understanding between CPFS and WA Health[11] (referred to as "the Schedule") outlines the joint processes and procedures between CPFS and providers of community health services to support provision of health assessments and health care planning for a child in the CEO's care, where entities and contractors of the WA Health system are the service providers.

The Health Care Planning Pathway describes a multi-agency model for the management of the health needs of children in care through coordinated, regular health assessments which inform and review a child's health care plan. In order that a child's current and emerging health needs are identified the health assessment must be holistic; addressing the physical, developmental and mental health domains. CPFS is responsible for identifying when a child in care requires a health assessment through their case review cycle.

The pathway comprises three phases:

- **Initial Medical Assessment:** a General Practitioner (GP) or Paediatrician provides screening and preliminary assessment of the child's health and wellbeing to identify and treat any immediate health concerns. In the case of a newborn, a recent paediatric review such as at hospital discharge may be substituted for an Initial Medical Assessment.
- **Comprehensive Health Assessment:** a health care provider, most commonly community health nurses or a GP, provides a more in depth assessment across each health domain.
- **Annual Review:** a health care provider, most commonly a nurse or GP, provides ongoing monitoring of a child's health needs to ensure current and emerging health issues and required actions are identified. Each child's health care plan should be reviewed annually by a health care provider, using a comprehensive health assessment form as a guide. However, the frequency of monitoring different components of the assessment should be a clinical decision for each individual and have both case-dependent and age-dependent considerations. The depth of the assessment should be appropriate for the age, risk factors, clinical needs and any major changes in circumstances of the child at the time of assessment.

All processes in the health care planning pathway must focus on the best interests of a child in care and include:

- A child centred, age appropriate and culturally respectful assessment process.
- Effective information sharing and collaboration between community health staff and CPFS.
- Engagement of children in the assessment process. Wherever possible, their views on their own health and wellbeing is invited and taken into account. Children are kept informed of matters that affect them, according to their age and capacity to understand

and consent to a service. Their rights to confidential health care and issues of consent must be acknowledged, discussed (including the limits of confidentiality) and respected.

- Engagement of carers, considering their views and, where appropriate, sharing information with them. Carers can be invited to support a child by attending assessment appointments (where age appropriate), provide information to help identify areas of concern for a child and be made aware of any health issues and requirements.
- Acknowledgement of issues of trauma and associated effects on physical health, development, social and emotional wellbeing, and educational outcomes. These are considered holistically rather than in isolation.
- Continuity of health care providers to allow relationships to develop. Maintenance of this relationship supports the ongoing health needs of a child. If a child already has a relationship with a particular primary care provider, then that relationship is utilised in health care planning assessments wherever possible. A carer's preference for a particular health care provider is also considered.
- Utilisation of standardised, evidence-based screening and assessment tools wherever appropriate/practicable in assessments.

Groups of children in care with special considerations for their health care pathway

1. **Children from a culturally and linguistically diverse background (CaLD)**: There are a number of considerations needed in meeting the health needs of these children, such as whether an interpreter service is required, gender of the health assessment provider, use of culturally appropriate screening tools and assessments, an understanding of trauma experienced prior to (such as war) or since moving to Australia (e.g. social isolation), and specific physical health considerations such as potential exposure to communicable diseases.
2. **Aboriginal children**: More than 55 per cent of children in care in Western Australia are Aboriginal[2]. It is important to determine whether the child/carer would prefer for the health care planning health assessments be completed by an Aboriginal service provider.
3. **Children with a disability**: Children in care with a diagnosed disability may be engaged with disability-specific services. Although a child may already be under the care of a health team, the case manager should discuss health care planning assessments with current health providers to ensure all aspects of the child's health care are being addressed, such as immunisation or oral health care. The process of assessment through this pathway may lead to some children becoming eligible for disability services.
4. **Newborns**: Where a child is taken into provisional protection and care at birth their immediate health needs will have been addressed in discharge planning processes as outlined in the *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as At Risk of Abuse and/or Neglect* (OD 0518/14). Health care planning assessments therefore need to align with these arrangements, and involve those professionals already engaged in the care of the newborn. A recent paediatric review may be accepted for new to care referrals in lieu of an Initial Medical Assessment.

Information Sharing, Communication and Consent

The information sharing protocols that support the Schedule[12] and this guideline are outlined in the *Joint guidelines on the mutual exchange of relevant information between WA Health and the CPFS*[13] for the purpose of promoting the wellbeing of children.

The method for sharing information between community health staff and CPFS staff is bound by organisational policies[11]. In health care planning:

- CPFS policy is to email all referrals and supplementary information.
- Community health staff must communicate all confidential information, including health assessment information, to CPFS in accordance with the Department of Health (DoH) *Information Security Policy* (MP 0067/17). My File Transfer / My File eXchange (MyFT/MyFT) allows for encrypted electronic transfer of confidential information. Confidential information should not be sent via unencrypted email.
- DoH *Guidelines for the Transmission of Personal Health Information by Facsimile Machine* (IC0179/14) requires nurses to notify the case manager or CPFS District Office if the report is being sent by fax, or follow up to ensure the report has been received.
- In the first instance, communications should be with the CPFS case manager. The CPFS team leader should be contacted when a case manager is not contactable. Contact details are provided on the CPFS Form 510.

Consent for health assessments is given by the person who has parental responsibility for decisions made on behalf of the child. Where CPFS does not have parental responsibility to provide consent, the case manager will obtain consent from a person who has parental responsibility. In the case of a child assessed as a mature minor, he or she can provide consent on their own behalf to assessment, treatment and release of confidential information[4]. See CAHS-CH *Consent for services* policy.

Process

A child's CPFS case manager will make a referral for a comprehensive health assessment, either for a child new to care or as an annual review, by completing and sending CPFS Form 510. This referral form provides background information on the child, contact details for the carer, CPFS case manager and CPFS team leader, and consent to receive services and share information. Refer to CAHS-CH *Consent for Services* policy for further information on consent requirements.

The system for managing referrals from CPFS requesting CIC comprehensive health assessments by CAHS-CH or WACHS (see Appendix A) relies on two main points of coordination:

- **Central Referrals Administration:** The Central Referrals Administration (CRA) receives ALL comprehensive health assessment referrals from CPFS case managers state-wide for community health services in WA. It screens referrals for completeness of required information, not clinical information. If information is incomplete CRA returns the referral to CPFS for completion. Complete referrals are then allocated to CIC Key Contacts. The CRA manages the central email address for CIC referrals, DOH.CICreferrals@health.wa.gov.au
- **CIC Key Contact:** The CIC Key Contact provides a point of contact and coordination for the local area management of the healthcare planning pathway for children in care

within WA. Each CIC Key Contact will review and allocate CIC referrals within their health service area to community health nurses who then conduct the assessment. The CIC Key Contact also liaises with the local CPFS District Office staff regarding comprehensive health assessment referrals.

Appendix B outlines the key steps in the process for CIC Key Contacts managing CIC referrals.

Steps	Additional Information
Receive referral **CAHS-CH:** Each CIC Key Contact has a list of CIC referrals in the CDIS. A notification will be sent by email once a referral has been allocated to a CIC Key Contact. **WACHS:** Each CIC Key Contact monitors a CIC email account for their local area. All CPFS comprehensive health assessment referrals are sent to these email accounts by the CRA. All children (0-18 years) who are in the care of CPFS require a *child at risk alert* to be entered into webPAS, which flows through to Community Health Information System (CHIS) automatically. Refer to the WACHS *Child at Risk Alert* procedure for more information.	Alert flags are generated automatically by Child Development Information System (CDIS) for children in care when CRA enter the referral. No comprehensive health assessment referrals are to be accepted directly from CPFS or another CIC Key Contact (except where this occurs through reassignment in CDIS). Return to sender and request the referral is sent to: DOH.CICreferrals@health.wa.gov.au Permission to access local CIC email accounts must be approved by logging an IT request using the HFN_030 form. Set up instructions can be obtained from the CRA or Health Support Services.
Review referral • Review the suitability of community health services to provide the assessment by considering identified health needs and other current, or previous, service providers. • Identify missing health information on each child's referral and follow-up with the CPFS case manager. • If the child attends a school not receiving services from CAHS-CH or WACHS, contact the child's case worker to discuss whether an assessment may be provided in another setting, or whether the assessment needs to be provided by an alternative service provider, such as a GP. • A special request for an assessment to	To promote continuity of care, if a child has ongoing medical or health needs which are currently managed by another service provider, and that service provider is able to provide a comprehensive health assessment, the referral should be returned directly to the CPFS case manager with a recommendation to forward the referral to that provider. This is particularly applicable to: • children with a CaLD background • newborns, infants and children who have health needs being monitored/ managed by a paediatrician or general practitioner • children with disabilities, chronic or complex medical issues • Aboriginal children who have previously

Steps	Additional Information
be conducted outside the normal annual review cycle should be considered where there is, or will be, a significant change to a child's circumstances which may affect the management of their health needs e.g. reunification with parents. • Where a referral is received less than nine months after the last assessment, query the reason with the child's CPFS case manager prior to accepting or declining the referral. **Aboriginal children** **CAHS-CH:** if the child is under 5 years of age, ask whether the carer would prefer to receive an assessment from the Aboriginal Health Team (AHT) or another Aboriginal Health/Medical Service. If the AHT is nominated, assign the referral to the AHT CIC Key Contact in CDIS. If a different Aboriginal health service is nominated, decline the referral in CDIS, compose the decline referral letter including the name of the preferred service provider, and provide directly to CPFS case manager. **WACHS:** The child's health assessment may be provided by WACHS Community Health Services or a partner agency, according to local and contractual arrangements.	accessed another Aboriginal health/medical service. Knowledge of previous service providers may come from previous contact with the child or may be contained in the Service Summary section in CDIS (CAHS-CH). If there is no information on previous service providers, the referral should be allocated to a CHN who will then establish if there is a preferred service provider when contacting the carer.
Accept and allocate Considerations for allocation: • Prioritise on the basis of clinical need and service availability. • Priority is given to referrals for children new to care who require an assessment within 30 working days of the referral being accepted. **CAHS-CH:** Allocate through CDIS each accepted referral directly to a nurse, or assign to an alternative Nurse Manager (including CIC Key Contact for the AHT) for allocation to a nurse. **WACHS:** Allocate each accepted referral to a nurse. Record the name of the nurse and	Allocation is guided by additional factors such as the child's age, where the child resides or goes to school and previous assessment provider/s. Referrals may be allocated to a nurse in a child health setting (0-4.5 years), in a school setting (4-18 years), a generalist nurse or Remote Area Nurse as available, taking into consideration resourcing and competencies. **School holidays** School health services vary during holiday periods. It is the responsibility of the CIC Key Contact to develop and maintain a local process for managing CIC referrals during school holidays according to local resources.

Steps	Additional Information
date the referral was allocated in the CIC referral register. CIC referral is scanned to CHIS and documented under clinical item – “Administration Client Review”. A child’s CPFS case manager must be notified of any foreseeable delay in allocation or assessment.	
Decline referral If the referral is not accepted for assessment the CPFS case manager must be notified.	**CAHS-CH:** Document the reason for decline in CDIS if the nurse has not already done so. Print the decline referral letter and provide directly to CPFS case manager. **WACHS:** Return the referral to the CPFS case manager stating the reason for decline.
Manage The CIC Key Contact: • provides a local coordination point between the CRA, nurses and CPFS case manager for referrals allocated to their area, and • monitors their local referral list to ensure timely assessments. **WACHS:** Clinical Nurses Specialists maintain oversight of the regional CIC referral register.	The CIC Key Contact provides support to nurses conducting a comprehensive health assessment and attends to enquiries from CPFS.
Close record Close the referral record in the relevant list or register.	**CAHS-CH:** Key Contact or Nurse Manager will open and review the CIC Active List in CDIS. When the referral status is “Report Printed” for applicable referrals, the Key Contact or Nurse Manager will check for a CNP record for the report provided to the CPFS case manager (service type: CIC Report sent to DCPFS (CIC only)). If complete, close the referral. **WACHS:** The local area’s CIC referral register will be updated with: • date referral allocated • name of CHN • date assessment completed • date report forwarded to CPFS • comments or information • whether the child in care is Aboriginal • if no assessment, reason and date

Steps	Additional Information
	referral returned to CPFS.

Community Health Nurse

The role of the community health nurse is to provide comprehensive health assessments as requested though the referral process. Refer to the CAHS-CH *Children in Care – conducting an assessment* procedure.

Documentation

Community health staff must keep a record of the comprehensive health assessment referral form, CAHS-CH or WACHS and CPFS consent documents for individual assessments and the Health Improvement Plan/Report forwarded to CPFS. All documentation regarding children in care must be completed using minimal medical terminology and no shorthand, as the information reported will be read, interpreted and recorded elsewhere by CPFS staff who may not have a health system background or clinical training.

Monitoring

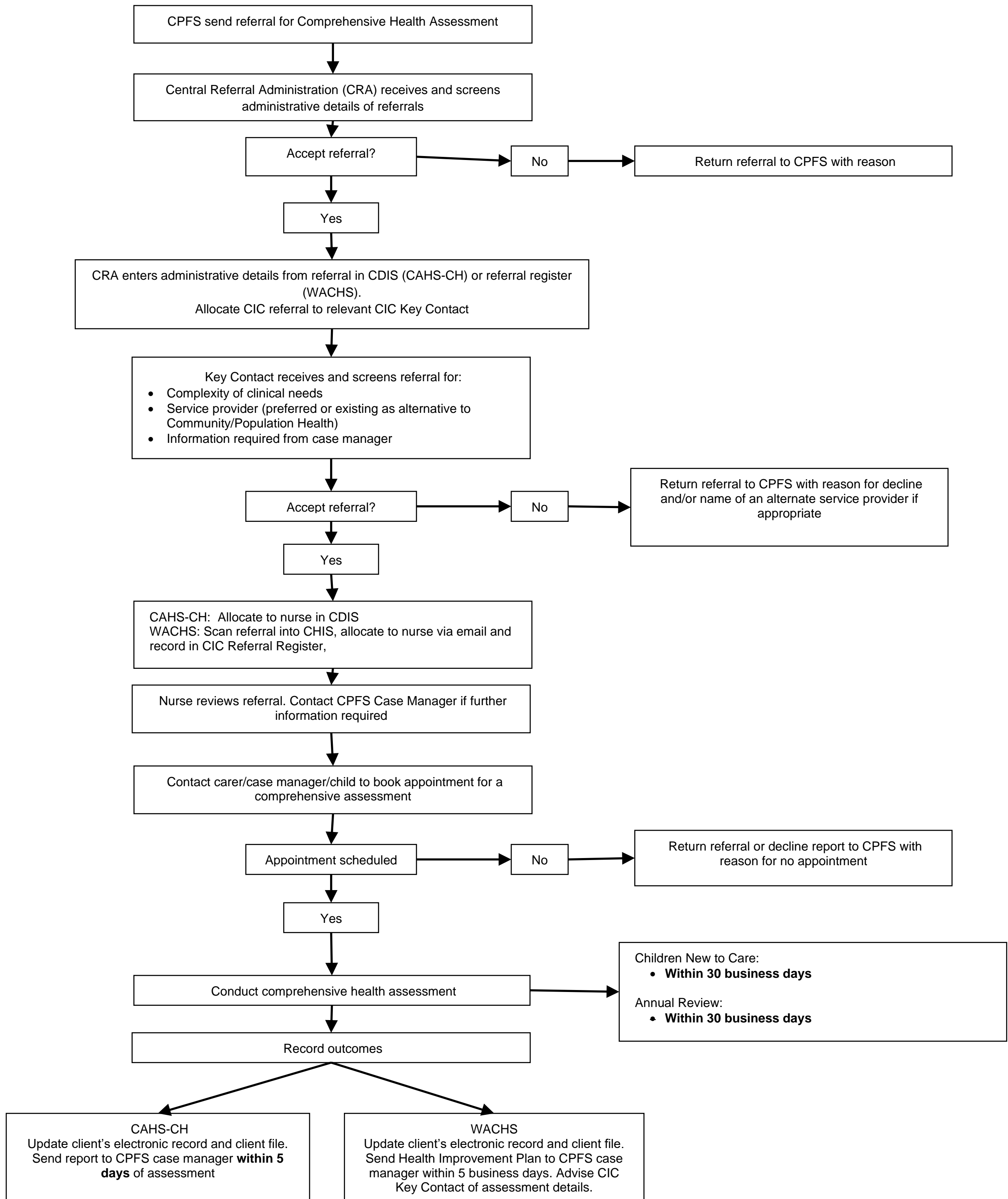
- Assessments for children new to care will be undertaken within 30 business days of receipt of a completed referral from CPFS.
- Annual reviews will be undertaken within 30 business days of receipt of a completed referral from CPFS.
- The report will be sent to CPFS within 5 business days of completing the assessment.

Appendices

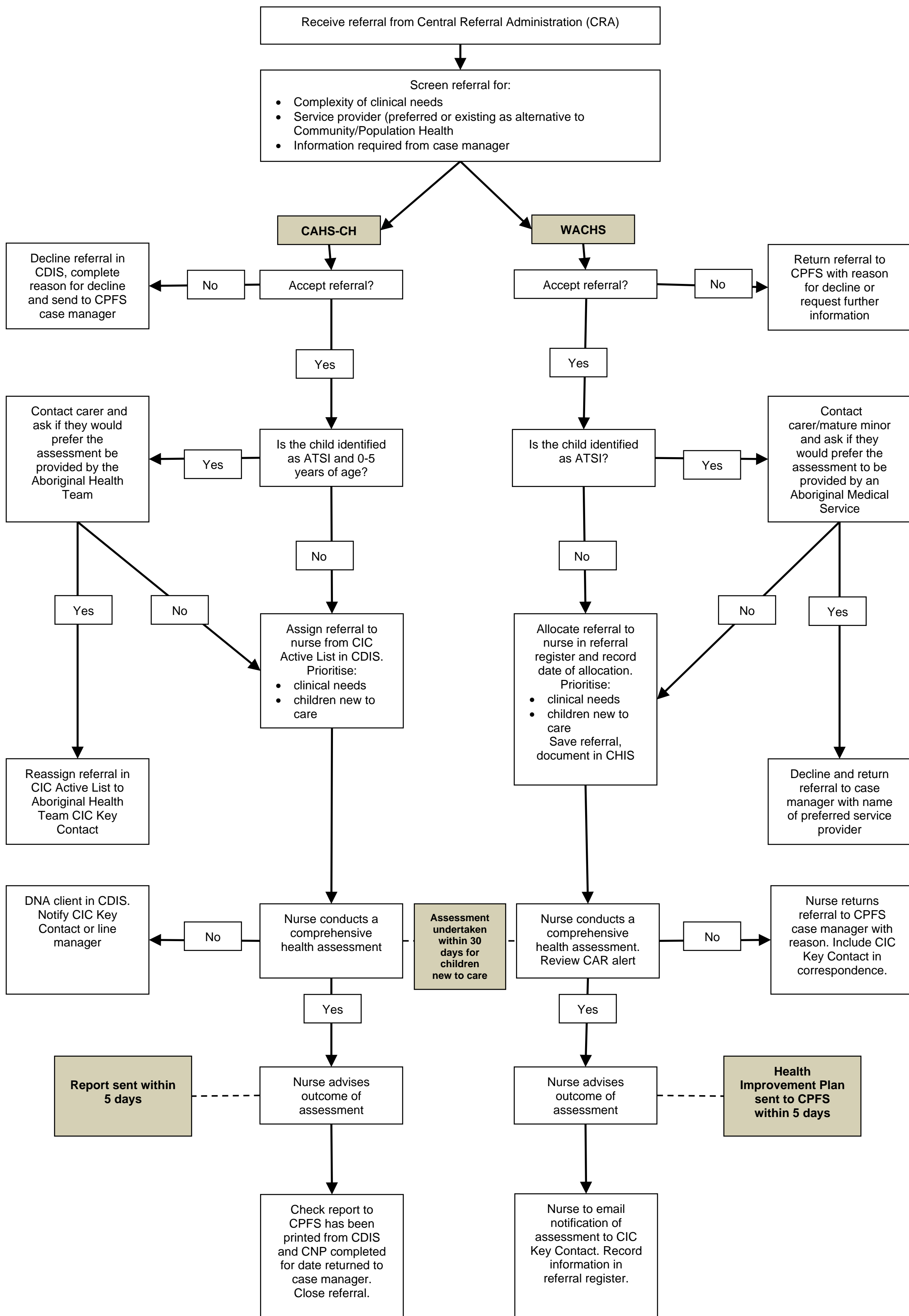
Appendix A: Overview of community health CIC referral for assessment management process

Appendix B: CIC Key Contact referral for assessment management process

Appendix A
Overview of community health CIC referral for assessment management process



Appendix B
CIC Key Contact referral for assessment management process



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14. Department of Communities. Rapid Response: Prioritising services for children and young people in care. 2019.
15. Western Australian Department of Communities. Child Protection Activity Performance Report 2017-2018. Perth, Western Australia; 2018.

Related policies, procedures and guidelines

The following documents can be accessed in the **Clinical Nursing Manual** via the HealthPoint link, or the Internet link or for WACHS staff in the WACHS Policy link

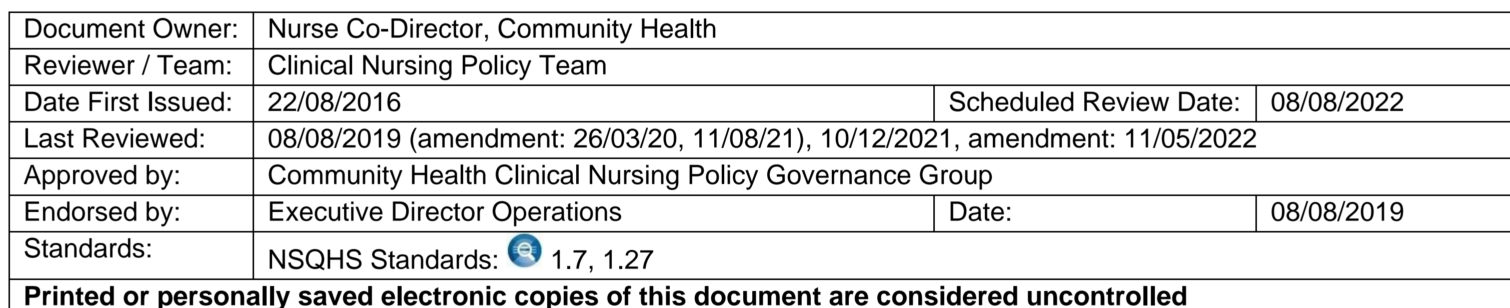
Children in Care – conducting an assessment

The following documents can be accessed in the CAHS-CH Operational Manual

Client Record Transfer
Consent for Services
The following documents can be accessed in WACHS Policy
WebPAS Child at Risk Alert
The following documents can be accessed in the CAHS Policy Manual
Child Safety and Protection
The following documents can be accessed in the Department of Health Policy Frameworks
Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as At Risk of Abuse and/or Neglect (OD 0518/14)
Guidelines for the Transmission of Personal Health Information by Facsimile Machine (IC0179/14)
Information Security policy (MP0067/17)

CAHS-CH CDIS tip sheets
eHFN_030 form
Guidelines for Protecting Children 2020
My File Transfer / My File eXchange

This document can be made available in alternative formats on request for a person with a disability.



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