

Who? Am I

Making Records Meaningful

Research to support archiving and record-keeping
in Victorian Out of Home Care

A Backpack of Identity – what happens to records when young people change placement?

Margaret Kertesz

School of Social Work, University of Melbourne

January 2012

Research from the Current Practice Strand of the *Who am I?* project



Centre for Excellence
in Child and Family Welfare Inc.



Funded by the Victorian Government department,
The Department of Human Services



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Summary

This summary presents the most significant findings and conclusions from the *Backpack of Identity* research project, mostly in dot point format. References and discussion can be found in the full report.

The *Backpack of Identity* research was a small project nested within the much larger *Who am I?* research project, a multi-disciplinary action research project investigating the role played by records and archives in supporting the well-being and sense of identity of children and young people in out-of-home care, and of adults who were in care as children. Research partners include the University of Melbourne, the Australian Catholic University, eleven Victorian community sector organisations, the Victorian Aboriginal Child Care Agency, the Department of Human Services, the Centre for Excellence in Child and Family Welfare and three consumer organisations.

The research explored in depth the finding from earlier *Who am I?* research (*100+ points of identity* project) that many out of home care records become inaccessible when young people change placement. The researchers aimed to establish what happens to records when young people change placement, what the barriers and facilitating factors are regarding the transfer of records, and what policies and procedures exist to support records management that facilitates long-term access to the records, especially by care leavers.

The *Backpack* research also set out to explore the possibilities of a “personal portable record” - a set of personal records kept together throughout a child’s time in out-of-home care, and travelling with the child. Earlier research suggested that the following types of records are most likely to be of interest or use to the child throughout their life span.

- Looking After Children forms, including
 - birth certificates & other ID documents
 - immunisation history and other medical records
 - school reports and plans
- Life story book, photos, videos, memory box, etc.
- Other reports and plans, including information about why a child was placed in care and reasons for any placement changes
 - case closure summary
 - case plan
 - cultural support plan
 - leaving care plan

Information was gathered in several ways –an audit of written policies and procedures about records management of all partner organisations, the identification of other legal and regulatory standards through conversations with key informants, and a series of focus consultations with five out-of-home care teams caring for adolescents, and the five managers who had completed the audit.

What standards regulate record-keeping?

- The most relevant standard to the out-of-home care sector is a section of the recently released new DHS standards, which now requires the collation of a personal portable

record. The children, youth and family indicator of standard 4, criterion 4.2, reads as follows: *“Placement details, records of life experiences and achievements, school reports, medical records, photographs of meaningful and significant events and the names of significant people involved in the child or young person’s life are available in a portable format (for example a Life Book) that the child or young person can take with them when changing placement or leaving care.”*

- At a broader level, the Information Privacy Act, new standards being developed by the Public Records Office of Victoria, the *Australian Standard on Records Management*, and the *Australian Standard on Metadata for Records* should also be noted.

Policies and procedures in care-providing organisations - audit

- All five organisations who responded to the audit have policies and procedures relating to issues such as file creation, records security, privacy, and file closure and storage.
- The level of detail in these documents varies, and actual practice also varies between different out-of-home care teams within any one organisation.
- Practices which make the location and access of client information easier include:
 - a client’s whole file being passed between teams or programs within an organisations, so that information is kept in one place;
 - a standard file structure across an organisation;
 - recording the location of a file (or specific documents such as a birth certificate) on an agency database or computer system.
- Privacy policies focussed on measures to ensure the security of records. However, without guidelines about which information is appropriate to share across organisations and jurisdictions, the tone of these policies overall discourages any sharing of records. The need to protect privacy needs to be balanced with the importance of information sharing in the best interests of the child.

Many young people in care today will read their records in the future

Many out-of-home care sector professionals have not yet thought about the long-term identity needs of their clients, beyond considering the importance of the life book for their clients’ current therapeutic needs. Those interviewed for this research were quick to recognize the significance of the records that make up a “portable personal record” in assisting children and young people to understand their childhoods and come to terms with their identity - at any time during their life course. Once it is accepted that young people in care today are likely to access their records in the future, professionals are generally open to considering the implications for how and what is recorded, and how records are managed and stored, within the constraints of their current workloads.

Barriers to the transfer of records (from focus group consultations)

- Lack of clear policies / guidelines / responsibilities
- Lack of worker time - the crisis nature of some placements may also prevent practitioners from collecting or recording information
- Information is not always available for inclusion in *Looking after Children* (LAC) or referral forms
- Views on ownership of records and privacy issues can discourage the transfer of records.

What works or could work (from focus group consultations)

- Clear guidelines and procedures about records transfer and management
- Clarification of roles and responsibilities regarding the transfer and sharing of client information
- Tools – a checklist for what information to pass on to the next placement, closure summary proforma
- Support for practitioners (file management and archiving, life story work or “coaching” for records transfer)
- Sector-wide regulation

Principles of record keeping and information transfer

- Written information is more reliable than verbal information and longer lasting
- Absence of information should be explained in records (eg. LAC) rather than forms being left blank.
- The location of information should be noted, including changes over time
- The context of information should be recorded – eg. date of creation, who created or wrote the item, what organisation was responsible for its creation and what is the purpose of the document.

Checklist and Document Tracking Sheet – tools to aid practice

The researcher developed preliminary drafts of two tools (appended to the full report).

The Checklist summarises the tasks to be carried out when a child or young person who already been in out-of-home care, enters a team’s care. It was designed to assist practitioners and can be adapted by individual organisations to fit in with their individual processes.

The Document Tracking Sheet was designed to enable workers and care leavers to locate information, both currently and in the future, by noting the location of records and recording details of any moves. When any type of record is transferred from one location to another, or from one person to another, the following information needs to be recorded, so that the “story of the record” is retained, and to make it easier to locate records.

- Date item was moved or copied
- Who moved or copied item (eg. case manager, admin., archivist, manager)
- Where it was moved or copied from
- Where it was moved or copied to

While some tools can be developed at a local level to assist practitioners and provide guidelines about what information should be transferred, it will be most effective to integrate new information collection tools (such as the tracking sheet) into current record keeping systems (eg. CRIS).

We need to create a record keeping system which enables the creation and safe transfer and storage of a personal portable record for children in out-of-home care, incorporating both personal information and the official records which will help them understand their experiences of care. A well functioning personal portable record will ensure that personal information is not only recorded but is accessible (where appropriate) to young people in care, and is able to be easily located in the long term for future access by those who have spent all or part of their childhoods in care.

Recommendations

To further sector-wide good practice in the area of record keeping to support identity, it is recommended:

1. That a training package on record keeping to support identity be developed as a resource for the sector, incorporating care leaver testimony.
2. That guidelines clarifying the roles and responsibilities involved in records transfer be developed and incorporated into sector-wide regulations, and all organisational policies.
3. That organisations develop policies, procedures and tools which balance the need to protect privacy with the importance of information sharing in the best interests of the child and which clarify what information should be passed on at change of placement.
4. That a central LAC database be developed to facilitate the sharing of LAC information, possibly based in CRIS, with revised access arrangements.
5. That the LAC Essential Information Record be adapted to incorporate more detailed information about identity documents and medical records, as well as information about the location of personal information and reports.
6. The Life story is the core of the personal portable record. It is recommended that organisations keep local copies and act to ensure that the life book does not become dispersed to a range of locations.
7. That files have a standardized format across a whole agency, even across different program areas, in order to facilitate the location of specific information
8. That a local copy (paper or electronic) of all files and documents be kept by care-providing organisations.
9. That contextual information about records be recorded in the present to assist those concerned with records release in the future, both care leavers and out-of-home care professionals.

Dr Margaret Kertesz
Research Fellow
School of Social Work, University of Melbourne
mkertesz@unimelb.edu.au

January 2012

Introduction

The Backpack of Identity research was a small project nested within the much larger *Who am I?* research project, a multi-disciplinary action research project investigating the role played by records and archives in the health, well-being and identity construction of children and young people in out-of-home care and of adults who were in care as children. Research partners include the University of Melbourne, the Australian Catholic University, eleven Victorian community sector organisations (CSOs), the Victorian Aboriginal Child Care Agency, the Department of Human Services, the Centre for Excellence in Child and Family Welfare and three consumer organisations.

The *Who am I?* research project began with a series of scoping workshops. Researchers, managers and policy makers, out-of-home care practitioners, archivists, care leavers and young people still in care, were brought together to gather information and conceptualise the key issues for record keeping in current out-of-home care practice.¹ Following these workshops, the *100+ points of identity* research² was developed to establish the extent to which a selection of personal records (covering the history of the child's time in care) were locatable and accessible by professionals in community sector organisations which provide out-of-home care. The research concluded that much of the information asked about was accessible to workers, but identified that particular types of records warranted further attention from the out-of-home care sector. These included the dispersal of medical records among a large number of locations, inconsistent practice in the area of life story work and the fact that not all children in care have a birth certificate. A number of themes also emerged, which require attention from the sector.

- Are we recording too much information and of the wrong kind?
- The fragmentation of records among a number of locations – how to facilitate access to the information care leavers want;
- Using language that is accessible for those who are or have been in care;
- Constructing the record in collaboration with young people;
- Practitioners lack skills and confidence to doing life story work across the sector;
- Many records become inaccessible when young people change placement.

It is this last issue which was chosen for the focus of further research – the Backpack of Identity research. The *100+ points of identity* findings suggested that records are not routinely moved with children and young people when they change placement, resulting in lost or

inaccessible information for both workers and the young people themselves. School reports, medical information, sometimes birth certificates, and life story materials were some of the items that remained in agency files rather than being passed on to a new placement worker for continued accessibility. Even where the expectation was that information would be passed on, such as with information recorded in the Looking after Children (LAC) documents, this frequently did not happen.

The *100+ points of identity* research had suggested that the following types of records together make up a “personal record” containing personal information about a young person in care that would most likely be of interest or use to him or her throughout the life course.

- Looking After Children forms, including
 - birth certificates & other ID documents
 - immunisation history and other medical records
 - school reports and plans
- Life story book, photos, videos, memory box, etc.
- Other reports and plans, including information about why a child was placed in care and reasons for any placement changes
 - case closure summary
 - case plan
 - cultural support plan
 - leaving care plan

If this set of personal records could be kept together - as a “portable personal record”, then young people’s access to this information would be greatly facilitated. The Backpack of Identity research therefore set out to establish the extent to which this is possible.

The Backpack of Identity research aimed to answer the following questions:

1. What happens to records when young people change placement?
2. What policies and procedures exist to support records management that facilitates long-term access?
3. What barriers to good practice exist regarding the transfer of records?
4. What strategies will improve record keeping, so that young people and their carers have access to all their personal information, both while they are in care and later in adulthood?

Research Reference group

The Backpack research was guided by a reference group, which had also overseen the *100+ points of identity* research carried out in 2010. The author thanks these members who provided support and guidance throughout the research.

- Cathy Carnovale and Loren Polzot, CREATE Foundation
- Zoe London, MacKillop Family Services
- Craig Marshall, Anglicare
- Enza Marino, DHS
- Lee Cameron, Westcare
- Peter Lewis, VACCA
- Jim Oommen and Meredith Kiraly, Office of the Child Safety Commissioner
- Judith Newbold, Centre for Excellence
- Professor Cathy Humphreys, School of Social Work, University of Melbourne

Methodology

Information was gathered in several ways. All partner organisations currently providing out-of-home care services to adolescents were asked to complete a brief audit of written policies and procedures in relation to records management, and particularly the transfer of records when placements change. Other legal and regulatory standards were identified through conversations with key informants.

Focus group consultations were conducted with five out-of-home care teams caring for adolescents. These were recruited through partner organisations and consisted of three home-based care teams and two residential care teams, each from a different organisation. Two teams worked in regional Victoria, while three were based in Melbourne's suburbs. The consultations focussed on normal records management practice when young people change placement, move to independent living or return home, and what factors hinder or facilitate the transfer of records. Each team was interviewed twice – firstly to discuss normal records management practice in general, and secondly to describe specifically what happened with records in each of two case examples. A sixth focus group was also held with the five managers who had completed the audit, to discuss records management issues from a management perspective. Focus group transcripts were analysed using grounded theory and NVivo. Approximately 50 people were consulted during the research phase of the project.

Preliminary results were then presented to a workshop of about 40 participants, including care leavers, out-of-home care practitioners, managers and policy makers, archivists and researchers. The workshop program included small group and plenary discussions, as well as the opportunity for all participants to provide written feedback on research findings. These have been incorporated into this report.

Research findings

What standards regulate record keeping?

Discussions with a number of key informants have highlighted a range of legislation and standards which regulate records management within care-providing community sector organisations.

The most direct and specific is a section of the recently released new DHS standards³, which now require the collation of a personal portable record. Standard 4 is about participation and criterion 4.2 states that “people actively participate in their community by identifying goals and pursuing opportunities including those related to health, education, training and employment”. The children, youth and family indicator reads as follows:

“Placement details, records of life experiences and achievements, school reports, medical records, photographs of meaningful and significant events and the names of significant people involved in the child or young person’s life are available in a portable format (for example a Life Book) that the child or young person can take with them when changing placement or leaving care.”

At a broader records management level, all community sector organisations are currently bound by the Information Privacy Act. While this Act is concerned with the security of personal information, its key message for the out-of-home care sector is that subjects of records created are entitled to access information about themselves at any time.

The Public Records Office of Victoria is also in the process of developing standards for records management, which are to be introduced into new service agreements with out-of-home care providers from 2012.⁴

The *Australian Standard on Records Management* discusses access, retrieval and use of records, as well as the importance of tracking systems so that the location of any particular record is always known.⁵ In addition, the *Australian Standard on Metadata for Records*

discusses the types of metadata that should be collated at the point of creation and later on to promote accessibility.⁶ Metadata is structured information that describes, explains, locates, or otherwise makes it easier to retrieve, use, or manage an information resource. These standards were brought to the researcher's attention by the archivists involved in *Who am I?*, and do not appear to be widely known among out-of-home care organizations.

What policies and procedures exist in care-providing organisations? – audit

The audit was sent to an identified staff member within each of the ten *Who am I?* partner organisations which provide out-of-home care. Five completed questionnaires were returned. All five organisations have developed policies and procedures in relation to records management, although how detailed these policies are varies. Policies in four out of the five organisations also require or encourage out-of-home care teams to provide records to young people. These policies apply overarching principles to the whole of each organisations (particularly in the case of larger organisations) but management and staffing differences create regional differences in terms of processes and tools. Records management practice therefore varies between different out-of-home care teams within the one organisation.

All five responding organisations provided a selection of policies, procedures and tools. The policies and procedures related to issues such as file creation, records security, privacy, and file closure and storage.

A number of practices were advocated which make the location and access of client information easier. The need for a smooth transfer of records or information between workers or between teams within an organisation was emphasised in several of these documents. Several agencies specify that a client's file should be passed on as a whole if the client moved between teams in the same organisations, in order that information be kept in one place. In two cases, procedures also make it clear that the file's location should always be recorded on an agency database or computer system. Several organisations also specify that a standard file structure be used across the whole agency, which will make it easier to locate specific information in the future.

Two organisations cited guidelines requiring staff to provide relevant client information to the organisation managing the new placement. However, in policies provided by other organisations, references to passing on information to professionals in other agencies were

framed by conservative interpretations of the Privacy Act, and did not encourage the sharing of information in the best interests of the child which needs to occur in the out-of-home care field.

As the documents provided through the Audit process constituted a number of examples from a small number of organisations, no conclusions about organisational policy across the sector can be drawn. It does seem, however, that CSOs may need to examine their policies to ensure that the need for data security and privacy is balanced with the equally important imperative to share relevant information in the best interests of those in care.

Focus group findings

At the beginning of a placement, practitioners hope to receive a referral form, current Looking After Children documents, and other documents such as court orders and birth certificates, medicare card and health care card. The evidence from the focus groups was that a referral is usually received, though it does not always contain adequate information. It is much rarer to receive the other documents.

As this research focussed on adolescents in care, practitioners were most familiar with end of placement scenarios involving the young person returning home or moving to some form of independent living or supported accommodation. In these circumstances, many documents are provided to the young person, such as birth certificate, school reports and certificates, bank statements, Medicare and Centrelink documents, medical records.

In scenarios where young people moved from one placement to another placement within the out-of-home care system, supported by a new team or agency, practitioners reported that young people were given their life story book or memory box with photos etc., and any Looking After Children documents that had been completed were also passed on. While some other documents might be passed on, practice varied between practitioners and between individual young people. It is not normal practice to record in the file what records have been given to young people or to new case managers, though occasionally a case note is made to this effect.

Practitioners were clear in the focus groups that it is vital to pass on information about young people in care in order to ensure well-matched placements, smooth transitions and a good quality of care. Many put a great deal of effort into this, particularly with clients they saw as

vulnerable. Verbal handovers to new carers or workers were often used to communicate particularly important information about a young person and to highlight particular points in the written notes, but they also often included information that was not written down. Despite practitioners' preferred commitment to passing on information, the focus group interviews did not create a convincing picture of LAC records being passed on. This is confirmed by the LAC reports sent to DHS.⁷

Practitioners were also asked about normal practice when files were closed. All agencies involved in the research have stipulated procedures about closing files, storing them locally for a period of time and then sending them to storage, with appropriate archival descriptions.

Barriers

Practitioners were frank about the difficulties of passing on written information, although it was easier for them to talk specifically about what they did not receive at the beginning of a placement than what they themselves did not pass on at the end of a placement. Through the case examples as well as more general discussion, a number of barriers to good records management practice were identified.

As always in this field, the time-pressured and crisis nature of working with children in out-of-home care was universally raised by practitioners. Practitioners reported not having time to assemble the relevant records to pass on, particularly where placements terminated suddenly, due to a crisis. Once the placement had finished, their time was quickly committed to the support of a new placement, so that this work was abandoned. Few practitioners reported requesting information from a former placement, so this prompt is also missing. A number of examples were also given of shorter placements, where the worker had to deal with crises on a daily basis, and therefore did not have the capacity to record or collect personal information before the placement terminated.

In an environment where DHS requirements (court reports, quarterly reports and many other accountability mechanisms) are given highest priority, practitioners perceive the completion of LAC forms to be lower on the agenda. If not completed, they are much less likely to be passed on at the end of a placement.

Different teams displayed a range of understandings about whose responsibility it is to pass on information. Many practitioners believed that their responsibility was to provide the Child

Protection worker with all relevant information and it was the Protective worker's responsibility to pass this on to the new placement. However, this division of responsibilities became less clear in situations where the placement worker was the contracted case manager. In regions which stipulated that handover meetings occur within two or three days of placement change, practitioners agreed that this was a useful practice, that placement workers should be part of this and it is an ideal forum for gathering information. This lack of clarity regarding roles and responsibilities creates confusion about processes and allows individuals to shift responsibility to others.

Many practitioners also feel the lack of clear guidelines in knowing which documents should be transferred when placements end. This leaves individual practitioners to each develop their own practice rather than there being consistent practice across an agency or across the sector.

Practitioners presented a range of reasons for not receiving information when a placement began. In circumstances when the child had no care history, the information may not have been collected, or the family may have been unwilling or unable to share information. Where a child had been in care for a period of time, reasons included no information being on file, or information being buried in DHS records. With a high turnover of workers, particularly at DHS, workers may not have had the time to extract information from the files to provide to the placement.

A final issue that arose concerns ownership and privacy. Some carers and practitioners, proud of the work they have put into a life book, retain it in their files in order to keep it safe. There is also considerable confusion about what information can be shared outside the organization. Discussions also touched issues of what records are "owned" by the agency.

Strategies to facilitate records transfer

Many practitioners interviewed for the research work hard to ensure stable placements for their young people, and smooth and supported transitions for them. Many practitioners also worked hard to establish or re-establish family connections.

From a records point of view, several organizations have developed checklists for handover or end of placement situations. In several organisations, a child or young person has only

one file rather than separate teams starting new files. One organisation has a client file database for all its programs – the location of the file is recorded on this database, as well as the location of ID documents such as birth certificates and medicare details. In another organisation, caregivers have been provided with a locked cabinet for records relating to the young people in their care, and the contents of these are audited regularly.

The message from the focus group discussions was clear that a number of things could be done to make the transfer of records routine.

1. Clear guidelines and procedures, and a clear delineation of responsibility, was raised by all groups as essential.
2. The development of tools, such as checklists or a closure summary proforma, was also advocated by practitioners.
3. Some form of case support was discussed in all interviews. Support for practitioners with some of the administrative tasks was seen as making good records management and transfer much more achievable, with a number of models being put forward. In fact, a number of teams already have administrative support in the creation of files, their management and archiving. With large amounts of material downloaded from CRISSP, assistance is given in some teams for adding this paper to the file. Another possible form of support involves one member of an out-of-home care team having a “portfolio” for records transfer, and the role of reminding and encouraging other team members to do this. Several practitioners also advocated that one team member specialize in doing life story work with all clients. This, they suggested, would overcome the problem of life story work not being done because practitioners lack confidence or skills.
4. Finally, the idea of a written closure summary was debated in all interviews. While there was no consensus, many practitioners agreed that a written summary was essential in addition to verbal handovers, and that such a document would provide the opportunity to create a narrative summary of a young person’s circumstances, something not provided by the format of LAC. Some practitioners, however, believe that the referral form plays this role.

Workshop

The *Who Am I?* workshop held on 23 November 2011 was attended by 40 participants representing nearly all of the *Who Am I?* partner organisations. The workshop opened with a presentation from Rachel, a young consultant from CREATE, who spoke about her

experiences as a teenager in care and as the mother of a child in care, and particularly the distress caused by finding that for three or four years of her time in care there is not a single photo of her. Preliminary findings from the research were then presented, and some principles of record keeping were proposed. These included:

- Written information is more reliable than verbal information and longer lasting
- Absence of information should be explained in records (eg. LAC)
- The location of information should be noted, including changes over time
- The context of documents should always be recorded - for example:
 - Date of creation
 - Who created or wrote the item?
 - What organisation was responsible for its creation?
 - What is the purpose of the document?

Responses from workshop participants as noted on feedback forms, showed concern and commitment to improving both the story *of* the record (record keeping practices) and the story *in* the record (the content). Accuracy, accessible language and the need to incorporate more positive content about young people in care into the record were reiterated as issues needing attention.

Participants raised a number of issues in response to the presentations, including time pressures, the need for resources to make changes in this area, barriers raised by CRISSP in its current state, and the importance of engaging DHS staff in any discussions of record keeping and identity. The need for training was emphasised, particularly so that practitioners understand the links between records and supporting the identity of their clients. Testimony from care leavers such as Rachel was noted as a powerful training tool.

Participants also provided some examples of current good practice, including:

- The use of plain language in recording
- Good life story work practice and keeping multiple copies of life books
- Encouraging young people to participate in creating their own records
- Specific protocols regarding closing files and transferring information to a new placement

A checklist and a document tracking sheet were presented to workshop participants as possible tools to assist record keeping practices.

The checklist (Appendix 1) was designed to assist practitioners in knowing what records they should be receiving at the beginning of a placement and passing on at the end of a placement. It draws for inspiration on checklists already in use in some partner organisations. It also includes a list of tasks to be completed when a placement ends or a file is closed. It was received with general support from workshop participants, though some concerns were raised that it creates extra workload, especially if it is used to measure practitioners' performance. The checklist was designed to respond to practitioners' comments about lack of clarity and guidelines in this area rather than to create extra work, and can be adapted by individual organisations to fit in with their individual processes. Incorporating the checklist idea into the LAC framework may be a way of integrating all recording processes and making clear the connections between different forms, without unnecessarily imposing a new form on workers.

The document tracking sheet (Appendix 2) was designed to enable workers and care leavers to locate information, both currently and in the future, by noting the location of records and recording details of any moves. When any type of records is transferred from one location to another, or from one person to another, the following information needs to be recorded, so that the "story of the record" is retained.

- Date item was moved or copied
- Who moved or copied item (eg. case manager, admin., archivist, manager)
- Where it was moved or copied from
- Where it was moved or copied to

While most participants supported the concept of tracking the location of records, a number of concerns were raised, which made clear that this tool needs considerably more development in consultation with DHS and the out-of-home care sector. As the draft stands, as a paper document, it was seen as unwieldy, time consuming and complicated to fill out. Proposals were made that the tracking sheet could be used as a checklist for transfer of documents. However, doing this raises the danger that unlisted documents may not be noted, and that the tool would become a record of current location only. Archivists stress that all instances of record relocation need to be kept on record to provide a full story of the record. It was also noted that item descriptions need to be carefully drafted, so that they lead to the easy identification of the actual document - eg. "Psych Assessment (9/10/2011)". To be useful, the tracking sheet needs to refer to both paper and digital records. Integrating the tracking sheet into the CRIS/SP system, so that both placement workers and DHS workers

can access and record in it, may be the most effective and least burdensome means of implementing this tool.

Discussion

It was apparent when commencing the focus group interviews that, with the exception of the life book, few practitioners had thought about the written records they were creating as records to support the identity of their clients in the long term. However, when introduced to the idea, they took it on board immediately, and were particularly concerned about the well-being of clients when they access their records - the professional language of much report-writing that is inaccessible to non-professionals and the much larger amount of negative rather than positive detail in the files.

Recommendation 1.

That a training package on record keeping to support identity be developed as a resource for the sector, incorporating care leaver testimony.

The structure and management of records was discussed by practitioners as a set of procedures which framed their work. The degree to which these procedures were established by the organisation varied, but where guidelines were absent, workers complained about lack of clarity or developed procedures themselves, based on the logic of their own information needs in caring for their clients. It was noticeable that the practitioners interviewed were not always familiar with the policies and procedures developed centrally, particularly by the larger organisations. Indeed, one of the audit respondents acknowledged that the existence of policies and procedures does not guarantee that they are acted on in practice - a familiar challenge for all organisations.

The relationship between practice and organizational policies

Policies and procedures nevertheless can play an important role in establishing a practice culture within an organisation, particularly when supported by staff education and good supervision. The organisational privacy policies provided to the researcher tend to emphasise the need for caution in disclosure and sharing of information. For larger organisations, these policies apply across a range of program areas, which may have differing approaches to information sharing. The overall message is one which discourages the sharing of information, although this is almost always in the best interests of children in

the out-of-home care field. The need to share information applies equally to sharing information with other teams within an organisation, with other care providing organisations and with organisations in different jurisdictions or outside the out-of-home care sector.

The sector also needs to cooperatively develop guidelines which clarify the roles and responsibilities involved with ensuring that relevant records are transferred. Currently, the respective roles of Child Protection case managers, contracted case managers, care managers, and placement workers and carers appear to be somewhat unclear in the area of records management. The “care team” model was proposed by several focus group participants as a suitable forum to discuss and share out the tasks of recording the location of records, passing them on, and storing them safely for the future. However, this model can only work if one team member clearly has the chairing role and takes primary responsibility for the delegation of tasks. Guidelines clarifying these issues should preferably be incorporated into sector-wide regulations, or at least into organisational policies.

Recommendation 2.

That guidelines clarifying the roles and responsibilities involved in records transfer be developed and incorporated into sector-wide regulations, and all organisational policies.

Recommendation 3.

That organisations develop policies, procedures and tools which balance the need to protect privacy with the importance of information sharing in the best interests of the child and which clarify what information should be passed on at change of placement.

Looking after Children records

Aside from life story work, the Looking after Children records form the cornerstone of information gathering about children in out-of-home care. The Essential Information Record records much of the information useful both to professionals currently caring for a young person and to that young person now or in the future. As such, there is a universally acknowledged expectation that the Essential Information Record will be forwarded to the new placement worker when placements change, but only within the out-of-home care system. A number of case examples were presented in the focus groups where young people moved to a new placement interstate, or at 18, to some form of supported accommodation or case management outside the out-of-home care system. In these cases, the LAC documentation was never passed on, as the receiving system did not use LAC. Instead workers completed detailed referral forms duplicating information contained in the Essential Information Record

or were frustrated about not being able to provide information at all. These examples epitomize the common attitude towards LAC as a system of paperwork rather than as a tool to record and share useful information in the best interests of the child - an ongoing challenge for the sector.

Focus group discussions about receiving the LAC Essential Information Record tended to focus as much on the quality of the information recorded in it as whether it was actually received or not. However, as was outlined earlier in the report, there are a number of reasons why information may not be available. Noting the reason for information not being available – parents not willing to share information, some enquiries have been made with no success, waiting for action from a third party, etc. – ensures that new workers are aware of what efforts have been made to date. It also provides evidence for the young person that efforts were made to obtain information. Even if the information was not obtained, this makes a very different impression than a blank page, which can signify that no effort has been made.

In the focus group interviews, practitioners expressed a wide range of positive and negative views about LAC and its usefulness to their work, including some quite inaccurate beliefs. A large part of the difficulties in ensuring that LAC is passed on at placement change is related to these attitudes and the challenges for the sector in educating professionals to view LAC as a useful tool for managing a young person's care, rather than "a massive document full of nothing really", another set of paperwork. The LAC framework was not integrated into the existing reporting systems when it was introduced and there has been no attempt to adapt LAC to streamline reporting processes since, so that placement agency practitioners and their managers report that the same information needs to be recorded in multiple different formats for a variety of reporting purposes. If these reporting requirements were streamlined, using LAC as the central tool, it is much more likely that the LAC documents would be completed.

Another difficulty with passing LAC on at times of placement change relates to some very practical considerations. While many practitioners provide the relevant Child Protection worker with the documents, there was widely expressed doubt that they were often passed on to the new placement. Paper copies of the documents can be handed to the new worker at handover meetings, but these meetings do not universally occur. Some practitioners have considered emailing them, but report that the documents are too large to send through their agency email systems.

Some practitioners advocated the establishment of a central LAC database, where all of a young person's LAC records could be stored, and be accessible to anyone authorized to view them. This would avoid the need to physically pass them on at times of placement change. Currently, the LAC forms are generated in CRISSP, the placement-controlled part of the CRIS/SP case management system. Once a young person has moved to a new placement and the old placement agency has "closed" the case, the young person's records can no longer be accessed. The new agency also cannot access old versions of LAC documents, created by the old agency. It might be more useful to create a section on CRIS for the LAC documents and revise the arrangements for who can access this section of CRIS.

Viewing the Essential Information Record from the perspective of a care leaver seeking information at some time in adult life, there are several gaps in the current version of the form.

Health Information - the need for both current health information and a medical history is not made explicit. Nor is there provision on the form for recording the hospital or clinic at which treatment was given. Not all medical reports can be included in a young person's records - for example, psychiatrist's reports are often not available without a guardian's permission - so the inclusion of this information would assist a future care leaver to locate medical records of interest.

Identity - there is a question in the identity section of the LAC Essential Information Record about the location of a "copy" of the birth certificate. However, it would appear that copies (even certified copies) are of limited use as they are not accepted as proof of identity for purposes such as opening a bank account or obtaining a driving licence. Not only should birth certificate originals be passed on when young people change placement, but their location should be recorded in the Essential Information Record, as well as the location of other identification documents.

Recommendation 4.

That a central LAC database be developed to facilitate the sharing of LAC information, possibly based in CRIS, with revised access arrangements.

Recommendation 5.

That the LAC Essential Information Record be adapted to incorporate more detailed information about identity documents and medical records, as well as information about the location of personal information and reports.

Life Story Work

The focus group interviews confirmed evidence gained from earlier phases of the *Who am I?* research that the practice of life story work is inconsistent, and frequently does not occur, particularly with adolescents who are not interested in participating in this sort of activity. As life story books, memory boxes and other material was seen to be the property of young people, they were often in their possession and were transferred as part of their belongings. Therefore, practitioners did not know whether life story materials had been collected in previous placements, as this was not passed on to the new worker but stayed with the young person. Many teams make copies of photos, certificates, drawings and other items to keep in the file in case the original is lost but, even in this small sample, this was by no means a universal practice. Some practitioners expressed the view that file copies of photos are not necessary because young people have so many different places to store photos – phones, memory cards, computer, web storage such as Facebook, etc.

Several issues emerge as significant if care providers are to ensure that life story materials remain available for care leavers to access at a later stage in their lives. Firstly, it is essential that copies of life story materials are stored safely for future access. Many young people do not want to think about their life story as teenagers or young adults, and when they have left care, many experience living circumstances that are not conducive to keeping such material safe, even if they are valued.

Secondly, the practice of placing life story materials in the young person's possession has several implications. As practitioners do not receive life story materials at the beginning of the placement, they may not know what life story work has been done in previous placements or be able to build on this. In addition, any copies would be stored only for the current placement. In the event that a young person loses his or her copy, she or he must apply to all agencies with whom he or she was placed, in order to reassemble a life narrative. While it is important to acknowledge that life story materials belong to the young people themselves, particularly once they are of an age to decide who they share this information with, the out-of-home care sector has a duty of care to keep this material together as much as is possible.

Recommendation 6.

That the Life story is the core of the personal portable record. It is recommended that organisations keep local copies and act to ensure that the life book does not become dispersed to a range of locations.

A note about medical records

Practitioners reported examples of good practice where a comprehensive medical history was forwarded to all relevant professionals, but these tended to be situations where a child had significant medical problems. It is important, however, to systematically record a medical history, even for those children who are rarely ill. This should include a history of appointments and the clinics where they took place. One placement agency consulted for the research uses a form, which records the doctor, time and date of visit, and any details of the consultation if these are known. The form also makes provision for recording if the young person failed to attend the appointment. Such a form ensures that his information is not “hidden” in a casenote, by being easily accessible for future access and at the very least provides a written record that the young person’s health was taken seriously by those caring for him or her.

According to practitioners, the immunization section of the LAC Essential Information Record is rarely completed - in the focus group discussions a high level of confusion and ignorance was apparent about how to obtain this information.

Issues of access to records

Practitioners were generally comfortable with the files they created and they and their managers were confident that they and future professionals would be able to find specific information in them. A number of assumptions were made during the interviews, however, which allowed them to view future access to files as unproblematic. While these assumptions may not be universally believed, they need to be challenged.

While they are in care, young people in care do not have the right to view their files.

While some placement agencies acknowledge that files should be shared with clients, practitioners from other agencies were very cautious about this. They were concerned about the effect on young people of seeing difficult information about themselves and their families before they were emotionally ready, and believed that some documents (such as referral

forms) were directed at a professional audience and were not suitable for clients to see. However, the legislation is clear that young people have a right to see records about them, while they are in care and afterwards. Limitations to this right include considerations of the physical or mental health of the person concerned and the need to protect the privacy of third parties where appropriate.

Care leavers will not see the files themselves but will be given only relevant pieces of information. Care leavers will always be assisted and supported by a professional when accessing their file, so that they will have assistance in finding information, and any unfamiliar terms will be explained.

While some placement agencies employ specialist staff to assist and support care leavers when accessing their records, this is by no means universal across the out-of-home care sector, and there is no guarantee that such assistance will be available in the future (although it is hoped that services will improve rather than deteriorate!). In addition, some care leavers choose to receive and read their records without assistance.

Recommendation 7.

That files have a standardized format across a whole agency, even across different program areas, in order to facilitate the location of specific information

Data management systems such as CRIS/SP will successfully preserve data indefinitely into the future.

At this point in time, it is unknown how CRIS/SP data will be stored as new technologies develop. It cannot be assumed that data stored in CRIS/SP will be accessible in the future. We also do not know the future of social networking sites such as Facebook, and what will happen to information stored there when they are superseded. Record holding agencies should therefore ensure that local copies of all important information are safely stored.

Recommendation 8.

That a local copy (paper or electronic) of all files and documents be kept by care-providing organisations.

Archivists in the future will understand the context of today's decision-making and terminology.

A vast amount of knowledge within the out-of-home care sector is held within the minds of individuals rather than in written form. While these knowledgeable individuals are active in

the field, it can be difficult to perceive this as a gap, but it should be noted that this knowledge is lost very quickly once they retire or move on. The nuances of terminology and procedures very familiar now may easily be inadequately understood in ten years time. Organizations need to bring together archivists / records managers and practitioners to ensure that the contextual information which turns a collection of documents into narrative is recorded for future reference.

Recommendation 9

That contextual information about records be recorded in the present to assist those concerned with records release in the future, both care leavers and out-of-home care professionals.

Conclusions

The Backpack of identity research has confirmed earlier research showing that the out-of-home sector faces a challenge in terms of the completion both of the Looking after Children documents and life story work. While each organisation takes responsibility for the particular focus of its staff, a number of the issues raised in this report also require a sector-wide approach.

The new DHS standard quoted earlier in this report is an encouraging example of a regulation which supplies a framework in which to encourage life story work. LAC too is central if completed properly. Official reports such as case plans are also part of the personal record of care.

The main challenges highlighted by this research are about the story of the record - how to ensure that information is not lost in archives and filing systems during times of transition such as placement change. This challenge needs a three-pronged approach.

1. Education - many out-of-home care sector professionals have not yet thought about the long-term identity needs of their clients, beyond considering the importance of the life book for their clients' current therapeutic needs. Once they are introduced to the idea, however, most take it on board quickly. The concept of the link between records and long term identity support needs to be incorporated into orientation and other training across the sector.

2. Clarification of roles and responsibilities regarding the transfer and sharing of client information is essential. This is a challenge which requires a collaborative approach by all parties within the sector, in order to break down the jurisdictional barriers that exist.

3. While some tools can be developed at a local level to assist practitioners and provide guidelines about what information should be transferred, it will be most effective to integrate new information collection tools (such as the tracking sheet) into current record keeping systems.

This research has thus far focussed on the work of CSOs who provide out-of-home care placements. Further work needs to involve discussions with DHS about Child Protection record systems and their relationship to the information gathered by CSO workers.

We need to create a record keeping system which enables the creation and safe transfer and storage of a personal portable record for children in out-of-home care, incorporating both personal information and the official records which will help them understand their experiences of care. A well functioning personal portable record will ensure that personal information is not only recorded but is accessible (where appropriate) to young people in care, and is able to be easily located in the long term for future access by those who have spent all or part of their childhoods in care.

Recommendations

To further sector-wide good practice in the area of record keeping to support identity, it is recommended:

10. That a training package on record keeping to support identity be developed as a resource for the sector, incorporating care leaver testimony.
11. That guidelines clarifying the roles and responsibilities involved in records transfer be developed and incorporated into sector-wide regulations, and all organisational policies.
12. That organisations develop policies, procedures and tools which balance the need to protect privacy with the importance of information sharing in the best interests of the child and which clarify what information should be passed on at change of placement.
13. That a central LAC database be developed to facilitate the sharing of LAC information, possibly based in CRIS, with revised access arrangements.
14. That the LAC Essential Information Record be adapted to incorporate more detailed information about identity documents and medical records, as well as information about the location of personal information and reports.
15. The Life story is the core of the personal portable record. It is recommended that organisations keep local copies and act to ensure that the life book does not become dispersed to a range of locations.
16. That files have a standardized format across a whole agency, even across different program areas, in order to facilitate the location of specific information
17. That a local copy (paper or electronic) of all files and documents be kept by care-providing organisations.
18. That contextual information about records be recorded in the present to assist those concerned with records release in the future, both care leavers and out-of-home care professionals.

Appendix 1

CHECKLIST FOR RECORDS MANAGEMENT AT THE BEGINNING OR END OF A PLACEMENT

New DHS Standard 4, criterion 4.2 - Children, youth and family indicators

“Placement details, records of life experiences and achievements, school reports, medical records, photographs of meaningful and significant events and the names of significant people involved in the child or young person’s life are available in a portable format (for example a Life Book) that the child or young person can take with them when changing placement or leaving care.”

⇒ Case manager to have responsibility for checklist tasks being completed, though tasks may be carried out by placement worker.

Beginning of placement

This checklist summarises the tasks to be carried out when a child or young person who already been in out-of-home care, enters care with your team.

| | |
|---|---|
| <i>If there has been a former placement, check that the following records have been received, or their location is known. If not, request them from former placement worker</i> | |
| <input type="checkbox"/> | Birth Certificate and other identity documents |
| <input type="checkbox"/> | Medicare card, Healthcare card |
| <input type="checkbox"/> | LAC Essential Information Record |
| <input type="checkbox"/> | LAC Care and Placement plan |
| <input type="checkbox"/> | LAC Assessment & Progress Record |
| <input type="checkbox"/> | LAC Review of Care and Placement plan (if applicable) |
| <input type="checkbox"/> | Life book |
| <input type="checkbox"/> | Memory Box |
| <input type="checkbox"/> | Other photos, DVDs etc. |
| <input type="checkbox"/> | Case Closure Summary |
| <input type="checkbox"/> | Best Interests / Case Plan (if CSO has case management) |
| <input type="checkbox"/> | Reports from Health professionals |
| <input type="checkbox"/> | School reports |
| <input type="checkbox"/> | Individual Education Plan (if applicable) |
| <input type="checkbox"/> | Cultural support plan (if applicable) |
| <input type="checkbox"/> | Leaving Care Plan (if applicable) |
| <input type="checkbox"/> | Updated Tracking Sheet |
| <input type="checkbox"/> | Ensure any documents received are filed with information about purpose, date of creation, who created them and where they have been transferred from. |

End of placement

This checklist summarises the tasks to be carried out when a child or young person's placement with your team ceases in the following circumstances:

- child or young person is moving to a new placement or program
- child or young person is returning home
- young person is moving to independent living

When all tasks are completed the file is passed on to the team within your agency receiving the child or young person, or is archived according to agency policy.

| <i>File Closure / transfer</i> | |
|---|---|
| <input type="checkbox"/> | Copy lifebook and place on file |
| <input type="checkbox"/> | Ensure all belongings are moved with the child or young person, including lifebook and memory box |
| <input type="checkbox"/> | Where applicable, ensure caregiver has returned all documents relevant to the child |
| <input type="checkbox"/> | Update CRISP, and close if child has left the agency's care. |
| <input type="checkbox"/> | Update Tracking Sheet to record location of records, including data that remains only on CRIS/SP |
| <input type="checkbox"/> | Place updated tracking sheet at front of file to be archived or moved |
| <input type="checkbox"/> | Archive electronic files in accordance with organisational policy |
| <input type="checkbox"/> | Archive paper files in accordance with organisational policy - if child has left the agency's care. |
| <i>The following records are made available to the new placement, to the family or to the young person.</i> | |
| <input type="checkbox"/> | Case closure summary completed on CRIS/SP |
| <input type="checkbox"/> | Birth Certificate and other identity documents |
| <input type="checkbox"/> | Medicare card, Healthcare card |
| <input type="checkbox"/> | LAC Essential Information Record |
| <input type="checkbox"/> | LAC Care and Placement plan |
| <input type="checkbox"/> | Assessment & Progress Record |
| <input type="checkbox"/> | Review of Care and Placement plan (if applicable) |
| <input type="checkbox"/> | Life book |
| <input type="checkbox"/> | Memory Box |
| <input type="checkbox"/> | Other photos, DVDs etc. |
| <input type="checkbox"/> | Case Closure Summary |
| <input type="checkbox"/> | Best Interests / Case Plan (if CSO has case management) |
| <input type="checkbox"/> | Reports from Health professionals |
| <input type="checkbox"/> | School reports |
| <input type="checkbox"/> | Individual Education Plan (if applicable) |
| <input type="checkbox"/> | Cultural support plan (if applicable) |
| <input type="checkbox"/> | Leaving Care Plan (if applicable) |
| <input type="checkbox"/> | Updated Tracking Sheet – include an explanation if any of the above records are not available. |

Appendix 2

OUT OF HOME CARE – DOCUMENT TRACKING SHEET

A Document Tracking Sheet should allow workers and care leavers to locate information, both currently and in the future, in the following circumstances:

- documents located outside the client file (eg. medical clinic, caregiver's home, etc.)
- documents moved between different volumes of one case file
- documents moved between files managed by different programs within an agency
- documents moved between files managed by different agencies

Documents and Items to be tracked include anything which may be of interest to the child / young person in the future (ie during their adult years) - for example:

| <u>LAC</u> | <u>Life Story Information</u> | <u>Other Information</u> |
|--|--|--|
| <ul style="list-style-type: none">- Birth Certificate and other ID documents- LAC Essential Information Record- Care and Placement plan- Assessment & Progress Record- Review of Care and Placement plan | <ul style="list-style-type: none">- Life Story Book or record reflective of the young person's experience in care- Photos or video of child and birth family- Photos or video of child and foster family or resi carers- Personal documents and items (eg. certificates, trophies, cards, letters, memorabilia etc.)- Memory boxes | <ul style="list-style-type: none">- Case Closure Summary- Best Interests / Case Plan- Reports from Health professionals- School reports- Individual Education Plan- Cultural support plan- Leaving Care Plan |

Draft Tracking Sheet overleaf

CLIENT NAME

UNIQUE IDENTIFIER (if any) - *CRISSP number? / agency client number?*

| Date | Item Description | Where is the original? | Who has copies? | Item moved from - to or Item copied from - to | By? | Comments |
|------------|-----------------------------------|----------------------------|--------------------------|---|-------------|---|
| 1/9/2011 | Life book | Bruce Jones (young person) | St Lukes file | | | |
| 1/9/2011 | Birth certificate | DHS | St Lukes File, caregiver | | | |
| 1/10/2011 | Essential Info Record (1/10/2011) | CRISSP St Lukes file | DHS | Copy emailed from St Lukes Foster care to CAFS Foster care | Case worker | |
| 1/10/2011 | Birth certificate | CAFS Foster care | St Lukes file | Original sent from St Lukes Foster care to CAFS Foster care | | Original remains at St Lukes |
| 1/10/2011 | Memory Box | Bruce Jones (young person) | | | | Moved with Bruce's belongings to new CAFS placement |
| 10/10/2011 | Psych. Assessment (9/10/2011) | Dr Smith, XYZ clinic | DHS | | | |

ENDNOTES

¹ Discussion papers and reports relating to this workshop series are available on the *Who am I?* project website, at <http://www.cfecfw.asn.au/know/research/sector-research-partnership/partnership-projects>.

² Margaret Kertesz '100+ points of identity – gathering young people's history for the future: final report', April 2011, available from <http://www.cfecfw.asn.au/know/research/sector-research-partnership/partnership-projects>.

³ Department of Human Services Standards, June 2011, available at <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/departments-of-human-services-standards/departments-of-human-services-standards>.

⁴ Public Records Office of Victoria, 2010, *Strategic Management Recordkeeping Standard*, PROS 10/10
Public Records Office of Victoria, 2010, *Strategic Management Specification 1*, PROS 10/10
These are supported by a number of guidelines and fact sheets. See <http://prov.vic.gov.au/>.

⁵ Standards Australia 2002, *AS ISO 15489 Australian standard on records management*, Standards Australia, Sydney.

⁶ Standards Australia 2006, *AS ISO 23081.1 Records management processes - Metadata for records, Part 1: Principles*, Standards Australia, Sydney.
Standards Australia 2007, *AS/NZS ISO 23081.2 Records management processes - Metadata for records, Part 2: Conceptual and implementation Issues*, Standards Australia, Sydney.

⁷ LAC reporting spreadsheets supplied by Ruth Champion, DHS.