Department of Health

health

Chief psychiatrist's guideline

Priority access for out-of-home care

State Government Victoria

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Key messages

In terms of their overall health and wellbeing, infants, children and young people involved with Child Protection and placed in out-of-home Care (OoHC) are a highly vulnerable group. Prior to their placement, they are likely to have been traumatised by significant abuse and/or neglect. The risk of mental health issues and the emergence of mental illness in this group is notably higher than in the general community.

This policy frames arrangements for mental health services to give weighted and preferential consideration to referral requests concerning infants, children and young people (to the age of 18) who are placed by Child Protection into OoHC. It does so by directing area mental health services (child, youth and adult streams) to establish a service response that ensures the most appropriate and timely assistance is either provided or facilitated for this client group.

Some mental health assessment and interventions may also require family-focused work to support parents with a mental illness in their parenting role.

Referral path

All referrals of infants, children and young people who are clients of Child Protection in OoHC will be flagged by the triage/intake service and a streamlined service response will be provided to best meet their needs.

Priority access service response

The introduction of a service mechanism, priority access service response (PASR), will ensure the most appropriate and timely assistance from the full range of mental health service options is provided or other service options facilitated for this client group.

In addition, the PASR will encourage designated Child Protection senior managers/practitioners to access its non-urgent consultation services.

The PASR, according to the issues raised, may offer to provide:

- a *primary* consultation delivering a face-to-face assessment with a child or young person
- a *secondary* consultation with service providers relating to the wellbeing of a particular child in OoHC who presents significant or increasing concern, or
- a *service level* consultation to support an OoHC or Child Protection team in its work.

The area mental health service (AMHS) will:

- commence its PASR by utilising existing resources (these may need to be combined across existing program streams and by facilitating streams and service types to work together in new ways)
- require a senior experienced clinician in a primary role to lead and coordinate the PASR
- ensure crisis assessment and triage/intake functions are well connected for the PASR
- identify and deploy staff who are knowledgeable and skilled to work with children and young people from a developmental framework and who are also trauma-informed in their practice
- meet triage guideline response times for OoHC referrals
- construct a consultation service response to directly cover consultation requests from designated Child Protection managers or senior practitioners
- communicate PASR arrangements to the relevant Child Protection regional managers.

Background

Infants, children and young people in OoHC and their families are some of the most vulnerable and disadvantaged members of our community. Their complex experiences of loss and trauma can impact profoundly on every aspect of their development.

On any single day in Victoria, approximately 5,000 children are living in OoHC placements.

In 2009–10 there were 3,112 Victorian children and young people admitted to OoHC. During this year, 2,972 children and young people were discharged from OoHC. Nearly all children (91 per cent) were placed in home-based care (41 per cent in foster care and 40 per cent in kinship care) and 26 per cent were in care for less than a year.[1]

Although Victoria has the lowest rate of children in OoHC in Australia and its rate has been declining over the past 10 years, the rate of Aboriginal children in out-of-home care has been increasing in Victoria.

As clinicians we know only too well the importance that the child's attachment to their parents and carers and their connection to community and culture have in their healing and recovery process. Skilled, prompt and joined-up responses are the key to good outcomes and must underpin our efforts to deliver mental health services for this client group.

Purpose

This document provides guidance to mental health services on implementing priority service access for infants, children and young people who are placed in Child Protection – out-of-home care.

About Chief Psychiatrist's guidelines

The information provided is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

1 Australian Institute of Health and Welfare 2011, *Child Protection Australia 2009–10*, AIHW, Canberra.

1. About out-of-home care

Out-of-home care is the term used to describe a range of living options for children and young people up to 18 years of age who are unable to reside at home with their parents due to a range of issues, usually related to actual or likely abuse or neglect.

In Victoria there is a range of models of OoHC for children and young people, usually provided by community service organisations (CSOs) funded by the Department of Human Services. These models of care are designed to meet the differing needs of children and young people due to their previous life circumstances, the impact of their experiences of trauma and disrupted attachments and their developmental stage.

Models of OoHC covered by this policy can see infants, children and young people placed in:

- kinship care
- home-based care
- residential care
- lead tenant care.

Due to a range of high-risk behaviours, young people may be assessed as requiring secure welfare for a brief period of time and, for the purpose of these guidelines, this placement is considered as OoHC.

1.1 Legal status and out-of-home care

A small proportion of children and young people are voluntarily placed in OoHC under a childcare agreement made between the parent(s) and a CSO with the involvement of Child Protection. This arrangement is generally made to alleviate immediate risks while a full Child Protection assessment is conducted.

The majority of children placed in OoHC are subject to a protection order, made by the Children's Court under s. 275 of the *Children Youth and Families Act 2005* (CYFA).

A number of these orders are short term and subject to early review by the court. They include interim accommodation orders and interim protection orders. These orders determine who has day-to-day care of the child, but parental consent is required for medical treatment, although the Secretary can order that the child be medically examined to determine their medical, physical, intellectual or mental condition under CYFA s. 597(1).

The court can also grant final protection orders in relation to infants, children and young people, including custody to Secretary and guardianship to Secretary orders.

Child protection may at any time order a person to be placed:

- in the care or custody of the Secretary as a result of an interim accommodation order, custody to Secretary order, guardianship and long-term guardianship order to Secretary or a therapeutic treatment (placement) order
- in the legal custody of the Secretary (Youth Justice clients in custody)
- with a suitable person in OoHC services, declared hospital or declared parent and baby unit under an interim accommodation order, or
- in safe custody to be examined to determine his or her medical, physical, intellectual or mental health condition.

All CSOs contracted to provide OoHC are given an Instrument of Authorisation – Medical Consents. This enables, on the advice of a medical practitioner, the authorised person from the CSO to provide consent to urgent medical treatment for children and young people who are subject to:

- an interim accommodation order
- a custody to Secretary order
- a guardianship to Secretary order
- a long-term guardianship to Secretary order, or
- a therapeutic treatment (placement) order.[2]

Permanent care orders allow permanent care parents to consent to all medical treatment because they have both custody and guardianship responsibilities.

Descriptions of all types of placement options are provided in the appendices.

A list of Children's Court protection orders that apply to children in OoHC subject to priority access is also available in the appendices.

1.2 Confidentiality

Many different people may be involved in the care of a child or young person in OoHC, including Child Protection workers and a range of other service providers. In order to ensure the best care possible is provided from all involved, it will often be necessary to share information in the best interests of the child or young person.

Section 120A of the *Mental Health Act 1986* is the principal law that regulates the disclosure of mental health information by mental health workers. Section 120A prescribes the general and specific circumstances under which identified consumer information may be disclosed. In practice, the most common grounds for disclosing information are with the consent of the person (or their guardian), to other health service providers to enable further treatment, to guardians and carers to provide ongoing care, and to individuals or organisations to lessen or prevent a serious and imminent threat to a person's life, health, safety or welfare.

Section 120A also prescribes that information may be disclosed where it is expressly authorised or permitted by another law, such as the CYFA. The CYFA prescribes specific circumstances when mental health services and staff may disclose mental health information, including to Child Protection to investigate a report, and where it is relevant to the protection or development of a child subject to a protection order.

The interaction of the laws governing disclosure of information is complex. Clinicians should familiarise themselves with the relevant provisions in the Mental Health Act and the CYFA, which enable sharing of information in the best interests of children and young people in OoHC in most circumstances.

The Department of Health program management circular *Confidentiality under the Mental Health Act 1986* (2008) provides general information about the operation of the confidentiality provisions in the

2 Authority of CSOs to give medical consent for children in out of home care, Advice no: 1471, Department of Human Services – Victoria, Protecting Victoria's Children - Child Protection Practice Manual, 17 July 2008.

Mental Health Act.[3] The Department of Human Services guideline *Providing support to vulnerable children and families – An information sharing guide for registered medical practitioners and nurses, and people in charge of relevant health services in Victoria* (2007) provides general information about the operation of the CYFA.

1.3 Policy

Key elements of the priority access policy

Referrals to mental health services can be made by any person, including a young person themselves, a parent(s), guardian(s) or carer(s). Access is gained through mental health triage and intake services or may result from presentation to an emergency department.

Referrals are responded to according to the guidelines for the statewide mental health triage scale and this guideline. Clinical urgency (acuity, severity and risk) is the dominant consideration in the prioritisation of all service responses.

At the point of referral, information is sought to determine whether an infant, child or young person is a client of Child Protection and if they are in OoHC.

A disposition that is judged to be the most helpful possible response will be made by the mental health service for all referrals relating to infants, children and young people in OoHC.

All behaviour has meaning. Emotional disturbance in childhood and adolescence will differ according to the young person's age, developmental stage and the nature of their problems. Emotional distress and behavioural disturbance in children and young people have meaning, and must not be ignored.

In the case of children and young people in OoHC, service access is not governed by existing requirements that the referred person should meet criteria for a likely diagnosis of a mental illness. The mental health service will also provide a helpful response when the referred infant, child or young person is experiencing significant developmental delay, emotional and psychological distress, and/or functional impairment.

Area Mental Health Services (AMHS), will create a coordinated PASR that draws together staff with appropriate knowledge and skills from all necessary service options (such as triage, crisis assessment treatment team (CATT), enhanced crisis assessment treatment team (ECATT), community care, youth early intervention, child assessment and treatment, infant mental health) to deliver quality responses centred on the needs of the client, their carers and families.

A senior experienced clinician should lead and coordinate the PASR.

Once a disposition for the referral is made, a response must be received within the defined timeframes as set out in the triage guidelines. Where timeframes are not specified (such as triage scale disposition rating 'E'), OoHC referrals will be prioritised.

Referrals of infants, children and young people in OoHC that are allocated for a service response will not be placed on any waiting lists that may be kept by mental health services.

3 *Confidentiality under the Mental Health Act 1986*, Program management circular, Mental Health Branch, Mental Health and Drugs Division, Victorian Government Department of Human Services, November 2008.

The PASR will be able to deliver consultation services within business hours in response to direct requests made by designated managers or senior practitioners working in Child Protection.

The AMHS will increase their capacity to deliver evidenced-informed and flexible treatment approaches that engage children, young people, their families and their OoHC carers (for example, detailed assessments, single session assessments, solution-focused brief interventions and trauma-informed treatment).

A locally organised and clearly communicated process to resolve any interagency issues with referral will be put in place.

Mental health services will alter their existing policies and procedures to incorporate the new access arrangements and communicate all new processes to the relevant regional Child Protection manager(s).

2. Practice – making it work

The needs of the infants, children and young people who have been placed in OoHC and referred to mental health services are to be kept at the forefront of clinical practice. We clearly respond to these clients' individual difficulties as well as to the context of their family circumstances, their experience of the world and their relationships with others. This includes supporting their relationships with paid and unpaid carers involved in their lives.

2.1 Mental health service access

Triage and intake assessment[4]

Mental health triage is generally the first point of contact with mental health services. Triage may also be used for assessment of current and former clients who make unplanned contact with the mental health service.

Triage is a clinical function. The role of the triage clinician is to conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder in order to ascertain their need for service and to then make a determination as to the nature and urgency of the response required.

Where it is considered that an AMHS is not the most appropriate option for the person, they will be referred to another organisation or given other advice.

Where a mental health triage assessment indicates that specialist mental health services are required (or possibly required), a more comprehensive assessment is provided through the intake assessment. The intake assessment may result in referral to another organisation or in the person being treated within the specialist mental health service.

In the case of children and young people in OoHC, this guideline sets a precedent that service access is not governed by a requirement that the referred person meet criteria for a likely diagnosis of a mental illness. The mental health service will provide a helpful response when the referred infant, child or young person is experiencing significant developmental delay, emotional and psychological distress or functional impairment.

Centralised triage was introduced in 2010. In some services, intake and triage continue to share management of accepting and responding to referrals during business hours.

The Mental Health Drugs and Regions Division's Mental health triage program management circular (Department of Human Services, 2005) more fully describes the triage function in Victoria's AMHS. This document can be found on the division's website at <www.health.vic.gov.au/mentalhealth/pmc> (PMC05011).

4 Statewide mental health triage scale: Guidelines, Department of Health, Victorian Government, May 2010.

Triage guidelines and triage scale

The mental health triage scale, developed in collaboration with the Chief Psychiatrist, is utilised to guide the allocation of a service response (see <www.health.vic.gov.au/mentalhealth/triage/scale>).

It is important to re-emphasise that when applying the triage scale, particular consideration from a developmental perspective is necessary when children and young people are referred. Additional weight is to be given to the vulnerability of children and young people in OoHC by reducing the service entry threshold.

Ratings on the triage scale are made after the triage mental health clinician has conducted an assessment. Importantly, this requires the collection of sufficient demographic, social, health, and clinical information to allow the clinician to determine a course of action.

When service contact is made, the most immediate response will always be to emergency situations. This is classified on the triage scale as code 'A', and results in direct onward referral to emergency services (ambulance, police or fire brigade).

A range of face-to-face access options span the codes 'B', 'C', 'D' and 'E' on the triage scale. They are graduated in terms of the time frame within which a service response will be provided.

The scale's code 'F' pertains to when a face-to-face response is judged not to be required. In this instance, it has been deemed that the most helpful response can be achieved by making a formal or informal referral to an alternative service provider.

Code 'G' applies when additional information is needed.

The triage guidelines will soon be updated. They will, on review, reference the priority access arrangements for OoHC. However, until the guidelines are updated, service access for OoHC referrals will occur in accordance with the existing guidelines and the practices outlined in this guideline.

Mental health service access – presenting to emergency departments

Frequently children and young people who are experiencing acute emotional distress, and who may be exhibiting chaotic, aggressive or self-harming behaviour, are brought to hospital emergency departments by ambulance or by police. Child Protection practitioners, staff from CSOs, foster carers and residential care staff may also present children in their care to an emergency department.

It is also often the case when a referral is made to a mental health service after hours or on a weekend that the triage clinician will ask for the referred person to present to a hospital emergency department to be seen and assessed by mental health staff.

There is a range of responses that may occur when a child or young person is taken to a hospital emergency department. Responses are dependent on clinical presentation but are also influenced by a variety of local procedures.

Regardless of local circumstances, it is important that a crisis support plan be formulated when infants, children and young people who are placed in OoHC are brought to an emergency department. Such plans should account for the immediacy of the presentation and outline options to contain the child or young person's distress and to assist their caregivers in the short term.

The Office of the Chief Psychiatrist will be preparing further and separate advice that will provide guidance in relation to emergency department presentations of children and youth in crisis.

Access for children and young people in secure welfare

Secure welfare facilities (statewide services that accommodate young people from across Victoria) for boys and girls are located in Melbourne. Girls and young women needing a secure placement are accommodated in Maribyrnong. The facility for boys and young men is located at Ascot Vale. Currently there are 10 places available at each facility.

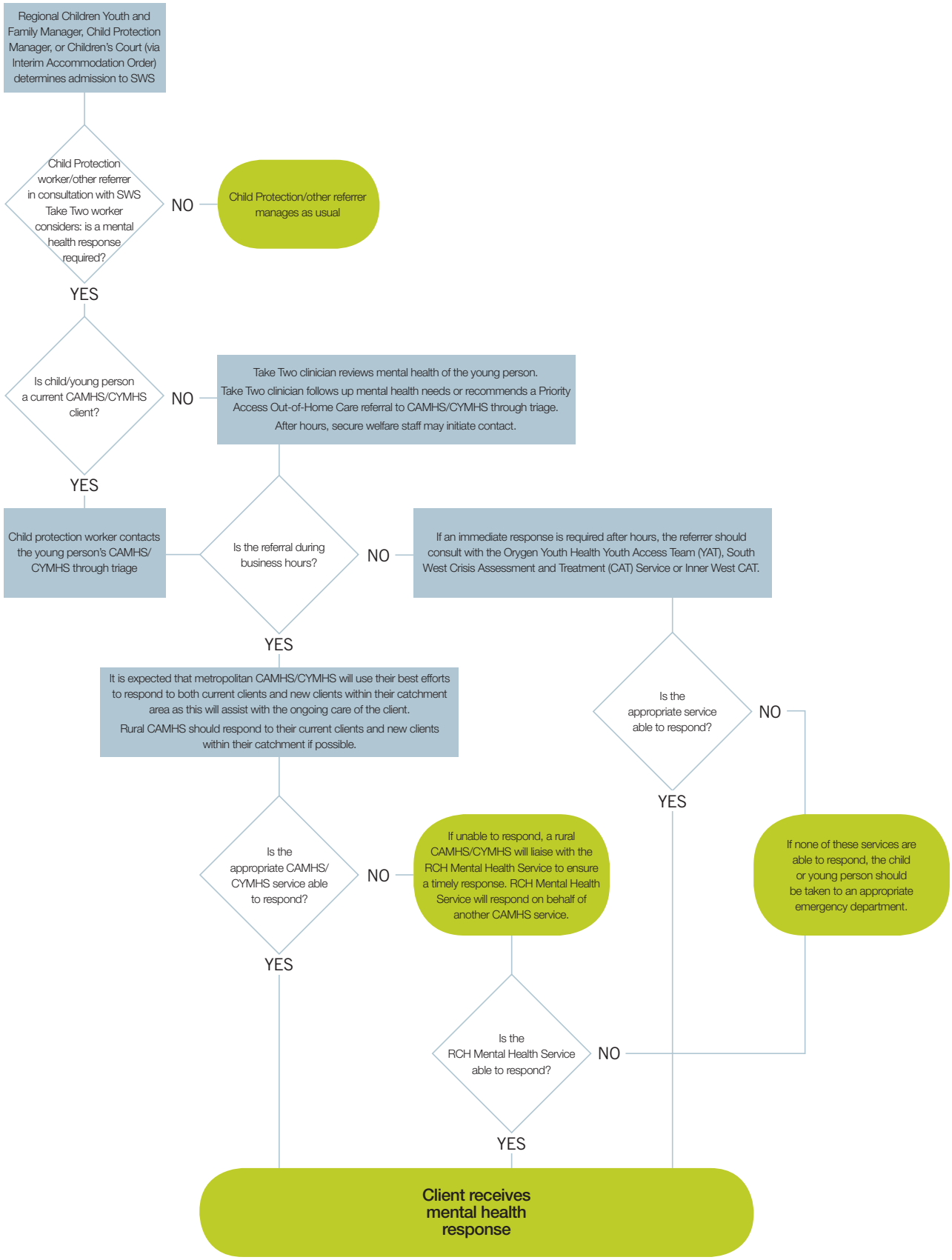
Referrals for mental health assessment of secure welfare clients are processed through the client's local mental health service triage. This process is essential to establishing and maintaining a level of continuity.

A Child Protection practitioner can make an OoHC referral should a young person in secure welfare require a mental health assessment. This should be made through triage.

If the client comes from a rural area and a mental health service clinician cannot visit secure welfare within the required time, the rural mental health service is to request support from The Royal Children's Hospital Integrated Mental Health Program to assess the mental health needs of the client and to communicate a plan to the rural service for ongoing management upon their return.

Metropolitan mental health services are required to provide assessments of allocated clients within the timelines set out by the triage guidelines.

CAMHS/CYMHS response to secure welfare clients' mental health needs



Secure welfare placement falls within the Priority Access Services Response Policy

Aboriginal children and young people

Particular attention and sensitivity must be paid by mental health services when the referred infant, child or young person identifies as Aboriginal or Torres Strait Islander.

Aboriginal and Torres Strait Islander children need to maintain connection to family, community and culture within a framework that respects the physical, mental and emotional security, and cultural safety, of the child. This is particularly important in light of the historical experiences that Aboriginal families have had with Child Protection and other government agencies.

At the point of referral, it is essential that the person(s) from the Aboriginal community who will be supporting the child is identified and that appropriate lines of communication are established with them.

Children and young people on permanent care orders

Children and young people who are under permanent care orders (PCOs) are not involved with Child Protection in any continuing or supervisory capacity. Their permanent care families have both custody and guardianship and can provide consent to treatment.

Should a child or young person in permanent care require a mental health service assessment or intervention, their permanent care caregivers should make the referral. Triage should assess the referral according to the triage guidelines, taking into account the additional vulnerabilities that may be associated for the child or young person.

The exception to these circumstances would be if it was necessary for Child Protection to become re-involved with the permanent care family and the child or young person due to a risk to the child in the permanent care family.

Mental health service responses

The outcome of all referrals will be based on how best the mental health service can help.

The service response may include, but is not limited to:

- participation with Child Protection OoHC in shared care planning and coordination
- a primary consultation with the child/young person, their caregivers and Child Protection workers
- intake to the mental health service for community-based treatment
- CATT and ECATT (assessment and interventions)
- outreach
- hospitalisation for inpatient treatment
- subacute short-term treatment within a youth prevention and recovery care (YPARC) unit
- facilitating an access path to psychiatric disability recovery and support (PDRS) or other support services
- an onwards referral to a more helpful service, including tertiary specialist mental health services (such as Spectrum, eating disorder specialist services, parent and baby units or the Victorian Dual Disability Service)
- consultation to Child Protection teams.

The AMHS will need to increase their capacity to deliver evidence informed and flexible treatment approaches that engage children, young people and their OoHC carers (for example, detailed assessments, as well as single session assessments, solution-focused brief interventions and trauma-informed treatment).

2.2 The priority access service response

Enacting this policy will require that all AMHSs across child, youth and adult streams establish a PASR.

Each AMHS will:

- commence its PASR by utilising existing resources (these may need to be combined across existing program streams and by facilitating streams and service types to work together in new way)
- require a senior experienced clinician in a primary role to lead and coordinate the PASR
- ensure all crisis assessment and triage/intake functions are well connected for the PASR
- identify and deploy staff who are knowledgeable and skilled to work with children and young people, from a developmental framework and who are also trauma-informed in their practice
- meet triage guideline response times for OoHC referrals
- construct a consultation service response to directly cover consultation requests from designated Child Protection managers or senior practitioners
- communicate PASR arrangements to the relevant regional Child Protection managers.

Consultation requests to PASR

In each departmental region, a small number of Child Protection senior managers and/or practitioners designated as consultation referral agents will be encouraged to directly contact the PASR on non-urgent matters.

In response to requests, the PASR may elect to:

- provide a primary consultation (face-to-face appointment with a child/young person) when the discussions with the designated Child Protection senior staff member indicates that this may be helpful in discerning the best course of action
- offer a secondary consultation with service providers relating to the wellbeing of a particular child in OoHC who presents significant and/or increasing concern (a secondary consultation can provide early intervention and is a support strategy that can contribute to building Child Protection workers' confidence in dealing with specific difficulties a child is experiencing)
- deliver a broader service level consultation enabling the PASR to support a Child Protection OoHC team in care planning processes or in its work with a group of children.

Creating opportunities for regular consultation will more likely support better understanding of service system responses and reduce barriers to collaboration. Mental health services that hold regular consultations with Child Protection report that referrals become more targeted over time. A consultation request can support the OoHC team and contribute fresh perspectives to the support and care of the infant, child or young person.

Referral information

Child Protection and OoHC provider organisations will increasingly understand the expectation that full and descriptive information about the infant, child or young person and the problems they are experiencing will be required with referral.

Given the range of people involved in the lives of children placed in OoHC and the many possible circumstances that may exist, it is imperative that, on referral, the child's legal guardian is identified. The name, status and contact details of the person providing consent for involving mental health services are to be obtained. As well, referral information (where possible) should include contact details for other key and influential people and organisations in the child's support system.

Clinicians accepting referrals will need to be made aware of the custody arrangements and care and accommodation orders that pertain to the child being referred.

Sample forms for direct referrals and for non-urgent consultation are included in the appendices. These are provided as examples of the type of information mental health services will require and find useful. They are examples only and may be adapted for local use.

Issues resolution

A locally organised and clearly communicated process to resolve issues must be put in place. Where issues of difference regarding the type of response suggested and offered are not addressed, a designated Child Protection senior manager/practitioner should be able to discuss the difficulty with the clinical director/manager of the relevant child, youth or adult stream of the mental health service.

Should a resolution not be reached locally, and Child Protection OoHC remains dissatisfied with how and when the mental health service is able to respond to an OoHC referral, the issue may be brought to the attention of the Chief Psychiatrist by phoning 9096 7571 or 1300 767 299 (toll free).

3. Getting started – what happens next?

3.1 Data collection and monitoring

Capturing information is especially important in order to follow shifts in demand for service and corresponding levels of service response.

All OoHC referrals are to be recorded in the triage minimum dataset.

A new code, *Child Protection – out-of-home care* has been added as a referral source on the screening register. Later changes will occur to the CMI/ODS to further back this up.

The Mental Health Drugs and Regions Division will extract quarterly data reports on OoHC referrals and service responsiveness, which will be tabled at the Child and Youth Services meetings with the division. After a period of monitoring, performance indicators will be established as part of the child and youth suite.

3.2 Implementation plan

All AMHSs (covering child, youth and adult streams) are to complete and submit an implementation plan detailing how their AMHS will put into practice priority access arrangements to meet the specifications and instructions of this guideline.

Where particular services are operating outside of a centralised triage model (for example, with a direct intake for a child service stream acting as the first point of contact and managing referrals during business hours), the existing structure must accommodate and act to meet the directions of this guideline. Referral data for OoHC clients must be collected, preferably through the triage database. How the service will enable this, must be fully described in the required implementation plan.

3.3 Workforce support

Mindful (Centre for Training and Research in Developmental Health), in partnership with Take Two and the HYPE Program (Orygen Youth Health), will prepare and deliver a program that encourages and provides a basis from which targeted mental health services staff can further the knowledge and skills they require to work with this highly vulnerable group. The program may include content related to developmental psychiatry, social psychology and the immediate and long-term effects of trauma, with a purposeful aim to empower participants to more confidently and appropriately assess, plan, intervene and collaboratively work with other services to address the complex needs of children in OoHC and their families.

PASR coordinators will be critical to the success of this policy and especially in the practice change it may engender for CATT, triage staff and clinicians whose work will primarily be within the PASR. Mindful will incorporate work with PASR coordinators focused on their leadership role with staff to maximise practice change and to influence service culture.

3.4 Child and Youth Services meeting – round table

Clinical directors and service managers meet on a two-monthly basis with Mental Health Drugs and Regions Division executive and senior staff. One of these meetings will be devoted to a round table discussion allowing services to share their plans and the progress they have made implementing priority access.

Resources

Web links

Take Two

www.berrystreet.org.au/services_taketwo

Department of Human Services, Protecting Victoria's children – Child Protection practice manual

www.dhs.vic.gov.au/office-for-children/cpmanual

Families where a Parent has a Mental Illness (FaPMI)

www.bouverie.org.au/programs/mental-health-team/fapmi

The Royal Australian& New Zealand College of Psychiatrists in its Position Statement 59, covering *The mental health needs of children in out-of home-care*, June 2008

www.ranzcp.org/images/stories/ranzcp-attachments/Resources/FCAP_paper_on_Out_of_Home_Care_June_ 2008.pdf

Further information

For further information about any aspect of this guideline contact the Chief Psychiatrist, on 9096 7571 or 1300 767 299 (toll free).

Appendix 1: Policy and planning context

Positioning of AMHSs to provide priority access to infants, children and young people in OoHC is part of a larger agenda of cross-sector service collaboration and partnership development to create closer service-level relationships. An agreement reached between the departments of Health and Human Services through a memorandum of understanding in August 2010[5] focuses on how a more united approach can accomplish earlier, more coordinated service responses for families experiencing difficulties.

Victorian AMHSs need to engage with infants, children and young people in receipt of OoHC and to support them by working cooperatively, collaboratively and in partnership with their guardians, caregivers and Child Protection. The priority access policy reflects a national movement to address issues of care in this area and is also a direct response to the findings of the Victorian Ombudsman's *Own motion investigation into Child Protection – out of home care* (May 2010).

This report by the Victorian Ombudsman[6] references an April 2006 audit conducted by the Department of Human Services of 342 children in OoHC residential care in Victoria that found that 65 per cent of the children were at abnormal risk of having, or of developing, a diagnosable mental health condition.

The national framework for protecting Australia's children 2009–2020 endorsed by the Council of Australian Governments on 30 April 2009 acknowledges the rights of all children. At the same time, the national framework reminds us that children in OoHC significantly experience poor long-term outcomes and it confronts us with the knowledge that each year 'in a small number of terrible cases, Australian children die while under Child Protection'.[7]

The national framework recognises the body of research indicating the dominant parental risk factors associated with child abuse and neglect as being:

- parental drug and alcohol abuse
- family violence
- parental mental illness
- homelessness.

In doing so it acknowledges that these risk factors often occur in the context of families where parents also face broader challenges of social exclusion and disadvantage.

The national framework commits all signatories (state and territory governments) to implementing the initial actions it contains in order to help prevent abuse and better protect children identified as being 'at risk'. One of these actions is the development of national standards in OoHC. Another is the development of a National clinical assessment framework for children and young people in OoHC, which is proposing the preparation of a health plan for each child or young person entering OoHC.

The Royal Australian & New Zealand College of Psychiatrists, in its Position Statement 59 covering *The mental health needs of children in out-of home-care* (June 2009),[8] states that access to competent, comprehensive, multidisciplinary mental health services needs to be a priority for children in OoHC.

5 Memorandum of understanding between the Victorian Department of Health, Mental Health Drugs and Regions Division and the Victorian Department of Human Services, Children Youth and Families Division , in relation to collaborative service delivery, 28 August, 2010 (www.health.vic.gov.au/mentalhealth).

6 Ombudsman Victoria 2010, *Own motion investigation into Child protection – out of home care*, No.308.

7 Commonwealth of Australia 2009 *Protecting Children is everyone's business: The national framework for protecting Australia's children 2009–2020*, Australian Government, Canberra.

8 Royal Australian and New Zealand College of Psychiatrists 2009, Position Statement 59: The mental health care needs of children in out-of-home care, RANZCP, Melbourne.

Appendix 2: Child Protection

The Department of Human Services has a statutory responsibility according to the provisions of the *Children Youth and Families Act 2005* (CYFA) in relation to the provision of Child Protection services for all children in Victoria under the age of 17 years or, if a protection order is in place, for a 17-year-old.

Child Protection provides services to children and their families in order to protect children from significant harm resulting from abuse and neglect within their families. A broad range of services are provided or funded by the Department of Human Services, and these aim to strengthen families so that children and young people can develop within a safe physical and emotional environment. Services are based on the principle that, normally, the best protection for children is within the family.

Where a child or young person is assessed as being 'at risk' of significant harm within the family, Child Protection will – in the first instance and in accordance with the law – take every reasonable step to enable the child to remain in the care of their family by strengthening the family's capacity to protect them.

Where, even with support, a child is not safe within the family, Child Protection will intervene to remove the child and bring the matter before the Children's Court. Until the parents are able to resume their custodial responsibilities, adequate care and protection will be provided as determined by the Children's Court.

Child Protection may need to place a child in OoHC to ensure their safety and wellbeing while problems are addressed. The length of time a child requires care away from home varies according to individual circumstances, and the court order in place.

Where the resumption of care by the parents is not possible, Child Protection will work towards an alternative permanent family care arrangement, or an independent living arrangement, depending on the age and circumstances of the child.

Child Protection has a coordinating role and responsibility to ensure effective care planning to meet the needs of their clients. Timely access to specialist AMHSs for infants, children and young people who require a mental health service response is one element in the range of services and supports coordinated by Child Protection.

Take Two

The Department of Human Services funds 'Take Two', a statewide intensive therapeutic service for Child Protection clients who are manifesting, or at risk of, significant emotional and behavioural disturbance as a consequence of substantiated abuse or neglect.

Berry Street Victoria is the lead agency implementing Take Two (in conjunction with La Trobe University, the Mindful Centre for Training and Research in Developmental Health and the Victorian Aboriginal Child Care Agency).

Mental health services should be aware of Child Protection's role in deciding the most appropriate referral path for infants, children and young people in OoHC who may require mental health services or therapeutic care and interventions.

The regional Child Protection manager or their delegate is the point of referral within the Department of Human Services to Take Two's statewide therapeutic service.[9]

9 Take Two provides other therapeutic services that are not accessed through the manager of Child Protection, that is, therapeutic specialists for therapeutic foster and residential care programs and the T2-Family Coaching program, which takes referrals from the Integrated Placement Prevention and Reunification Service.

Appendix 3: Types of out-of-home care placement

All OoHc placements are provided for infants, children and young people who are unable to live with their parents due to a range of issues that includes:

- homelessness
- abuse or neglect
- family breakdown and domestic violence
- being under a court order.

Kinship care

Kinship care is considered first when a child needs to be placed in OoHC.

Kinship care may be short- or long-term OoHC that is provided by relatives or members of a child or young persons' social network.

Kinship carers look after children and young people in their own homes and receive a contribution for the costs of caring for the child or young person.

Child Protection initiates kinship placements but may then contract community service organisations (CSOs) to provide support and either casework support or case management

Home-based care

Home-based care is sometimes known as foster care or adolescent community placement (ACP).

Approved volunteer caregivers look after children and young people to age 18 in their own homes and receive a contribution for the costs of caring for the child or young person.

CSOs are responsible for recruitment, assessments, training and support of caregivers and also for either casework support or case management.

The placement is supervised and supported according to the child or young person's assessed level of need, and may be designated as home-based care – general, intensive or complex – or an adolescent community placement.

Therapeutic foster care

Therapeutic foster care is provided by carers specifically recruited, trained and supported to provide a therapeutic model of care. It is a temporary form of OoHC, and may be short or long term.

Approved therapeutic foster caregivers look after children and young people in their own homes and receive a contribution for the costs associated with caring for a child or young person in a therapeutic context.

CSOs providing therapeutic foster care are responsible for the specialised recruitment, supervision and training of carers and the provision of enhanced placement support.

In addition, the CSOs providing therapeutic foster care work in partnership with a specialist therapeutic support service whose role it is to provide therapeutic assessment, guidance and support to placements.

Residential care

Residential care provides short- or long-term accommodation in community-based houses for children and young people who are unable to be placed in home-based care because they display a significant level of challenging behaviour or because they are a part of a large sibling group.

Paid residential carers, usually employed by CSOs, provide the day-to-day care, supported by caseworkers or case managers. The ratio of staff to children and young people varies according to their assessed level of need.

Therapeutic residential care

Therapeutic residential care provides intensive therapeutic care through the development and implementation of therapeutic models utilising specifically trained and supported staff. The CSOs providing therapeutic residential care work in partnership with a specialist therapeutic support service whose role it is to provide therapeutic assessment, as well as guidance and support to care staff.

Lead tenant

Lead tenant services provide semi-independent accommodation and support for young people aged 16–18 years who are unable to live with their family due to issues of abuse or neglect, and who are in transition to independent living.

A volunteer lead tenant lives in a residential unit with a small group of young people and provides them with support and guidance in developing their independent living skills.

CSOs are responsible for recruiting, training and supporting lead tenants, and provide either casework support or case management to the young person.

Secure welfare service

Secure welfare services (SWS) are specialist statewide services located in the North & West Metropolitan Region providing two secure 10-bed gender-specific residential units that are staffed on a rostered 24-hour 'stand up' model.

Children or young people who present a substantial and immediate risk of harm to themselves, or from others, and where existing community services are unable to manage the risk, may be placed in an SWS for a period not exceeding 21 days. In exceptional circumstances, the period in SWS may be for one further period not exceeding 21 days.

Children or young people can only be placed in secure welfare if they are subject to a custody to Secretary order, a guardianship to Secretary order, a long-term guardianship to Secretary order, or if the court is satisfied there is a substantial and immediate risk of harm, an interim accommodation order.

A Take Two clinician supports the mental health of secure welfare clients and may inform a referral to a specialist mental health service.

Permanent care

When Child Protection makes a decision that a child cannot live safely with their parents on a long-term basis the Secretary may apply to the Children's Court for a permanent care order (PCO). PCOs confer custody and guardianship responsibilities upon existing home-based or kinship carers, or approved permanent care parents with whom an adoption and permanent care team has placed the child.

Permanent care parents are volunteer caregivers who receive a contribution for the costs of care.

Infants, children and young people on PCOs, as they are no longer involved with the Child Protection system, are outside the scope of the mental health priority access policy. However, their vulnerability and the circumstances leading to their need to be in permanent care should be taken into consideration by triage and intake when a direct referral is made.

Appendix 4: Protection and other court orders

What is a protection order?

A protection order is an order made by the Children's Court of Victoria when the court finds that a child or young person is in need of protection. There are eight protection orders that the court can make. However, as some of these orders do not result in a child or young person being removed from their home and placed in the OoHC system, only some of the protection orders are presented here.

Impact on custody and guardianship

Some of the protection orders discussed below change either the custody arrangements or both the custody and guardianship arrangements for a child or young person.

As custodian

In general, the rights and responsibilities of the Secretary as a custodian include:

- the power to decide where a child shall reside
- the power to give consent to a child's attendance at an excursion or an overnight stay
- the power to order that a child be examined to determine their medical, physical, intellectual or mental condition
- the power to give consent to the medical treatment, surgical or other operation, or admission to hospital of a child on the advice of a registered medical practitioner that such treatment, operation or admission is necessary
- the capacity to demand, sue for and recover any money due to a child and, in the name and on behalf of the child, commence and prosecute any proceeding relating to any property or rights of the child
- the power to detain a child without a warrant
- in some circumstances, the power to enrol a child in an educational institution.

As guardian

The rights and responsibilities of the Secretary as a guardian include the rights and responsibilities of a custodian and the rights and responsibilities of a natural parent.

Protection orders applicable to out-of-home care

Custody to third party orders

A custody to third party order is usually made to someone in the community able to care for the child, not to professionals. In practice, it is expected that relatives would be the main custodians under these orders. The order grants sole or joint custody to the person or persons named in the order.

Such an order is made by the Children's Court when it is considered that a child would be at risk of abuse or neglect if they continued to reside with the parents.

This type of order may be made where there are protective concerns that necessitate the child being placed in the care of a third party and there is confidence that the parents can resume custody without risk to the child within 12 months. This order might be made where the parents are motivated to change and to receive any needed support and assistance from community networks and the third party is able to undertake custody responsibilities in a manner that ensures the safety of the child.

It is an order where it is considered that access arrangements and the addressing of the protective concerns by the parents *do not* require monitoring and support by the Secretary of the Department of Human Services.

The Department of Human Services closes the case once a child has been placed on a custody to third party order.

Supervised custody order

A supervised custody order grants sole or joint custody of a child to a person who is not:

- the Secretary of the Department of Human Services in his or her official capacity
- a person employed by a community service in his or her official capacity, or
- a parent of the child.

This order lasts up to 12 months and can be extended for up to two years. There is no change in guardianship of the child or young person.

The Child Youth and Families Act stipulates that the court bear in mind the ultimate objective of a supervised custody order is the reunification of the child with their parent and that the order direct the parties to take all appropriate steps to achieve this.

While the order is in force, the Secretary, if satisfied that it is in the child's best interests, may direct in writing that the child return to the sole or joint custody of their parent(s).

Custody to Secretary order

A custody to Secretary order grants sole custody of a child to the Secretary of the Department of Human Services but does not affect the guardianship of the child. The Secretary has sole right and responsibility to make daily decisions about the daily care and control of the child including deciding where and with whom the child or young person lives. The order lasts for up to 12 months and can be extended for up to two years.

Guardianship to Secretary order

A guardianship to Secretary order grants guardianship to the Secretary to the exclusion of all others. The Secretary then has the responsibility for important long-term decisions on behalf of the child or young person, as well as decisions about the daily care and control of the child including deciding where and with whom the child or young person lives. This order lasts for up to two years and can be extended.

Long-term guardianship to Secretary order

This order is similar to a guardianship to Secretary order in that it grants both custody and guardianship of the child or young person to the departmental Secretary to the exclusion of all others. However, this order can only be made in respect of a child or young person who is aged 12 years or over and it lasts until they turn 18 or get married. This order may be made instead of extending a guardianship to Secretary order if all parties agree.

Interim orders

Interim accommodation order

This order specifies with whom a child or young person lives on an interim basis pending the final outcome of a protective application to the court. An interim accommodation order (IAO) may stipulate the infant, child or young person reside with their parent(s), another person(s) named in the order, an OoHC service, a secure welfare service, a declared hospital or declared parent and baby unit. There is no change in guardianship under the order. Where the child or young person is in OoHC, the order lasts for up to 21 days and can be extended.

Interim protection order

This order may be in place for an infant, child or young person placed in OoHC on an interim basis; however, may also apply to children while they remain with their parent(s).

An interim protection order (IPO) is made when the court wants to test the appropriateness of a particular course of action before making a protection order. The child may be placed in their parents' care or in an OoHC placement. The order lasts up to three months and cannot be extended. The order will state who has responsibility for the child or young person's supervision, which may be the child or young person's parent(s). There is no change in guardianship under this order.

What other Children's Court orders may apply?

In addition to protection and interim accommodation orders, there are also other Children's Court orders that may apply to a child or young person under Child Protection and the OoHC system that either change the custody arrangements or both the custody and guardianship arrangements for the child or young person.

Therapeutic treatment and therapeutic treatment (placement) orders

Therapeutic treatment orders (TTO) and therapeutic treatment (placement) orders (TTPO) are orders of the Family Division of the Court that have been available since 2007.

These orders require the child to participate in an appropriate therapeutic treatment program. Where a TTO has been granted by a court, Child Protection can also apply for a TTPO, which will allow the child to be placed away from home for the duration of the treatment order.

These orders can be made for one year, with capacity to extend for a further 12 months. Should a child turn 15 years of age during the specified period of the order, the order continues to be in force.

A TTPO grants sole custody of the child or young person to Child Protection; however, there is no change to the guardianship of the child or young person under this order.

Permanent care order

This order grants custody and guardianship of the child or young person to a person(s) named in the order, who then assumes responsibility for the permanent care of the child or young person.

This order will not be granted to a parent or to Child Protection. The order may provide for joint guardianship between those named in the order and the child or young person's parent(s).

Appendix 5: Area mental health services, Department of Health regions and Child Protection offices

Metropolitan AMHS	Region(s)	Child Protection regional offices	Phone
Central East AMHS (Eastern Health)	Eastern	Box Hill	9843 6000
Outer East AMHS (Eastern Health)	Southern and Eastern	Frankston Cheltenham Box Hill	9784 3100 8585 6000 9843 6000
North East AMHS (Austin Health)	North & West Eastern	Preston Box Hill	1300 664 977 9843 6000
Inner Urban East AMHS (St Vincent's Health)	Eastern	Box Hill	9483 6000
Dandenong AMHS (Southern Health)	Southern	Dandenong	9213 2111
Middle South (Southern Health)	Southern	Frankston Cheltenham	9784 3100 8585 6000
Inner West AMHS (NWMH)	North& West	Footscray Preston	1300 360 462 1300 664 977
Mid West AMHS (NWMH)	North &West	Footscray	1300 360 462
North West AMHS (NWMH) – including Orygen Youth Health	North & West	Preston Footscray	1300 664 977 1300 360 462
Northern AMHS (Northern Health)	North & West	Preston	1300 664 977
Peninsula AMHS (Peninsula Health)	Southern	Frankston	9784 3100
Inner South East AMHS (Alfred Health)	Southern	Frankston Cheltenham	9784 3100 8585 6000
South West AMHS (Werribee Mercy)	North & West	Footscray	1300 360 462

Regional AMHS	Region(s)	Child Protection regional offices	Phone
Barwon AMHS (Barwon Health)	Barwon-South Western	Geelong Colac	5226 4540 5232 5140
Glenelg AMHS (Warrnambool)	Barwon-South Western	Warrnambool Portland	5561 9444 5523 9999
Goulburn and Southern AMHS (Goulburn Valley Health)	Hume	Shepparton Benalla Seymour	5832 1500 5761 1222 5793 6400
Loddon/Southern Mallee AMHS (Bendigo Health)	Loddon Mallee	Bendigo	5434 5555
North Eastern/Hume AMHS (Wodonga and Wangaratta)	Hume	Wangaratta Wodonga	5722 0555 6055 7777
Northern Mallee AMHS (Mildura)	Loddon Mallee	Mildura Swan Hill	5022 3199 5032 0100
Grampians AMHS (Ballarat Health)	Grampians	Ballarat Horsham Stawell	5333 6669 5381 9777 5358 4374
Gippsland DHS (Latrobe Regional Hospital)	Gippsland	Sale Warragul Morwell Leongatha Bairnsdale Traralgon	5144 9100 5624 0600 5136 2400 5662 4311 5150 4500 5177 2500

Appendix 6: Who can consent?

Where a child or young person in OoHC does not have capacity to consent to treatment in their own right, the following table may be useful in determining who can provide consent on their behalf.

Type of court order	Who has custody?	Who has guardianship?	Who can consent when the child does not have capacity?
No order – child taken into safe custody			For medical or mental health examination: • parent(s) • Secretary / Child Protection delegate For treatment: • parent(s) • Secretary / Child Protection delegate / authorised CSO – on advice of registered medical practitioner if parent refuses consent or cannot be found in reasonable time
Custody to third party order	A person or persons named in the order; cannot be a parent, Child Protection or a community service	Parent(s)	Parent(s)
Supervised custody order	A person or persons named in the order; cannot be a parent, Child Protection or a community service	Parent(s)	Parent(s)
Custody to Secretary order	Child Protection	Parent(s)	Parent(s) Secretary / Child Protection delegate / authorised CSO
Guardianship to Secretary order	Child Protection	Secretary / Child Protection delegate	Secretary / Child Protection delegate / authorised CSO
Long-term guardianship to Secretary order	Child Protection	Child Protection / Child Protection delegate	Secretary/ Child Protection delegate / authorised CSO
Interim protection order	A person or persons named in the order; custody may remain with a parent	Parent(s)	Parent(s)

Type of court order	Who has custody?	Who has guardianship?	Who can consent when the child does not have capacity?
Interim accommodation order	A person or persons named in the order; custody may remain with a parent	Parent(s)	For medical or mental health examination: • parent(s) • Secretary / Child Protection delegate For treatment: • parent(s) Secretary / Child Protection delegate / Authorised CSO – on advice of registered medical practitioner if parent refuses consent or cannot be found in reasonable time
Permanent care order	A person or persons named in the order; cannot be a parent or Child Protection	A person or persons named in the order; may include parent(s) as joint guardian	The child's legal guardian(s) as specified in the order
Therapeutic treatment order	A person or persons named in the order; custody may remain with a parent	Parent(s)	Parent(s)
Therapeutic treatment (placement) order	Child Protection	Parent(s)	Secretary / Child Protection delegate / authorised CSO

Note: Sections 597(3) and (4) of the *Children, Youth and Families Act 2005* allow authorised senior CSO managers to consent to treatment of a child (on the specified orders) on the advice of a registered medical practitioner that medical treatment or a surgical other operation or admission to hospital is necessary to consent **even if the child's parent objects**.

Appendix 7: Priority access referral of an infant, child or young person in out-of-home care

EXAMPLE ONLY
This document is designed purely to guide the information required to mental health services. There is no expectation that it will be completed prior to the acceptance of the referral

Cover sheet

Referral received **Date:**___/___/___ **Time:** _____

Referral received from: _____

Relationship to referred person:_____

Phone: _____ Email: _____

Referred child's details

Name of person referred: _____ Date of birth:___/___/___

Aboriginal or Torres Strait Islander? Yes No

Aboriginal community contact : Name:_____ Phone: _____

Previous referral(s) to AMHS? Yes No

Is this person a registered client? Yes No

Out-of-home care status (see over page): Court order Voluntary agreement

Legal guardian (see over page): _____ Phone: _____

Primary carer (see over page): _____ Phone: _____

Consent to referral obtained (see over page): Yes No

Mental health triage

Triage/intake clinician: _____ Date: ___/___/___ Time: _____

Triage outcome code: A B C D E F G

Mental health service acceptance

Mental health service/program accepting the referral: _____

EXAMPLE ONLY

Out-of-home care status

Child is in out-of-home care as a result of a: Court order Voluntary agreement

Where the child is subject to a court order, please select the relevant order from the list below:

Custody to third party order	Supervised custody order
Custody to Secretary order	Guardianship to Secretary order
Interim protection order	Long-term guardianship to Secretary order
Interim accommodation order	Therapeutic treatment (placement) order
Permanent care order	Other (please specify)

Living arrangements

Please select the living/accommodation arrangements for the child at the time of referral:

Living with a kinship carer	Living in an out-of-home care service
Living with a foster carer	Living in a declared parent and baby unit
Placed in secure welfare	Other (please specify)

Primary carer

Name of primary carer: _____ Relationship to child: _____

Phone: _____ Mobile: _____

Legal guardian

Name of primary carer: _____ Relationship to child: _____

Phone: _____ Mobile: _____

Consent

Consent to the involvement of a mental health service has been obtained: Yes No

Consent obtained from: _____

If there are any known issues relating to consent, please describe below:

_____

_____

_____

_____

_____

_____

_____

EXAMPLE ONLY

Take Two

Has this child/young person been seen by or involved with Take Two? Yes No

Take Two contact: _____ Phone: _____ Email: _____

Secure welfare

Has this child or young person had previous placement in secure welfare? Yes No

If *Yes*:

When was their last placement? Date:____/____/____ to Date____/____/____

Was a mental health assessment completed at that time? Yes No

If so, please provide information that should be noted from this assessment.

_____

_____

_____

_____

_____

_____

_____

Parents

Mother: Name:_____ Father: Name:_____

Is either of the infant / child / young person's parents a client of an AMHS?

Mother: Yes No Father: Yes No

Information that should be noted:

_____

_____

_____

_____

_____

_____

_____

Additional key people in the child's support system

Please provide details of any other key individuals and/or organisations within the child's support system:

Name:_____ Phone:_____ Organisation:_____

Name:_____ Phone:_____ Organisation:_____

Name:_____ Phone:_____ Organisation:_____

EXAMPLE ONLY

Mental health issues – presenting problems: (please write or print clearly)

Describe presenting problems: including onset, duration of problem and frequency of concern as well as risk issues (for example, psychotic or delusional phenomena, suicidal behaviour, deliberate self harm, depression, chaotic behaviour).

Current medications or previous medications: (if any)

Drug and alcohol use:

Appendix 8: Consultation request

Children and young people in out-of-home care – consultation request

EXAMPLE ONLY

Black sections are information provided by Child Protection – out-of-home care

Purple sections are completed by clinical staff accepting and completing consultation

Referral received Date:___/___/___ Time: _____

Referral received by: Name_____

Department of Human Services region: _____

Referral from designated senior Child Protection manager/practitioner.

Name: _____

Position: _____

Phone: _____

Email: _____

Child at the centre of this request for consultation N/A

Name:_____ DOB: _____/_____/_____ Age_____

Sex: Male Female

Out-of-home care status

Child is in out-of-home care as a result of a: Court order Voluntary agreement

Where the child is subject to a court order, please select the relevant order from the list below:

Custody to third party order	Supervised custody order
Custody to Secretary order	Guardianship to Secretary order
Interim protection order	Long-term guardianship to Secretary order
Interim accommodation order	Therapeutic treatment (placement) order
Permanent care order	Other (please specify)

Living arrangements

Please select the living/accommodation arrangements for the child at the time of referral:

Living with a kinship carer	Living in an out-of-home care service
Living with a foster carer	Living in a declared parent and baby unit
Placed in secure welfare	Other (please specify)

EXAMPLE ONLY

Primary carer

Name of primary carer: _____ Relationship to child: _____

Legal guardian

Name of primary carer: _____ Relationship to child: _____

Consent

Consent to the involvement of a mental health service has been obtained: Yes No

Consent obtained from: _____

If there are any known issues relating to consent, please describe below:

_____

_____

_____

_____

_____

_____

_____

Take Two

Has this child/young person been seen by or involved with Take Two? Yes No

Take Two contact: _____ Phone: _____ Email: _____

Secure welfare

Has this child or young person had previous placement in secure welfare? Yes No

If *Yes*:

When was their last placement? Date:____/____/____ to Date____/____/____

Was a mental health assessment completed at that time? Yes No

If so, please provide information that should be noted from this assessment.

_____

_____

_____

_____

_____

_____

_____

EXAMPLE ONLY

Parents

Mother: Name:_____ Father: Name:_____

Is either of the infant / child / young person's parents a client of an AMHS?

Mother: Yes No Father: Yes No

Information that should be noted:

_____

_____

_____

_____

_____

Timing – A consultation is requested at *this time* because:

_____

_____

_____

_____

_____

Purpose – The consultation is requested to assist with:

_____

_____

_____

_____

_____

_____

Child Protection out-of-home care participants in consultation

Please provide details of the key individuals who will participate in the consultation(s):

Name of main contact: _____

Position/role/relationship _____

Phone: _____ Email: _____

Name of other contact: _____

Position/role/relationship _____

Phone: _____ Email: _____

Name of other contact: _____

Position/role/relationship _____

Phone: _____ Email: _____

EXAMPLE ONLY

Lead clinician for this consultation is: Name: _____

Phone: _____ Email: _____

Consultation arrangements:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Arrangements confirmed with Child Protection: Date:____/____/____

Telephone consult(s): Yes

Single Date:____/____/____

Multiple Date: ____/____/____ Date:____/____/____ Date:____/____/____ Date: ____/____/____

Face-to-face consult(s): Yes

Single Date:____/____/____

Multiple Date: ____/____/____ Date:____/____/____ Date:____/____/____ Date: ____/____/____

_____

Outcome(s)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____