# Out-of-Home Care Health Pathway Program

May 2025

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# Health needs of children in Out-Of-Home Care (OOHC)



Children in OOHC are likely to have unmet, undiagnosed and complex health needs

The Pathways of Care Longitudinal Study (POCLS) shows, children in OOHC are more likely than their peers to present with a cognitive delay or a mental health concern

Children in OOHC continue to face barriers when accessing health services and achieving continuity of care

# Creation of the Out-of-Home Care Health Pathway Program





Established in 2010, the Out-of-Home Care Health Pathway Program is a joint initiative between DCJ and NSW Health to deliver timely health assessment, planning and health service navigation and intervention to children where Parental Responsibility is assigned to the Minister.



The program is delivered as a partnership model and relies on engagement between the health teams, caseworkers, carer and parents/extended family.



The Coordinator is the central contact point in each Local Health District, the Coordinator or their staff will liaise with caseworkers or carers directly. They have the knowledge of the services within their district and can support with service navigation.

## The OOHC Health Pathway program process



#### The Out-of-Home Care Health Pathway Program



A referral, signed by DCJ enables a child or young person to access to HPP

Should be provided to Health within 14 days of entry into care



An assessment of the physical, developmental, psychosocial and mental health of a child or young person



Comprehensive Health Assessment

An assessment when the primary assessment identifies areas of concern for further investigation



Health Management Plan

An outline of identified health concerns and recommended follow up



A periodic review of a child or young

person's health

Occurs annually, recommended to occur sixmonthly for under 5's



An assessment or consultation for young people aged 15 -17 to support leaving care and aftercare

Includes linking young people to adult services

#### How does this relate to FASD?



#### Everyone has a pivotal role in meeting the child's health needs



The OOHC Health Pathway Program is not an exclusive diagnostic service, they are a key partner in helping you navigate the child's health needs and the health system.

Better engagement with the OOHC Health Pathway Program and collaboration with key stakeholders can support the child to access planned, trauma informed and coordinated health assessment and intervention.

# What does this mean in practice?





### Information gathering



What information do I need, where do I get that information and who can support me to get that information

Respectful conversation with the child's family about their own health history and how that may relate to the child's current health

Information about the child from the parents, when did the child meet their developmental milestones?

Any worries? Past interventions?

Respectful conversation with child's mother about their pregnancy journey, being mindful of the shame, guilt or worry that a disclosure may carry for them

Information gathering from past and/or private providers, remembering their records are not linked with public health records

Information from the carer and the preschool/school, including information on their abilities and difficulties, past and current learning, and social skills

### Planning



Work with the OOHC
Health Pathway
Program team to
support you navigate
the health system

Consult with your clinical specialist i.e. DCJ, Psychological and Specialist services, for NGO your internal clinical teams

Explore assessments or other supports - what supports can be in place prior to the diagnostic assessment

the parent, can they provide additional information? Can they attend the appointment?

Engage carer supports
to assist carers to
provide a reparative
home environment

Attend the appointment prepared, have the information available to support the assessment

#### Collaboration



Collaboration brings all the key stakeholders together to allow for joint planning and service delivery, pre and post assessment

Collaboration should aim to provide wrap around support for the child and their carer/parent Collaboration supports targeted service intervention, aims to reduce duplication assessments

Collaboration promotes accountability and role clarification

Collaborate with key stakeholders to deliver post assessment intervention, reinforces the concept of team around the child

Collaborate with specialist services to help you navigate broader systems like the NDIS

#### For more information





DCJ webpage:

https://dcj.nsw.gov.au/service-providers/oohc-and-permanency-support-services/oohc-health-pathway.html



NSW Health webpage:

https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/programs/Pages/out-of-home-care.aspx



PSP learning hub E learning module:

https://psplearninghub.com.au/document/oohc-health-pathway-e-learning-course/