

Health for our most vulnerable: a qualitative analysis of an innovative approach to healthcare facilitation for children in out-of-home care

Abstract

Background Many children in out-of-home care (OoHC) have complex healthcare needs. This, paired with the complexity of the healthcare system, resulted in difficulty providing timely, coordinated and effective healthcare in a regional setting in Queensland, Australia. In response, a new model was developed which included the introduction of a unique health advisor (HA) role. This study explored key stakeholders' perceptions – including facilitators and barriers – regarding the implementation of this new model of care delivery to children in OoHC.

Methods A qualitative study design using face-to-face interviews and focus groups was used to explore key stakeholders' perspectives relating to issues faced by children in OoHC seeking healthcare and their experiences with the HA role. Purposive sampling was used to recruit participants from four key groups – carers, child safety officers (CSO), paediatricians and general practitioners (GPs). Thematic analysis using a reflexive approach was used to generate themes from qualitative data which was transcribed verbatim.

Findings The responses from interviews (n=20) and two focus groups (n=14) generated four key themes:

- Getting in the door: initial access to healthcare
- Who's who in that big zoo: key providers of healthcare
- Navigating the maze: communication and collaboration
- Working together: coordination, advocacy and support

Discussion The majority of participants reported positive experiences with the new model, particularly relating to improved initial access to healthcare, communication and coordination; however, this varied according to level of engagement with the HA. The dual coordinator–clinician role of the HA was identified as particularly beneficial. Barriers to healthcare included lack of prioritisation and difficulties accessing mental health and allied health services.

Conclusions This study demonstrated the positive impact of the HA model and provides a blueprint for implementation in other healthcare services.

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Summary of relevance

What is already known about the topic / what this paper adds

Children in out-of-home care (OoHC) have complex healthcare needs, with long-term impacts. An ad hoc approach to healthcare is inadequate. A health advisor (HA) for children in OoHC, undertaking a dual coordinator–clinical role, appears to positively impact on the provision of healthcare to this group. Some barriers remain, including lack of prioritisation as well as difficulties accessing mental health and allied health services. To our knowledge, this model remains unique in the setting of children in OoHC in Australia.

Introduction

Out-of-home care (OoHC) refers to alternative living arrangements for children who cannot live with their biological parents or guardians, most commonly following a child protection intervention.¹ These living arrangements include foster care, care with relatives (kinship care), group homes, institutions or living independently.² Recent reports cite 45,756 Australian children lived in OoHC as of 30 June 2018 – approximately 8.2 children per 1000 – and this trend is increasing.² Children placed in OoHC are in a state of social vulnerability¹, with the associated complex physical and mental health needs being well documented.^{3–7} These health disorders are known to persist into adulthood.^{8,9}

National and state-wide reports have identified key standards and recommendations which place timely, effective and appropriate healthcare at the forefront in response to the needs of children in OoHC.^{10,11} In addition, the introduction of roles such as a “Care Coordinator Health Officer”^{11(p242)} were recommended to facilitate timely access and continuity of care. Within Queensland, the then Department of Child Safety, Youth and Women (henceforth referred to as Child Safety) is the lead agency for child safety and adoption services with a focus on building families’ capacity to care for their children.

Government funded, local health services are tasked with the responsibility of providing health care to children and their families as required. For the purposes of this study this was a large, regional hub known as the Sunshine Coast Hospital and Health Service (henceforth referred to as the Health Service).

In the past, healthcare was provided to children in OoHC in this study’s regional setting on an opportunistic basis, for example if an issue was identified by the carer or child safety officer (CSO). This system was insufficient to meet the complex needs of these children¹², and there was substantial variation in identification of health needs and how health assessments were conducted and documented.¹² This is supported by the literature, as ad hoc approaches result in

a lack of routine health surveillance which in turn leads to failure to adequately diagnose and manage health conditions in this population.¹³

The Child Protection Liaison Unit (CPLU) at the study site responded to these deficits by way of a new model. A health advisor (HA) for children in OoHC was introduced, together with some associated changes to the referral, triage, assessment and follow-up processes (Figure 1). Initially, the HA was primarily a coordinator; however, the role evolved to include both coordination and provision of healthcare. The current holder of the HA role is a clinical nurse with a child health background and additional education on the effects of trauma on child development.

Currently, there are approximately 432 children in OoHC in the study region [HA, personal communication, 24 February 2020]. Prior to implementation of the new model, approximately 100 children received healthcare by paediatricians in the CPLU. The remainder were managed by general practitioners (GPs) on an ad hoc basis. Now, the majority (around 352) of children have been assessed by either the HA or CPLU paediatricians, with the minority being managed by their existing paediatricians in the health service or choosing to remain under the care of their GP [HA, personal communication, 24 February 2020].

A recent systematic review evaluating organisational healthcare models for children in OoHC outlined four “promising models of good practice”^{3(s4, p1)} from England, Norway, Denmark and the USA. The common factor linking these models was that they were governed by healthcare systems rather than child welfare authorities.³ No Australian studies were identified in this review, affirming the paucity of high quality research evaluating current models.

Health coordinator roles for children in OoHC have now been widely established around Australia.^{14,15} Various models for assessment and provision of healthcare have also been described in recent literature; some make use of primary care¹⁶ and others utilise multidisciplinary teams.¹⁷ Roles that combine clinical and coordinator tasks are becoming more prevalent in other disciplines. For example, many Australian clinical teams include clinical nurse consultants.¹⁸ However, to our knowledge, this model of the dual coordinator and healthcare provider nature of the HA role remains unique in the setting of children in OoHC in Australia.

Evaluation of this innovative model’s impact from the perspective of key stakeholders embedded in care of children in OoHC was a priority. Stakeholders included carers, CSOs, paediatricians and GPs. A qualitative approach allows for open-ended exploration of complex relationships along with underlying perceptions and motivations.¹⁹ It may also pave the way for future quantitative research to supplement the findings. Qualitative studies exploring stakeholders’ perspectives regarding access to healthcare for children in OoHC have been undertaken in Australia^{20,21} and overseas²²;

however, none explore a similar model to the one reported here. This evaluation serves the purpose of local refinement, while at the same time providing a blueprint for a model that could be implemented on a wider basis, both in Australia and globally, with the ultimate aim of improving healthcare for this vulnerable population of children.

Aim

This study aimed to explore key stakeholders' perceptions – including facilitators and barriers – regarding the implementation of a new model of care delivery to children in OoHC in a regional health service in Queensland, Australia.

Methods

Research design

A qualitative enquiry using interviews and focus groups was undertaken. Enquiry into complex systems of care is best met through qualitative approaches to facilitate a breadth and depth of enquiry not possible with quantitative methods.¹⁹

Ethical considerations

This study was conducted with full ethical approval from the Children's Health Queensland Hospital and Health Service (HREC/15/QRCH/245), and the partnering University of the Sunshine Coast [S/16/835]. Informed voluntary consent was

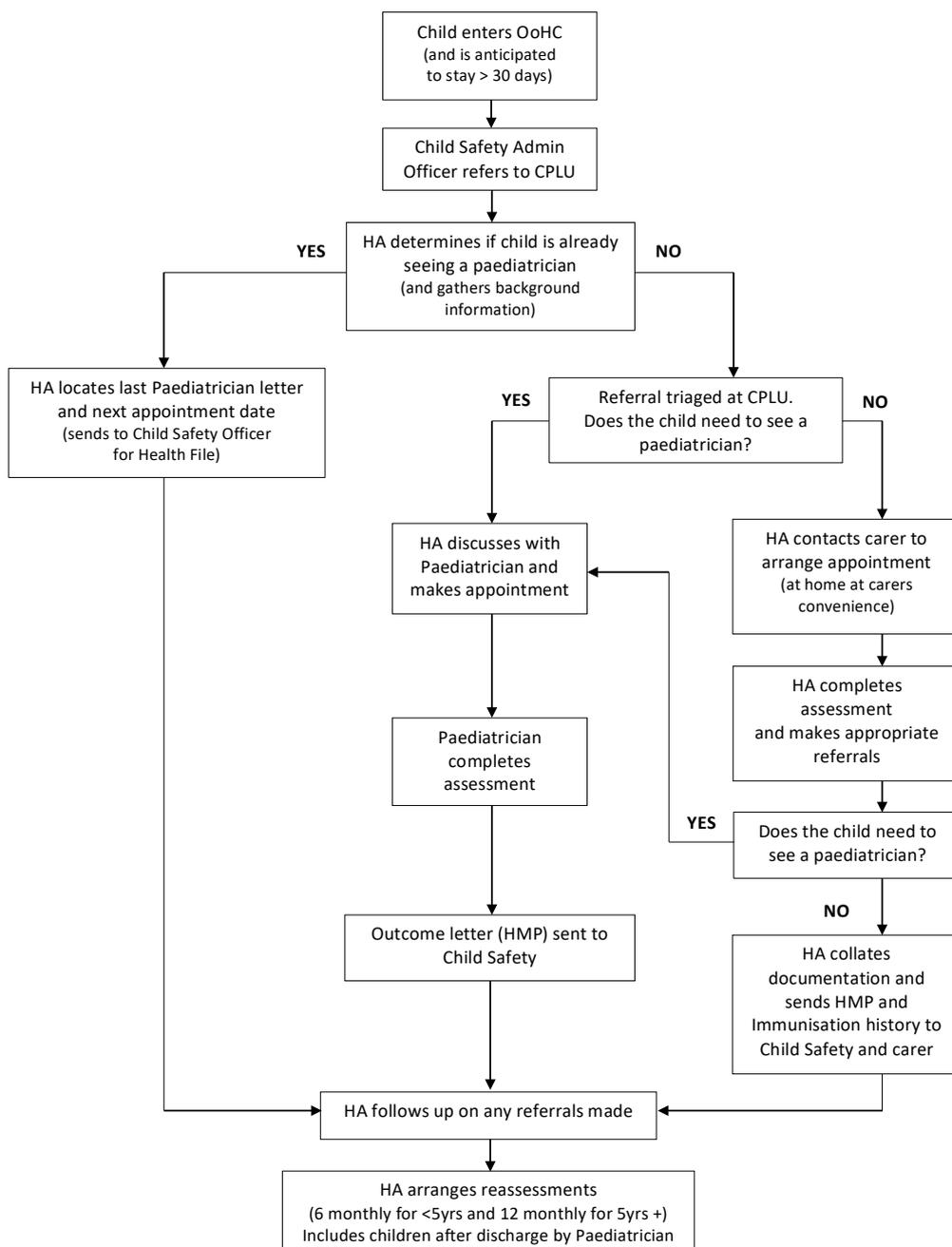


Figure 1. Health assessment pathway for children in OoHC. Adapted from Baer et al.¹² with input from a HA [personal communication, 25 March 2020].

Abbreviations: CPLU: Child Protection Liaison Unit; HA: health advisor; HMP: health management plan; OoHC: out-of-home care

recorded from all participants, and the study conformed with the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).²³

Sampling and recruitment

Purposive sampling was undertaken consistent with a qualitative enquiry.²⁴ Inclusion criteria included key stakeholders identified as either carers (n=7), CSOs (n=16), paediatricians (n=9) or GPs (n=2). Although children in OoHC are recognised as having contributed valuable views and experiences within research studies in Australia^{25–27}, children were not included in this study.

The issue of potential bias in participant selection was carefully considered. Specific methods of recruitment varied between stakeholder groups, with attempts to balance bias, ethical issues and feasibility. Carer and GP participants were purposively selected to ensure a range of experience was represented, whereas all paediatricians in the health service and all local CSOs were invited to participate. Invitations to participate were distributed by organisational teams rather than by the researchers, where possible.

Data collection

Semi-structured interviews (n=20 participants) and two focus groups (n=14 participants) were chosen as the method of data collection. Focus groups were offered to CSOs determined by likelihood of similar experiences due to a common workplace. There was more diversity within the other stakeholder groups in relation to experiences, including a variety of different workplaces for the healthcare staff. Focus groups result in less speaking time per participant; however, this was ameliorated by encouraging all participants to speak and allowing sufficient time for their contribution. There is also the risk of bias if one opinion appears to prevail; however, counter to this is the concept of symbolic interactionism where a focus group can actually collectively construct meaning through their interactions.²⁸

Topic guides were generated as informed by the current literature^{20,22} (Supplement 1) whereas the semi-structured nature of the interviews and focus groups allowed for flexibility in discussion driven by participant responses. Pilot interviews were conducted with healthcare staff within the CPLU to test the topic guides in order to improve rigour.

Table 1. Study sample

Stakeholder group	Number of participants	Data collection method (n)
Children	0	N/A
Carers	7	Phone interviews (7)
Child safety officers (CSO)	16	Phone interview (1) Face-to-face interview (1) Focus group 1 (6) Focus group 2 (8)
Paediatricians (total)	9	Face-to-face interviews (9)
• Child protection paediatricians	2	
• General paediatricians	3	
• Developmental paediatricians	3	
• Combined: general and developmental	1	
General practitioners (GPs)	2	Face-to-face interviews (2)
Total	34	

Data collection occurred between September and November 2019. Interviews lasted between 12–28 minutes per participant and focus groups lasted between 44–55 minutes. All interviews and focus groups were audio-recorded and transcribed verbatim. All of the carer interviews and one CSO interview were by phone. The face-to-face interviews mostly took place at locations within the Health Service, although one took place in a GP's home by participant request and mutual agreement. The focus groups took place at the two local Child Safety offices. Study participants (n=34) are presented in Table 1.

Interim analysis occurred as data were collected. As key themes were generated from each stakeholder group, recruitment and data collection were ceased at thematic saturation.²⁴

Data analysis

Reflexive thematic analysis using an inductive approach was employed to analyse the data.²⁹ This process provided a means to summarise and code qualitative data, develop themes, and allowed subsequent analysis, refinement and interpretation to build theories and arguments to support whether or not an innovative model of care to assist navigation of complex health systems would be beneficial for children in OoHC.³⁰ Verbatim quotations have been presented throughout to substantiate the theme generation.

Results

Analysis of the transcriptions resulted in the generation of four key themes – Getting in the door: initial access to healthcare; Who's who in that big zoo: key providers of healthcare; Navigating the maze: communication and collaboration; and Working together: coordination, advocacy and support. Table 2 presents the themes and categories generated, with example quotations to demonstrate analytic processes.

Getting in the door: initial access to healthcare

Initial referral to the health service

In the past, healthcare was provided to children in OoHC in our region opportunistically. This was difficult to achieve in a timely, coordinated and effective manner, as reported by all stakeholder groups:

Table 2. Key themes

Overarching themes / categories	Verbatim data
Getting in the door: initial access to healthcare	
Initial referral to the health service	<i>Access has become so much easier... you send her an email, you have a chat to her... and she just really gets things moving on – CSO #10</i>
Triaging of referrals to the CPLU	<i>We're now seeing a much more targeted group since the health care advisor's role – Paediatrician #2</i>
HA assessments and HMPs	<i>It was through (the Health Advisor) that then she put me in touch with other people so that I could have these health checks so that I could go and see a paediatrician – so that I could go and see a behavioural person – a language person – a hearing person – Carer #1</i>
Collation of information and documentation	<i>We don't really have any knowledge of the parents' health background and things like that. So that's really challenging because there are things that have come up during the journey that we now realise we should have been paying more attention to – Carer #1</i> <i>Normally, we would see the child as an initial (appointment), then request all that information... In a lot of those cases, we've been able to move forward and make a plan six months earlier – Paediatrician #5</i>
Prioritisation	<i>I think criteria could be a little bit different for children who are in out-of-home care already... in an ideal world, bypass the waiting list, because they've already been subjected to so much hardship already – CSO #12</i> <i>Initially on the referral (to the Child Development Service), we might not have found that there are urgent issues to respond to, and then the Health Advisor's contacted us and asked for a higher prioritisation rating – Paediatrician #6</i>
Who's who in that big zoo: key providers of healthcare	
CPLU	<i>There could be nutritional deficiencies, trauma, psychological interventions, which I think is really important to capture in a specialist service – CSO #3</i> <i>If you've been pulled out of a trauma situation, you need to be able to see someone who has a trauma lens fast to know the appropriate places to link you into, and what you need – Paediatrician #3</i>
General paediatrics	<i>I've looked after them while they've been in the care of their parents, they've then been moved to foster care, and that foster carer doesn't know as much about their health background as I do – Paediatrician #9</i>
Mental health services	<i>It is not uncommon to seek mental health input for these patients and be denied access to that service because the conditions from a diagnostic perspective are primarily labelled developmental or behavioural rather than mental illness... It often takes a lot of effort to get assessment or input or therapy and then that will be short term if it's given – Paediatrician #7</i> <i>When you're looking for a psychologist for one of our kids, you're looking for someone who's got that experience with trauma... and understands things like reactive attachment disorder... Because there's definitely that gap for therapeutic services – CSO #13</i>
Allied health services	<i>(They) need intense counselling, OT [Occupational Therapy], speech, physio... It takes a very long time to actually provide the service that (they) need quite desperately – Carer #7</i>
Role of private services	<i>(There is a role for private services) particularly in the sphere of things like allied health care... or if there are no suitable public services, or if a child needs to be assessed reasonably urgently for developmental things – Paediatrician #1</i> <i>It's sometimes a struggle when our kids in care get put on these huge waiting lists... We had a little one that was waiting on an ENT... It then got to the point where we actually paid for it to go private... But it becomes a real issue with government funds to be doing that – CSO #5</i>
Role of GPs	<i>(One barrier) is a lack of knowledge from GPs as to what is available and how to access it quickly – GP #1</i>
Navigating the maze: communication and collaboration	
Communication between the Health Service and Child Safety	<i>I think because (the Health Advisor) is on the inside in health, she can actually have those conversations... because quite often we actually can't get to have that conversation – CSO #2</i> <i>It's been really helpful having that face-to-face contact... because sometimes you just want to bounce something off her instead of writing an email – CSO #6</i>
Communication between the Health Service and carers	<i>...a lot better than years ago... treated as part of the cycle – Carer #5</i>

Table 2: Themes continued

Overarching themes / categories	Verbatim data
Working together: coordination, advocacy and support	
Coordination	<i>...chasing up, digging around and organising – Paediatrician #1 (ensuring children) stayed in the system – Paediatrician #3</i>
Advocacy	<i>It gives you a contact where you can actually speak to somebody who knows what they're talking about... For years gone by, you were virtually on your own trying to manoeuvre through the health system to find what was best for your child – Carer #5 (In the past) it was up to me to drive it and to help try and look for specialists and things. Whereas now if I had that same situation, I could speak to someone and say I'm just a bit worried about this little person... and that would almost get fast-tracked – CSO #3</i>
Support for carers	<i>The foster carers... are often just left with this complicated child. They don't have support for who to turn to when things aren't quite working – Paediatrician #9 Giving me that one-on-one help and really sitting down and listening to me.... I can contact (the Health Advisor) anytime if I've got an issue with his health or if I'm not getting support from my doctor – Carer #1</i>

It was unfortunately put to the background because there were so many other things in the forefront – CSO #6

Under the new model, all children are referred to the CPLU on entering OoHC. In addition to the referral form, CSOs also frequently contact the HA to discuss any child they are particularly concerned about. CSOs unanimously reported that having a specific person to contact regarding referrals and concerns was invaluable:

Access has become so much easier... you send her an email, you have a chat to her... and she just really gets things moving on – CSO #10

Additionally, the HA meets with the administrative officers at Child Safety on a weekly basis to ensure that all children who entered OoHC have been referred.

Triaging of referrals to the CPLU

Under the new model, referrals to the CPLU are triaged and allocated for initial assessment by either the HA or a paediatrician, depending on complexity. Children already known to a paediatrician – either within the CPLU or a general paediatrician – remain with this doctor and are not booked for an initial assessment on entering OoHC. The HA refers on for CPLU paediatric review if required:

We're now seeing a much more targeted group since the health care advisor's role – Paediatrician #2

HA assessments and health management plans (HMPs)

Children triaged to have an initial assessment by the HA undergo a screen for medical, developmental, mental health and behavioural issues. A health management plan (HMP) is generated, and referrals made or recommended. These children are then reviewed every 6–12 months, depending on their age, for ongoing monitoring. Where possible, the HA conducts these assessments in the carer's home at a convenient time, such as outside of school hours. This can lead to a more authentic assessment:

It's one less stress factor – it's one less strange place we have to go and attend... they're in their environment so they're behaving more naturally – Carer #1

The new model has served to expedite important treatment:

If you're waiting for that initial diagnosis... it's really hard to put any private services in or anything like that while you're waiting, because you're kind of blind – CSO #3

Didn't that improve once (the Health Advisor) got here? – CSO #6

Yes – CSO #3

It was through (the Health Advisor) that then she put me in touch with other people so that I could have these health checks so that I could go and see a paediatrician – so that I could go and see a behavioural person – a language person – a hearing person – Carer #1

The HA is able to direct referrals more appropriately and ensure that they contain adequate information to meet criteria for a particular service:

It's the ability of (the Health Advisor) to get the information out of us as CSOs that's needed to get it across the line in health – CSO #2

Collation of information and documentation

Carers unanimously reported that lack of background information regarding the children in their care was a significant issue. It was a barrier to caring for them on a day-to-day basis as well as identifying and accessing appropriate healthcare:

We don't really have any knowledge of the parents' health background and things like that. So that's really challenging because there are things that have come up during the journey that we now realise we should have been paying more attention to – Carer #1

When we go to a specialist and they say, were they born on time, what was their birth weight, were they breastfed... we can't answer none of that – Carer #6

As part of the initial assessment, the HA gathers background and collateral information where possible and arranges appropriate screening tests such as vision and hearing. This can be complex and time-consuming, therefore greatly increases the efficiency of the CPLU outpatient clinic and expedites diagnosis and intervention:

Normally, we would see the child as an initial (appointment), then request all that information... In a lot of those cases, we've been able to move forward and make a plan six months earlier – Paediatrician #5

Paediatricians working within the Child Development Service (CDS) saw similar benefits with the new model; however, paediatricians working in general paediatric outpatients continued to find it difficult to collate relevant information regarding children in OoHC:

I spend a lot of time trying to gather information for these children... – Paediatrician #7

Prioritisation

In some hospitals, children in OoHC are automatically triaged a category 1 for outpatient services, which means a specialist consultation is recommended within 30 days. Almost all respondents in this study, across all stakeholder groups, spontaneously advocated for this vulnerable group of children to be given priority access to health assessments and treatment:

I think criteria could be a little bit different for children who are in out-of-home care already... in an ideal world, bypass the waiting list, because they've already been subjected to so much hardship already – CSO #12

These children (should) get the best care as soon as they need it because they've experienced so much emotional trauma, physical trauma – Carer #1

On a positive note, prioritisation of these children sometimes occurs on an informal basis:

Initially on the referral (to the Child Development Service), we might not have found that there are urgent issues to respond to, and then the Health Advisor's contacted us and asked for a higher prioritisation rating – Paediatrician #6

Who's who in that big zoo: key providers of healthcare

There are several key groups who provide healthcare to children in OoHC. Stakeholders' perceptions of their roles were explored in order to provide clarity around the structure and function of the new model within a health system that was often viewed as complex:

Because you do get lost... who's who in that big zoo? – CSO #6

CPLU

As previously identified, all children entering OoHC not previously known to a paediatrician are now referred to the CPLU for initial assessment by either the HA or a paediatrician. Some stakeholders raised the importance of the involvement of a specific child protection service:

There could be nutritional deficiencies, trauma, psychological interventions, which I think is really important to capture in a specialist service – CSO #3

If you've been pulled out of a trauma situation, you need to be able to see someone who has a trauma lens fast to know the appropriate places to link you into, and what you need – Paediatrician #3

Management within a specialist service needs to be weighed up against the capacity of the CPLU to provide this

comprehensive degree of care for all children in OoHC. The CPLU primarily sees children in the acute phase, then refers them back to general paediatrics for ongoing care.

General paediatrics

Children who were known to a paediatrician prior to going into OoHC remain under the care of that paediatrician, and are not seen within the CPLU. This relationship had benefits, including continuity of care:

I've looked after them while they've been in the care of their parents, they've then been moved to foster care, and that foster carer doesn't know as much about their health background as I do – Paediatrician #9

However, some general paediatricians may have had less experience with children in OoHC:

You do notice if our kids see other paediatricians, outside of the child protection system, it's different. Yeah, just less aware of all the factors that are impacting on them – CSO #9

Some paediatricians outlined barriers to managing these children in general paediatric clinic, including time constraints, difficulty gathering information and barriers to accessing a multi-disciplinary team. Reported access to a multidisciplinary team varied according to individual paediatricians across different general paediatric clinic settings:

The barrier is just having that dedicated time and space that's protected to really making sure that we're delving deep into whatever issues these kids might have and what needs to be sorted – Paediatrician #1

There's a lot of psycho-social (issues), and that's the workload... We just don't have access to social work. Which is a real deficit – Paediatrician #8

Mental health services

Difficulties in addressing mental health needs of children in OoHC were raised by members of all stakeholder groups. In part these difficulties are related to the application of strict referral criteria for particular services, and disagreement regarding the role of mental health services in caring for these complex children:

It is not uncommon to seek mental health input for these patients and be denied access to that service because the conditions from a diagnostic perspective are primarily labelled developmental or behavioural rather than mental illness... It often takes a lot of effort to get assessment or input or therapy and then that will be short term if it's given – Paediatrician #7

In other cases, the difficulties are related to lack of availability of appropriate providers:

When you're looking for a psychologist for one of our kids, you're looking for someone who's got that experience with trauma... and understands things like reactive attachment disorder... Because there's definitely that gap for therapeutic services – CSO #13

Some stakeholders advocated that all children entering OoHC should automatically be provided with access to mental health support:

It would be great for any child in out-of-home care to automatically be under a package of nurturing of emotional and mental health needs as part of their general care – Paediatrician #7

Allied health services

Stakeholders almost unanimously raised the issue of timely access to allied health services:

(They) need intense counselling, OT [Occupational Therapy], speech, physio... It takes a very long time to actually provide the service that (they) need quite desperately – Carer #7

There were several contributing factors raised, including delay in the detection of problems due to changing carers, delay in initial assessment and diagnosis, and delays associated with the communication and approval process within Child Safety. Lastly, availability of public outpatient allied health appointments was limited:

We have the Children Development Service now which is really good, doing assessments and telling us what children need. But then it's accessing those things and that's more difficult and costly – CSO #9

Role of private services

The public health system is the main provider of healthcare for this group of children, and was regarded by all stakeholders to be of paramount importance in ensuring optimal health outcomes. Nevertheless, the private system continues to play an important role. CSOs and carers alike raised cost as a significant issue:

(There is a role for private services) particularly in the sphere of things like allied health care... or if there are no suitable public services, or if a child needs to be assessed reasonably urgently for developmental things – Paediatrician #1

It's sometimes a struggle when our kids in care get put on these huge waiting lists... We had a little one that was waiting on an ENT... It then got to the point where we actually paid for it to go private... But it becomes a real issue with government funds to be doing that – CSO #5

Role of GPs

At one stage GPs played a role in completing the initial health and developmental assessments when a child entered OoHC. GPs in this local region were consulted regarding this process¹², reporting it challenging, primarily due to insufficient assessment time and lack of appropriate Medicare rebates. With the introduction of the new model, GPs are no longer being called upon to conduct these assessments.

GPs primarily see children in OoHC for intercurrent illnesses and immunisations as reported by both GPs and carers. However, GPs often provide referrals or coordinate mental health or other care plans which can present challenges. The GPs in this study felt relatively disconnected from the management of these children:

(One barrier) is a lack of knowledge from GPs as to what is available and how to access it quickly – GP #1

Only one of the two GPs interviewed was aware of the HA, and were not aware of the full extent of the role.

Navigating the maze: communication and collaboration

Communication and collaboration were clearly essential factors when facilitating access to healthcare for children in OoHC:

One thing with children in care is that they move placements... unfortunately sometimes information can get lost if Health and Child Safety don't communicate – CSO #6

Communication between the Health Service and Child Safety

CSOs and paediatricians reported difficulties with communication between their services; however, the HA has played a role in improving this process:

I think because (the Health Advisor) is on the inside in health, she can actually have those conversations... because quite often we actually can't get to have that conversation – CSO #2

In addition to aiding transfer of information between the Health Service and Child Safety, the HA also serves to translate health language, procedures and pathways for CSOs:

I think it's her understanding of the health system, because with different government agencies we don't know each other's procedures – CSO #2

In the past, healthcare workers and CSOs rarely met each other face-to-face. The HA visits each of the two local Child Safety offices weekly:

It's been really helpful having that face-to-face contact... because sometimes you just want to bounce something off her instead of writing an email – CSO #6

Communication between the Health Service and carers

The feedback from carers regarding communication from the health service was mixed. One reported that “the system doesn't connect well”, and that this had resulted in children “missing out on vital services” (Carer #7). Another reported that it was “a lot better than years ago” and that they were “treated as part of the cycle” (Carer #5).

Working together: coordination, advocacy and support

The importance of coordination in the healthcare journey of these vulnerable children was raised by all stakeholders. Related to this are the sub-themes of advocacy and support of carers, as often those who have the coordinating role – including understanding the bigger picture of the child, health system and relationships between stakeholders – are in the best position to advocate for the child, and also provide a degree of support to the carers.

Coordination

With stakeholders across different organisations, communication and the flow of information was difficult and could be very time-consuming. The HA has taken on the role of primary coordinator for some of the children in OoHC. She has been more heavily involved in those children who were not previously known to a paediatrician. It has been valuable having a healthcare professional in this coordinator

role, bridging the gap between the health system and the child safety system. Paediatricians reported assistance with “communication” (Paediatrician #1), “chasing up, digging around and organising” (Paediatrician #1) and ensuring children “stayed in the system” (Paediatrician #3) was very valuable. Likewise, the CSOs felt that the HA stopped children “slipping through the cracks” (CSO #12) and was “proactive in providing information and engagement” (CSO #1) and “making sure assessments and referrals are done” (CSO #1). Carers felt that having “one consistent person” (Carer #1) with everyone else “on the same page” (Carer #5) had made a significant difference.

Advocacy

Any parent or carer can have difficulty navigating the healthcare system if their child has complex needs; however, this issue is compounded for non-biological carers who may have only been caring for a child for a short period of time. Not all carers had significant contact with the HA, but those who did saw them as an advocate:

It gives you a contact where you can actually speak to somebody who knows what they're talking about... For years gone by, you were virtually on your own trying to manoeuvre through the health system to find what was best for your child – Carer #5

CSOs also describe having difficulty advocating for children in OoHC in the past. They report this situation has improved since the introduction of the HA role:

(In the past) it was up to me to drive it and to help try and look for specialists and things. Whereas now if I had that same situation, I could speak to someone and say I'm just a bit worried about this little person... and that would almost get fast-tracked – CSO #3

Support for carers

Providing support for carers often goes hand in hand with advocating for children in OoHC. Some carers found it very difficult accessing adequate support. Other stakeholders echoed this issue:

It's the carer that has to deal with that behaviour, with the emotions, but there's no medical or psychological service. I find that's a real big problem – Carer #7

The foster carers... are often just left with this complicated child. They don't have support for who to turn to when things aren't quite working – Paediatrician #9

Carers had varied responses when asked who they would contact if they had healthcare concerns regarding a child in their care. Some would contact Child Safety first, others would go through their carer support agency, and some identified the HA as source of support:

Giving me that one-on-one help and really sitting down and listening to me.... I can contact (the Health Advisor) anytime if I've got an issue with his health or if I'm not getting support from my doctor – Carer #1

Discussion

Children in OoHC frequently have complex healthcare needs.³ In response to national and state recommendations^{10,11}, a new model for the coordination and facilitation of healthcare

was introduced within this regional health service, which included the introduction of the HA position.

There is a paucity of high quality evidence regarding the best models of healthcare for children in OoHC.³ Various models for assessment and provision of healthcare involving GPs¹⁶ or multidisciplinary teams¹⁷ have been described in recent literature. These were found to be unsustainable in our local region, therefore a new model was devised.

The new model has reportedly improved initial access to healthcare by ensuring all children are referred to the CPLU on entering OoHC with processes streamlined to ensure timely review. There is tension between the perceived importance of managing children within a specialist child protection service and the resources this would require. There is currently insufficient CPLU paediatrician availability to see all children entering OoHC, despite CSOs and paediatricians identifying that seeing someone with experience with trauma was very important, as general paediatricians can be “less aware of all the factors that are impacting on them”. A 2019 systematic review of trauma-informed care models in OoHC suggested that provision of trauma-informed practice is likely to result in considerable benefits for these children.³¹ This strain on CPLU resources is somewhat ameliorated by the HA conducting initial clinical assessments, including gathering background information, and then formulating and enacting HMPs. This has expedited access to intervention, as well as improved care efficiency if the children are later seen by a paediatrician.

When analysing stakeholder groups separately, the CSOs were unanimously positive regarding the new model, in particular the HA role. Having someone “on the inside in health” to “bridge the gap” between themselves and the health service, as well as pass on the responsibility of coordination, was reported to be invaluable. These findings support governance of healthcare for children in OoHC by health systems rather than child welfare, and align with the government recommendation to introduce roles such as a “Care Coordinator Health Officer”^{11(p242)} and fit with promising practice models identified in the literature.³

Carer feedback was mixed. A number of barriers to healthcare remain including delays and lack of prioritisation for services and difficulties with information sharing between stakeholders. Very similar barriers were identified in a recent Victorian study which explored the experiences of foster and kinship carers.²¹ In our study, carers who had more contact with the HA reported amelioration of these barriers and more positive experiences regarding accessing healthcare than those who had less contact.

Paediatrician feedback was also mixed. In general, child protection and developmental paediatricians felt the model worked well, whereas general paediatricians raised more barriers in providing healthcare to these children. Issues appeared to be multifactorial, including difficulties gathering information about the children, and difficulties accessing an adequate multidisciplinary team. A recent article published in *Pediatrics*³² discussed similar barriers and frustrations encountered by general paediatricians when endeavouring to coordinate the healthcare of children in OoHC.

The model was designed such that children already managed by general paediatricians retained this doctor as their primary coordinator, and consequently the HA was less likely to take an active role in their care. The difficulties faced by this group of paediatricians reinforces the value of the HA as a coordinator being extended to routinely encompass all children in OoHC.

The GPs in this study felt relatively disconnected from regular management of children in OoHC. Some models rely on GPs, but locally this was found to be challenging.¹² The local findings are consistent with Australian literature which found that while GPs hold continuity of care as a core value, they experienced barriers to caring for these children, including lack of professional development, issues with communication and collaboration, and lack of time and financial compensation.³³ It is important to recognise that these vulnerable children will continue to see GPs; maintaining communication is therefore important to ensure GPs are aware of the existence and role of the HA.

Participants in this study mostly reported positive experiences with the new model. Prioritising access was identified as important by every stakeholder. Improvement in access to mental health and allied health services was a priority for all groups. Providing reliable access to a multi-disciplinary team, including social work, would particularly benefit those children who go on to be managed in a general paediatric setting.

It has become apparent that there is a unique combination of factors that has contributed to the success of this model and the HA role. This combination of coordinator and clinician has added considerable value, allowing the HA to act as an advocate for children with vulnerabilities and as a support for their carers. Important clinical skills include experience in childhood development and trauma. It is also apparent in participant responses that coordinator characteristics of being approachable, reliable, proactive, flexible and accommodating contributed to the success of this role. Building strong, respectful relationships streamlines and improves all facets of access to healthcare for this vulnerable group. This is not surprising, given collaborative practice has been shown by the World Health Organization to be linked to an improvement in health outcomes, as well as patient satisfaction and use of resources.³⁴

Limitations

Consistent with qualitative methodology, there was purposive recruitment of participants and, as such, findings are specific to the local context; however, some transferable aspects may be evident. It is recognised that those who were more engaged with the CPLU were more likely to participate, therefore there is the potential for bias. Children in OoHC were not included as key stakeholders and this is a limitation of the study.

Conclusion

The new model of healthcare facilitation for vulnerable children in OoHC provided numerous benefits, including improved initial access and ongoing coordination of healthcare. Positive stakeholder experience appeared to vary according to the

level of engagement with the HA. Some barriers remain such as poor prioritisation as well as difficulties accessing mental health and allied health services. It is proposed that all children in OoHC would benefit from having a HA as their primary health coordinator, undertaking a dual coordinator and clinical role. This model has the potential to positively impact care delivery to children living in vulnerable situations on a wider scale.

Quantitative data would supplement these findings and would include effects on engagement with the health service – including attendance rates – and time to initial assessment and intervention. Further research on the economic impact of this model, including cost benefits of employing skilled clinicians (such as the HA) to conduct initial assessments in the place of paediatricians, as well as possible costs saved with improved coordination, are warranted. Improvement in long-term health outcomes for these children living in vulnerable situations is the ultimate aim, with potential health and economic benefits for the individual and society.

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Conflicts of interest

The authors have no conflicts of interest to disclose.

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